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RESEARCH ARTICLE

"You have to be street smart": Street capital and the social organisation of risk among people who inject drugs in Norway

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Abstract

This study explores the social organisation of risk among injecting drug users in Norway. Based on qualitative interviews with 80 people who regularly injected drugs, recruited from harm reduction services in five Norwegian cities, the analysis illustrates how users embody various forms of capital in order to mitigate harm. These forms of capital work along three axes that we conceptualise as sociocultural, injecting and structural capital. First, the sociocultural capital highlights how users accounted for a field-specific competence that enabled them to evaluate the trustworthiness of drug dealers, and the quality and purity of the drugs they bought. Second, the injecting capital illustrates the drug-related competence among users, and how they managed their drug use in certain ways to minimise harm. Third, structural capital emphasises how users learned to benefit from various low-threshold agencies and the welfare state. Together, these forms of risk capital illustrate the subtle, and often neglected, forms of capital embedded within marginalised populations and how they 'do' harm reduction in their everyday interactions and drug use. If interventions within this population are to succeed, there is need for a greater awareness of such forms of capital and how these are employed within the social environments in which drug-related risks are organised.

Keywords: Injecting drug use; risk environment; street capital; harm reduction

Introduction

Ecological approaches to public health have illustrated the need to emphasise how social, structural, and physical environments of street-based drug scenes contribute to the production or mitigation of harm (Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005). This insight has led scholars to investigate the complex practices of street life among people who inject drugs (Moore, 2004), and demonstrate how prevention interventions that focus solely on individual behaviour change are not likely to succeed, as they neglect how risks and their perception are context-dependent (Collins, Boyd,

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Cooper, & McNeil, 2019; Rhodes, 1997; Strathdee et al., 2010). In response to critiques of neo-liberal health policies and epidemiological-based objectives, such perspectives rather turn attention to the 'risk environments' in which risk is produced (Rhodes, 2002), and the practical rationality usually embedded within marginalised street cultures (Crawshaw & Bunton, 2009; Sandberg, 2008a). This involves focusing on the people who inject drugs, how they perceive risks and if, or how, they try to avoid them (Rhodes et al., 2001).

In this article, we follow such a tradition and study the social organisation of risk among 80 people who inject drugs, recruited from harm reduction services in five Norwegian cities. The aim is to explore how they account for the risks involved in their drug use and how they relate to such risks in their everyday interactions and drug-using practices. In doing so, we place emphasis on their particular resources and knowledge, in terms of their position within the social system they inhabit, their specific ways of using drugs, as well as the institutional aspects of being an injecting drug user within a Nordic welfare state. Together, these forms of competence constitute a specific capital that users employ to manage the risks associated with injecting drug use. We latterly move to discuss these findings in relation to the concepts of risk environment and street capital.

Open drug scenes and the social organisation of risk

The injecting drug users in this study were to a greater or lesser extent embedded in a street culture that involved drug use, drug dealing and low-level petty crime. As such, they were active participants in open drug scenes, typically defined as '*geographically-bound areas within urban centres characterized by high concentrations of people who use drugs and street-based drug dealing*' (McNeil, Shannon, Shaver, Kerr, & Small, 2014, p. 608). Although two of the cities had drug consumption rooms operated by the local health authorities, a large proportion of injections were still made in public places and shooting galleries (places where drug users congregate to inject and use drugs) (Ouellet, Jimenez, Johnson, & Wiebel, 1991). This elevated the potential health harms of the drug use itself (Rhodes et al., 2007), as well as the potential for structural and environmental violence (Marshall, Fairbairn, Li, Wood, & Kerr, 2008).

Norway has an extensive social welfare system, with various services free of charge for drug users, such as drug treatment, opioid substitution treatment, needle and syringe exchange, drug consumption rooms and widespread distribution of intranasal naloxone (Madah-Amiri, Clausen, & Lobmaier, 2017). In a historical context however, Norwegian drug policy has been characterised as 'schizophrenic' (Skretting, 2014), in its focusing on *both* criminal prosecution and health-related measures for people who use drugs. While this duality has become less pronounced in recent years, moving from a punitive to a more supportive approach (Larsson, 2021), the risk environment of street-based drug scenes in Norway still cause additional harms (Hanoa, Bilgrei, & Buvik, 2024) and the drug-induced mortality is among the highest in Europe (EMCDDA, 2020). This is partly due to a long-lasting culture of injecting poly-drug use (Gjersing & Bretteville-Jensen, 2014; Gjersing & Bretteville-Jensen, 2018), and that many users inject alone (Gjersing & Helle, 2021), thereby reducing the effectiveness of these health-related interventions.

Such local cultures of drug use are often bound by circumstances in which injection drug use is seen as non-exceptional or normalised, and sustained by subjective logics that rationalise risky behaviour (Mayock, 2005). The frequent exposure to injection drug use within such milieus may lead to the construction of acceptable risks, by which users may

see injection as an acceptable, and even desirable, method (Harocopos, Goldsamt, Kobrak, Jost, & Clatts, 2009). Following such insights, Fast and colleagues (2009) argue that the limited effectiveness of interventions that target individual behaviour has led to the development of approaches that rather emphasise the influence of structures, social processes and physical environments of drug scenes in shaping risk among drug-using populations (Rhodes, 2002; Rhodes et al., 2005; Strathdee et al., 1997). Interventions that strive to change the behaviours of individuals are thus likely to fail, because actors find themselves in social power contexts where they are unable to act on that knowledge (Bourgois, Prince, & Moss, 2004). Such ecological approaches therefore shift focus from individual risk factors, to social, political, and economic factors, as well as the importance of physical environments and how they interact with personal characteristics to determine health (Burris et al., 2004).

This framework, often referred to as a risk-environment approach (Moore, 2004; Rhodes, 2002; 2009), shifts the unit of analysis from individual risk behaviour to environments, emphasising the social situations and places in which harm is produced and reduced. As Duff (2010) stresses, this is not to ignore the significance of choice and responsibility, but to emphasise that all drug-use behaviours are mediated by diverse social, political and economic processes. The focus on contexts should thereby help explain how drug-use behaviours are shaped and transformed, and how they are rooted within shared social and symbolic meanings (Duff, 2007). However, such environments cannot be understood in isolation of the practices, interactions and behaviours of those individuals and groups who inhabit these places (Duff, 2010), highlighting an epistemological perspective in which the enabling resources among drug users and their lived experiences are accentuated.

Such perspectives are however scarce within empirical studies of injection drug users (Burris et al., 2004; Moore & Dietze, 2005), and may lead to assumptions that deny the agency of people who inject drugs and that they do not exercise influence over their own health (Olsen, Banwell, Dance, & Maher, 2012). However, an emerging body of literature challenges this assumption and suggests that people who inject drugs employ various strategies to reduce harms (Drumm, McBride, Metsch, Neufeld, & Sawatsky, 2005; Duterte et al., 2001; Nathani, Iversen, Shying, Byrne, & Maher, 2010). The role of social networks and relationships has also been found to promote engagement in harm reduction practices (Kirst, 2009; Kumar, McNeely, & Latkin, 2016; Lafferty, Rance, Dore, Lloyd, & Treloar, 2021). As such, social capital is associated with a range of protective, or health-promoting, resources. Yet, as Duff (2010) argues, '*the challenge is to characterise the unique social resources associated with this capital and the diverse ways these resources are produced and accessed*' (p. 340). While the concept of social capital usually includes forms of obligations and expectations, information flow and norms (Coleman, 1988) that in turn may promote more protective, drug-related behaviours (Kirst, 2009), we will in the following delineate the concept of street capital (Sandberg, 2008b; Sandberg & Pedersen, 2009), and how it may help inform an analysis of the social organisation of risk among people who inject drugs.

Injecting drug use and street capital

As Moore (2004) argues, open drug scenes are often characterised as seemingly 'chaotic' practices. However, for those involved, there are usually specific rules and rituals that guide the interaction. These may provide symbols of group membership, emotional energy, and

group solidarity (Duck & Rawls, 2012; Grønnestad, Sagvaag, & Lalander, 2020; Sandøy, 2015), and highlight the skills that help drug users navigate and participate within street-based drug scenes. As Bourgois (2003) argues, such knowledge involves '*[a] web of beliefs, symbols, modes of interaction, values and ideologies that have emerged in opposition to exclusion from mainstream society*' (Bourgois, 2003, p. 8), and helps form an alternative forum for personal dignity. Similarly, Anderson's (1999) conceptualisation of the 'code of the street' and being 'streetwise' follows from the same tradition in emphasising the competence and skills necessary to manage life on the streets.

More contemporary scholars have elaborated on the works of Bourgois (2003) and Anderson (1999), and emphasise that street culture should be analysed as a social system with its own values, rules and regulations. Ilan (2015) defines street culture as the '*values, dispositions, practices and styles associated with particular sections of disadvantaged populations*' (p. 8). Similarly, Sandberg (2008b) argues that street culture demands particular resources, knowledge, and that it has its own rationale. These skills, referred to as 'street capital', place emphasis on the embodied character of such cultural knowledge, the importance of early socialisation, and the practical rationality involved (Sandberg, 2008a). As such, this sort of competence, or habitus, is a result of repeated interactions that work to determine the practices, actions and responses within specific fields (Crawshaw & Bunton, 2009). Stemming from Bourdieu's (1985; 1991) theoretical framework, the concept of street capital thus highlights how the social space of the streets is founded on various kinds of capital that actors possess – it emphasises the relative positions of individuals within a social system, dependent on the amount of capital they have at their disposal, which in turn has the capacity to generate profit (Sandberg, 2008b). However, the notion of street capital differs from that of cultural capital, because it is difficult to transfer to other social arenas (Grundetjern & Sandberg, 2012). Still, it is a form of field-specific power among those structurally oppressed, as they have little to lose within mainstream society (Sandberg & Pedersen, 2009).

This perspective thus emphasises the importance of the *field* of the streets, highlighting the social domain in which these resources are situated, their agonistic nature and the complex set of resources and dispositions that allows for the accumulation of street capital (Shammas & Sandberg, 2016). Importantly, it is sensitive to the contextual space both within and between fields. It therefore helps illuminate the influence of structures, social processes, and physical environments, and how they interact (Burris et al., 2004; Moore, 2004; Rhodes, 2009). Especially for the current empirical case, our theoretical framework helps broaden the levels of analysis and illuminate the differing forms of capital that users employ to manage the risks associated with their drug-using practices.

Methods

The article is based on qualitative interviews with 80 people who, at the time of the research, regularly injected drugs and who were recruited from harm reduction services in five Norwegian cities. Our aim was to explore how they account for the risks involved with their drug use, and how they relate to these risks in their everyday interactions and drug-using practices. Such a perspective is important in order to demonstrate the often-neglected forms of capital embedded in street-level cultures and the various ways in which these resources may influence the drug-using practices of those involved.

During October 2019, the authors and two trained research assistants conducted the interviews, arranged in collaboration with low-threshold services in Oslo, Bergen, Stavanger, Sandnes and Trondheim. The term 'low-threshold' usually refers to harm reduction services that seek to reduce the health and social harms of drug use (Edland-Gryt & Skatvedt, 2013). In this study, two of the low-threshold services (Oslo and Bergen) included a drug consumption room, while the remaining sites covered services such as health and social care, needle exchange programmes, shelters and serving of food. Prior to our visits, we established contact with personnel at the low-threshold services, informing them about the research project and encouraging them to inform their clients about our visit. All services were positive and supportive, and helped facilitate contact with their clients.

Participants were recruited randomly by asking clients at the various premises, in addition to some that was facilitated by staff at the harm reduction services. Each participant was informed about the overall goal of the project, issues related to anonymity and how we would treat the data after the interviews. All participants were offered 200 NOK (approximately 20 €) for their time and we conducted the interviews within the premises of the low-threshold services, to facilitate an easy participation. The interviews were however conducted in separate rooms, sheltered from the other facilities. We emphasised that we did not represent the health services, but rather that we were researchers, curious to learn about their drug-using practices.

The interviews lasted approximately 40 minutes and we used a semi-structured guide with questions related to the participants' drug use, use of drug-related health services, views on drug-related risks and issues related to life on the streets, such as participation in drug markets, financial income, and socio-spatial aspects of the local drug scenes. The interviews were centred around open-ended questions and we encouraged the participants to speak freely. Rather than introducing specific questions about drug-related risks, we asked participants to reflect on issues they themselves consider as relevant. This allowed for an increased emphasis on the everyday lived experiences of the interviewees, how they perceived drug-related risks and if, or how, they tried to avoid them. We used digital audio-recorders during the interviews, wrote field notes about informal observations within the various harm reduction services, and discussed our impressions of the interviews at nearby cafes after the sessions. This process helped facilitate discussions about the quality of the interviews and assess whether any changes should be implemented during the data collection, as well as systematise the initial interpretation of the data and thus inform the later analysis.

The mean age of the interviewees was 45 years and 23 per cent were female, reflecting the overall composition of people who inject drugs in Norway (Gjersing & Bretteville-Jensen, 2018). Participants were recruited from Bergen ($n = 22$), Oslo ($n = 20$), Trondheim ($n = 20$), Sandnes ($n = 10$), and Stavanger ($n = 8$). Most had a long history of illicit drug use and more than 70 per cent were poly-drug users, injecting heroin and/or amphetamines, and consuming benzodiazepines on a daily basis. The remaining participants reported either heroin or amphetamines as their main drug of choice. Almost one in three told that they had an unstable housing arrangement during the time of interview, such as shelters for people without a permanent residence. Half of the participants rented apartments provided by the local municipalities, and the remaining sample lived together with partners or acquaintances or provided unclear information on their current housing arrangements.

Audio recordings from the interviews were transcribed verbatim, imported into the qualitative analysis software HyperResearch and coded thematically, reflecting the initial interview guide, as well as several codes based on the interviewees' own narrative emphases. One quarter of the interviews were coded independently by two of the authors, to ensure sound interpretation and shared understanding of the data. For this specific article, we made especial use of codes such as 'buying drugs', 'learning to inject', 'income', 'use of low-threshold services' and 'how to avoid risk'. In doing so, we systematised the participants' accounts and grouped them according to the relevant themes. This process helped illuminate stories of drug-related risks, how they were managed, and the various fields in which their street capital was accessed and utilised. Our study thereby highlights how the injecting drug users embody a certain capital to manage risks at different levels of social life and how they were utilised to achieve separate objectives.

Although the study is based on a substantial number of qualitative interviews with people who inject drugs, the findings reflect the Norwegian context alone and may not be generalisable to other contexts. Additionally, the final sample consisted of people who were already in contact with the various harm reduction services, and we may therefore have missed out on the views of people without established contact with these services. We use pseudonyms and all identifying factors have been removed. The project was approved by the Regional Committee for Medical and Health Research Ethics in Norway (ref.nr. 1206091).

Findings

Bjørn was in his late thirties when we met him in the local drug consumption room. He was a poly-drug user and injected heroin several times a day. During the interview, he recounted that he spent most days on the streets, without any place to live, trying to raise money for his daily fix. When asked about his first encounters with the streets, he reflected ambiguously:

> I've learned the hard way, you know. It's quite a cynical milieu. When I started out on the streets, I was very naïve. It takes a few years before you learn the codes. The longer you've been a part of it, the more enlightened you become, you know. So, after ten years, I kind of know what to do.

Bjørn's account was indicative of the stories we were told in this study. Life on the streets was tough and the injecting drug users were managing several risks on a daily basis. In addition to the imminent risks of overdoses and infectious diseases, they also had to navigate and deal with the risks related to the illicit drug economy and the social life of an open drug scene, and how to manage the rules and expectations of the various harm reduction services that operated on the streets. In order to do so, they had to develop and manage certain skills in order to succeed.

Our analysis shows how the interviewees, over time, embodied several risk-reducing strategies that helped mitigate harm. These strategies worked along several dimensions and illustrated the various forms of capital that were needed to cope with the life on the streets as an injecting drug user. We conceptualise these as chiefly pertaining to socio-cultural, injecting and structural capital. Together, these strategies expose the subtle, and often neglected, forms of capital embedded within marginalised populations, and help us grasp how these interviewees 'do' harm reduction in their everyday interactions and drug use.

Sociocultural capital

During the interviews, we asked users to portray a regular day in their lives. Usually, this involved hanging out in the city centre, meeting peers, picking up clean user equipment and, most importantly, buying drugs. On the streets, money moved quickly and the market could seem chaotic. However, there was more to these social dynamics and the interviewees explained how they operated in a seemingly hostile and mendacious drug scene. Kjell, who injected morphine and occasionally amphetamine, explained that: '*there's always a lot of people who are trying to hustle and sell you shit, so you have to be street smart. You gotta know the right people, who they are and what kind of stuff they're selling'*.

The illicit nature of the street drug markets, and their lack of regulations caused uncertainty among users, and could involve risks by purchasing adulterated drugs. As Kjell described, it was easy to be scammed, and certain skills were required in order to manoeuvre the potential pitfalls of such a market. Gunnar, who injected heroin, described the process in more detail:

> I've used drugs for quite a few years now and it really takes some time to find someone you trust, you know. Now I have some regulars that usually hook me up. However, if I were to buy from someone I didn't know, I would obviously look at it and smell it, and all that (. . .) Over time, you get to know the trade and what to look out for.

As Gunnar elaborated, the best way to avoid scammers was to establish a relationship with a dealer and buy from a somewhat trusted source. Relationships were however fragile and most of the users stated that trust was scarce within the street-based drug economy. As Hanne explained, '*I don't trust anybody in the milieu 100 per cent'*, thereby highlighting the level of uncertainty and lack of trust between participants. However, the users seemingly cooperated in evaluating the street-dealers and reputations circulated quickly. Synne, a female heroin user, explained:

> I always try to find someone I know. Someone I've bought from before or those who have a good reputation, by word of mouth. If there's any newcomers, I'm always really sceptical. They can be undercover, you know, pigs [slang for police officers].

As Synne described, members of the street-based drug market cooperated and shared advice on which dealers to trust. This evaluation concerned both the quality of drugs, as well as the dealers themselves and thereby helped minimise the potential of being swindled. Several scholars have emphasised similar mechanisms and argue that such interactions may help create group solidarity, in which members of street-based drug scenes develop their own set of rules and rituals, which also includes levels of intimacy and care (Grønnestad et al., 2020; Sandøy, 2015).

In addition to the interactional aspects, in which users cooperated in minimising the potential harms involved with the street-based market, users also developed skills in order to evaluate the drugs they bought. This field-specific competence involved assessing the drug's quality, due to fear of adulterants. As Trygve said, '*there's a lot of dealers cutting their shit, you know. I remember that some used sugar, and then, when fixing it up, it was just like . . . tsjjj, nothing.* Therefore, the users developed ways of assessing its quality, based on issues of taste, looks, feel and smell. Anne explained: '*I always take a good look at it and smell it. I can easily tell if there's anything wrong or if it's cut with something*'. Asbjørn elaborated further:

> Sometimes I also smell and taste it, just to be sure (…) just take your little finger into the bag and it should taste really bitter and disgusting and … ugh, yuck! Yeah, I know how amphetamine should taste, that's for sure.

Several of the participants told similar stories and explained that they assessed the drug-quality based on various cues they had learned over time. This involved a certain 'know-how' and, as Fredrik said, one had to *'be part of the game for a long time in order to know'*, thus demonstrating the embodied nature of such a capital.

For the street-based drug users, these skills worked as a sort of sociocultural capital and show how they developed certain ways of interacting with their social relationships to prevent harms from the illicit drug market. As Sandberg (2012) argues, it is 'the code of the street' or 'street capital' that applies within public drug markets. Similarly, the users in this study developed skills based on previous experiences, as well as advice from other users, that guided their ways of interacting within a milieu characterised by violence and lack of trust. These skills involved an assessment of the credibility of dealers and an experience-based knowledge that enabled them to assess the quality of the drugs they were offered, thereby reducing the potential risks stemming from such a market.

Injecting capital

In addition to the sociocultural capital that users developed, they also had to master several skills related to the drug use itself. This was perceived as important to reduce the risks of overdoses, infections and blood-borne diseases. As such, these practical skills involved specific ways of consuming drugs that sought to manage the risks involved in their injecting practices. However, when initiating their injecting drug use, many recounted that they were scared of the needle and asked friends for help. Christina described how: '*I thought it was so scary and I was scared to miss, you know (…) so, I got someone else to do it'*.

Several interviewees had similar stories and it was common for more experienced users to help perform the first injection, although it was associated with ambivalence. Joakim explained that '*it's the moral, you know, you don't do the virgin shot. If people find out, your reputation is shattered. You don't wanna be the guy who causes anyone to get hooked on the needle*'. However, most of the interviewees said that they had helped others inject and Synne explained that she did not '*like injecting others, but I prefer it to watching someone stab themselves to death'*, thereby demonstrating the duality associated with injecting on peers. On the one hand, it was associated with transgressing the norms within the scene, especially if it concerned a newcomer. On the other hand, it was also a sign of care, explained as reducing the potential risks associated with injecting. Gunnar explained:

> I don't like it, but if someone has been sitting there for half an hour without hitting the vein, I feel sorry for them and want to help. I would help and shoot up in their neck or on the back of the arm.

Over time, the users said that they learned to master the necessary skills in order to inject. Some even referred to themselves as '*doctors*', '*nurses*' or

'*anaesthesiologists*', due to their perceived high levels of competence. Christina, who was initially scared of injecting, said that '*after some time it was just like swimming*'. As such, the practical knowledge concerning their injecting practices evolved over time, based on experience and advice from other users, and involved several measures they presented as critical for mitigating harm. Jørgen explained how he learned to inject:

> I asked those who were older than me and I was so curious all the time. Like, how much should I use, can I do it like this, should I boil it, for how long, should I filter it? All these questions, you know. I got some advice and now I know the optimal way of doing it (. . .) If you do it right, keep it clean and don't overdose, it's really not that bad. When you've been using for a while, you get more focused and more hygienic.

As Jørgen explained, advice from other users seemingly helped reduce the risks of infectious diseases and overdoses. Over time, he also developed specific ways of injecting based on previous experience. These involved technical skills, which were usually detailed and comprised numerous steps. He said: '*It's like a ritual. All these details, everything needs to be in the right place and in the correct order*'. Marte elaborated:

> With heroin, you need a cup to cook it and a neutralizer. It usually come as a rock, so you need a chemical reaction. You need heroin, water and ascorbic acid, if not, you can keep cooking until you see the grim reaper, you know, nothing happens. But when you get all that; bring it to the boil, filter it, fill the syringe and cool it, then you need to find a vein.

The interviewees described similar methods when preparing their drugs and, to varying degrees, took measures to mitigate harm. Marte explained that she was more careful when injecting alone: ' *. . . then I usually snort some of it first. It gives me a sense of the quality, the strength and all that, so that I can adjust the dosage*'. Asbjørn took similar measures and said that he was cautious when unsure of the potency of the drugs: '*if I don't know the quality, I usually split it in two'*. As such, they developed skills that helped reduce the potential negative consequences of their drug use. However, they also followed specific lines of conduct when performing the actual injection. As Hanne noted, '*you always have to shoot in dark blood*'. This technique, referred to as the '*blood-response'*, was deemed to be an important step for reducing harm. Dag explained:

> It means that you gotta see the blood, and it must be dark. If the blood's bright, you need to pull it out, because that can be dangerous. You should try to use big veins, that's easier. Then you just stick it in, pull the pump slightly back and then it should respond, you know, you should see the blood floating into the syringe.

In the above quotes, the interviewees described practical skills to minimise the risk of blood-borne infectious diseases and overdoses. Importantly, this form of injecting capital was the result of repeated practice, as well as advice from fellow drug users, leading to an embodied form of capital. Without hesitation, the participants described how to perform a perceived safe and effective injection – it was thus within their habitus, an individual system of dispositions that were produced by their historical and social conditions (Crawshaw & Bunton, 2009; Sandberg & Pedersen, 2009). This practical sense was the product of many years of participation in the street-based drug scene and involved skills that sought to reduce the risks involved in their injecting practices.

Structural capital

Although the interviewees had developed several skills to help minimise potential drug-related harms, they were still reliant on the surrounding structures to facilitate such practices. These structures involved harm reduction services and the various organisations that operated on the streets, seeking to help those in need, as well as the wider welfare benefits that provided users with financial support. Most participants spoke positively about the various services that were offered and described them as enabling a safer injecting practice. Marte talked about the easy access to user equipment in positive terms:

> The ambulant team, they come every Thursday and it's so nice. I can deliver my used stuff and I get new ones in return. It's maybe an exaggeration, but I think I have more than 500 clean needles in my drawer, in different sizes and all. If anyone falls short, they can just get it from me, because I never use the same needle twice.

Marte's story highlighted the harm reduction services' role in reducing the flow of contaminated equipment. Several interviewees echoed Marte and argued that the harm reduction structures helped facilitate a safer injecting practice. As such, the practical support provided to the injecting drug users were seemingly abundant. However, these were accompanied by rules and regulations that users had to comply with. The participants therefore had to develop certain practices and learn how to take advantage of the various services. This also included bending the rules of conduct in order to maximise their benefits. Olav explained how he manoeuvred around the regulations at the drug consumption room he frequently visited:

> They usually ask you to split the dose. So basically, you want to build a good reputation, in order not to be expelled. I usually tell them that I'm going to shoot up less than I actually do.

Several of the interviewees recounted similar stories, and the presence of healthcare personnel within the drug consumption rooms seemingly altered the injecting practice, towards patterns of drug use which involved greater risk-taking. Petter explained:

> Luckily there's a drug consumption room here (…) I've had an overdose here a couple of times and they always helped me out. But I guess people can be a bit reckless when they shoot up here, because they know that they'll get help.

Similarly, Roger told that he '*wouldn't shoot up in the same way at home as in the drug consumption room, I would rather split the dose*', indicating that some users were less cautious when injecting in the drug consumption room, due to the presence of and prompt response from the healthcare personnel.

In addition to daily encounters with the various harm reduction services, the interviewed users were also reliant on the welfare state in terms of economic benefits. All interviewees experienced economic restraints and said that they received some sort of financial assistance. However, to receive such benefits, they needed to navigate the welfare system and know how to make the most of their disadvantaged status category. Martin explained how he had tried to have his financial benefits increased for years:

> I have work assessment allowance, but I'm trying to get disability benefit. There's been so many rounds, all of these agencies and what not, just to get enough to cover subsistence and rent. It's a really tiresome job.

Within these accounts, the users expressed lack of trust and characterised negotiations with the welfare system as a struggle. Importantly, and in stark contrast to their presentations as skilful drug users, these stories rather highlighted their disadvantaged state, and involved a certain structural capital that helped maximise their potential benefits. Similar findings have been made in other studies, and highlight some drug users' experience and related competence within institutional systems and their developing capital in learning how to navigate, negotiate and present themselves in ways deemed 'appropriate' by the street-level bureaucrats they encountered (Smith-Solbakken & Tungland, 1997). As such, this sort of capital involves the ability to present oneself as 'deserving' to neo-liberal welfare organisations where moral binaries have become central, and to speak the language of the system (Sandberg & Pedersen, 2009). According to Martin, this involved '*the oldest trick in the book*' and emphasised his skills in manoeuvring and navigating the welfare system to his own advantage: '*Now, I have a good place to live. 55 square metres. Very lucky. That's because I know my way around, you know*'. Similarly, Anders received work assessment allowance and described how he skilfully managed the rules of the welfare state:

> It's quite funny that you ask [about income], because I've had work assessment allowance for seven years now and that's something special. It's only allowed to have it for three years. You also have to submit an activity report, but I have a guardian who does it for me, and that's not allowed either.

These stories show how the participants in this study, on the one hand were skilful drug users and manoeuvred the illicit economy with ease. On the other, they were marginalised clients of the welfare system and in need of help. As such, their disadvantaged state became a ticket to prescription drugs, treatment and money (Sandberg & Pedersen, 2009; Smith-Solbakken & Tungland, 1997). However, this sort of structural capital required effort, systemic knowledge, and perseverance. Jørn explained how he received legal aid to maximise his financial benefits: '*I get regular social benefits, but I talked to a lawyer and he said that I'm entitled to disability benefits, so that's what I'm working towards*'.

The structural capital exemplified in the above quotes highlights how the injecting drug users learned to take advantage of the various harm reduction and welfare services that were offered, including how to bend the rules of conduct to maximise their benefits. This sort of capital also involved systemic knowledge and the ability to present themselves as victims, in need of help. In contrast to their self-presentation as skilful drug users, this sort of street capital involved a different set of embodied knowledge that rather focused on their ability to navigate as an injecting drug user within a Nordic welfare state.

Discussion

By focusing on the social organisation of risk, we have emphasised the specific resources and knowledge of our participants, both in terms of their position within the social system they inhabited, their specific ways of doing drugs, as well as the institutional aspects of being an

injecting drug user. Drawing on extensive qualitative data from five cities across Norway, we found that the interviewees developed certain lines of conduct to minimise the risks involved in their injecting drug use and their participation within open drug scenes. These harm reduction practices sat alongside related practices, similarly grounded in experiential knowledge, pertaining to accessing benefits from a relatively expansive yet complex set of welfare state provisions. Combined, these forms of risk capital involved the embodiment of a set of field-specific resources that sought to mitigate harms from their drug use and the risk environments in which they participated.

Our analysis highlights the three domains of sociocultural, injecting and structural capital as important. First, the sociocultural capital involved their ability to manoeuvre the street-level drug economy, cooperate, build relations and ultimately, assess the drug quality based on smell, taste and looks. Second, the injecting capital highlights how they developed ways of injecting to reduce the risks of infectious diseases and overdoses. Finally, the structural capital comprised the participants' ability to take advantage of various low-threshold agencies and the welfare state. These insights illustrate the various fields in which their capital was utilised and how they drifted between ways of self-presenting to accumulate profit. As such, the participants not only developed forms of capital that were valid on the streets, but they also embodied a repertoire of conduct for facing the structural barriers of a Nordic welfare state.

The framework and approach outlined in this article highlights the cultural logics involved in street-based drug scenes and how the participants developed practices to mitigate harms. Conceptualised as risk capital, we emphasise the streets as a particular field (Shammas & Sandberg, 2016), with its unique sets of rules and regulations (Grønnestad et al., 2020; Sandøy, 2015), that allowed for the acquisition and distribution of a field-specific capital (Sandberg, 2008a; 2008b; Sandberg & Pedersen, 2009). Importantly, this sort of embodied competence, or habitus, was a result of a field-bounded existence within the drug scenes (Shammas & Sandberg, 2016), which had transformative effects that enabled participants to grasp the 'logic of practice' within the risk environments they inhabited (Crawshaw & Bunton, 2009). Accumulated over time, these resources, skills, and dispositions thus provided the participants with knowledge that enabled them to partake in the street-based drug scenes as competent members, as well as concrete courses of actions that sought to minimise the potential negative consequences of their drug use. Importantly, this form of capital also highlights the interplay between individuals, the actions of other individuals, their communities and social environments in defining risk (Rhodes, 1997).

Echoing arguments by key theorists such as Beck (1992) and Douglas (1992), our analysis has shown how definitions of risk are subject to negotiations. The participants' accounts of their practices in this study must therefore not be seen as based upon differential judgements of risk, necessarily, but rather within the context of lifeworld's that deviated greatly from that of the 'expert' risk assessor (Fox 1999). The participants' level of risk capital thus illustrates how street-level drug use should be understood and analysed in conjunction with the practices, interactions and behaviours of the individuals and groups who inhabit these places (Duff, 2010). Individual risk perceptions were therefore mediated by social norms about what risk is and arise from the interplay of social factors exogenous to individuals themselves (Rhodes 1997). As Crawshaw and Bunton (2009) argues, this sort of risk management involves the often unconscious practices carried out within a particular habitus, '*as they are integrated seamlessly with past and present experience and by-pass conscious evaluation*' (p. 272). Therefore, by

focusing on the social situations and places in which harm is produced and reduced (Moore, 2004; Rhodes, 2002; 2009), such an approach might help illuminate the often-neglected resources and dispositions that develop through interaction within street-based drug scenes, and how these may affect the drug-using practices of those involved.

Several studies have explored similar harm reduction strategies among people who use drugs, especially considering the recent surge in fentanyl-related overdoses in North America (Ciccarone, 2017). Due to persistent adulteration of heroin with synthetic opioids, users in these studies adapted various practices, seeking to minimise drug-related harms, such as using test shots, or smaller doses of drugs to gauge potency, relying on trusted dealers, snorting and tasting the drugs, using fentanyl test strips, and carrying naloxone and/or using in the company of others (Bardwell et al., 2019; Carroll, Marshall, Rich, & Green, 2017; Mars, Ondocsin, & Ciccarone, 2018a; 2018b; McKnight & Des Jarlais, 2018). However, studies also indicate an inconsistent application of these overdose prevention methods, due to structural factors such as stigma, poverty and homelessness (Bardwell et al., 2019; McKnight & Des Jarlais, 2018). As such, the social, cultural and economic realities of people who inject drugs may undermine or hinder the successful adoption of overdose prevention strategies (Moore, 2004). As Moore and Fraser argue (2006), '*the notions of "agency", "empowerment" and "responsible drug use" may have little impact if they are not accompanied by policy and practice that attempts to address the political – economic conditions that contribute to the marginalisation of drug users*' (p. 3041).

Insights drawn from the current study may however illustrate potential avenues for harm reduction, developed in close cooperation with those in need. The concept of risk capital, as developed in this article, is sensitive to the contextual and cultural circumstances of risk, in which the distribution of various forms of capital affect health (Lovell, 2002). Similarly, street capital can be a fruitful concept to capture some of the tension between structure and agency among people who inject drugs. As Sandberg (2008b) argues, street culture can be seen as the external structure, while street capital is the structure within the actor, enabling different individual strategies while being structurally limited (p. 157). This invites greater attention towards the social, cultural, and economic marginalisation of street-based drug users (Moore, 2004), and the variety of factors that interact to increase or reduce the chances of drug-related harms (Rhodes, 2002; 2009). As Duff (2003) argues, more effective health promotion should seek to complement and reinforce the range of risk management practices that already exist within drug using populations. Future interventions should therefore build upon the capital developed among the people who inject drugs themselves. In contrast to a top-down perspective, this involves utilising the synergy between actor-based agency and harm reduction measures to a greater extent. However, such individual-based measures will not succeed without adequate structural adaptations. Findings from our study illustrate the need to assess the feasibility of drug checking programmes and measures to access to unadulterated drugs, as well as emphasising a continued development of drug consumption rooms, economic aid for people who use drugs, and harm reduction services that counteracts stigmatising attitudes.

Conclusion

In this study, we have illustrated the embodiment of a field-specific capital that were employed to mitigate risks among a large group of people who inject drugs. Based on

insights from different levels of social life – relational, practical, and structural – we have highlighted the importance of an analysis that is sensitive towards the lived experiences and practices of those under study. Conceptualised as risk capital, this framework illustrates the often-neglected forms of capital embedded within marginalised populations and how they 'do' harm reduction in their everyday interactions and drug use. If interventions within this group are to succeed, there is a need for greater awareness of such forms of capital and the social environments in which drug-related risks are organised.

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References

Anderson, E. (1999). *Code of the street: Decency, violence, and the moral life of the inner city*. W. W. Norton & Company, Inc.

Bardwell, G., Boyd, J., Arredondo, J., McNeil, R., & Kerr, T. (2019). Trusting the source: The potential role of drug dealers in reducing drug-related harms via drug checking. *Drug and Alcohol Dependence*, *198*, 1–6. https://doi.org/10.1016/j.drugalcdep.2019.01.035

Beck, U. (1992). *Risk Society: Towards a New Modernity*. London: Sage.

Bourdieu, P. (1985). The social space and the genesis of groups. *Theory and Society*, *14*(6), 723–744. https://doi.org/10.1007/BF00174048

Bourdieu, P. (1991). *Language and symbolic power*. University Press.

Bourgois, P. (2003). *In search of respect: Selling crack in El Barrio*. Cambridge University Press.

Bourgois, P., Prince, B., & Moss, A. (2004). The everyday violence of hepatitis C among young women who inject drugs in San Francisco. *Human Organization*, *63*(3), 253–264. https://doi.org/10.17730/humo.63.3.h1phxbhrb7m4mlv0

Burris, S., Blankenship, K. M., Donoghoe, M., Sherman, S., Vernick, J. S., Case, P., Lazzarini, Z. & Koester, S. (2004). Addressing the "risk environment" for injection drug users: The mysterious case of the missing cop. *The Milbank Quarterly*, *82*(1), 125–156. https://doi.org/10.1111/j.0887-378X.2004.00304.x

Carroll, J. J., Marshall, B. D., Rich, J. D., & Green, T. C. (2017). Exposure to fentanyl-contaminated heroin and overdose risk among illicit opioid users in Rhode Island: A mixed methods study. *International Journal of Drug Policy*, *46*, 136–145. https://doi.org/10.1016/j.drugpo.2017.05.023

Ciccarone, D. (2017). Fentanyl in the US heroin supply: A rapidly changing risk environment. *International Journal of Drug Policy*, *46*, 107–111. https://doi.org/10.1016/j.drugpo.2017.06.010

Coleman, J. S. (1988). Social capital in the creation of human capital. *American Journal of Sociology*, *94*, S95–S120. https://doi.org/10.1086/228943

Collins, A. B., Boyd, J., Cooper, H. L., & McNeil, R. (2019). The intersectional risk environment of people who use drugs. *Social Science & Medicine*, *234*, 112–384. https://doi.org/10.1016/j.socscimed.2019.112384

Crawshaw, P., & Bunton, R. (2009). Logics of practice in the "risk environment. *Health, Risk & Society*, *11*(3), 269–282. https://doi.org/10.1080/13698570902906447

Douglas, M. (1992). *Risk and Blame: Essays in Cultural Theory*. London: Routledge.

Drumm, R. D., McBride, D., Metsch, L., Neufeld, M., & Sawatsky, A. (2005). "I'm a health nut!" street drug users' accounts of self-care strategies. *Journal of Drug Issues*, *35*(3), 607–629. https://doi.org/10.1177/002204260503500311

Duck, W., & Rawls, A. W. (2012). Interaction orders of drug dealing spaces: Local orders of sensemaking in a poor black American place. *Crime, Law and Social Change*, *57*(1), 33–75. https://doi.org/10.1007/s10611-011-9353-y

Duff, C. (2003). The importance of culture and context: rethinking risk and risk management in young drug using populations. *Health, Risk & Society*, *5*(3), 285–299. https://doi.org/10.1080/1369857031000160698 7

Duff, C. (2007). Towards a theory of drug use contexts: Space, embodiment and practice. *Addiction Research & Theory*, *15*(5), 503–519. https://doi.org/10.1080/16066350601165448

Duff, C. (2010). Enabling places and enabling resources: New directions for harm reduction research and practice. *Drug and Alcohol Review*, *29*(3), 337–344. https://doi.org/10.1111/j.1465-3362.2010.00187.x

Duterte, M., O'Neil, S., McKearin, G., Sales, P., Murphy, T., & Murphy, S. (2001). Walking the tightrope: Balancing health and drug use. *Journal of Psychoactive Drugs*, *33*(2), 173–183. https://doi.org/10.1080/02791072.2001.10400482

Edland-Gryt, M., & Skatvedt, A. H. (2013). Thresholds in a low-threshold setting: An empirical study of barriers in a centre for people with drug problems and mental health disorders. *International Journal of Drug Policy*, *24*(3), 257–264. https://doi.org/10.1016/j.drugpo.2012.08.002

EMCDDA. (2020). *European drug report 2020: Trends and developments*. Publications Office of the European Union.

Fast, D., Small, W., Wood, E., & Kerr, T. (2009). Coming 'down here': Young people's reflections on becoming entrenched in a local drug scene. *Social Science & Medicine*, *69*(8), 1204–1210. https://doi.org/10.1016/j.socscimed.2009.07.024

Fox, N. J. (1999). Postmodern reflections on 'risks', 'hazards', and life choices. In Lupton, D. (Ed.). *Risk and Sociocultural Theory: New Directions and Perspectives*. Cambridge: Cambridge University Press

Gjersing, L., & Bretteville-Jensen, A. L. (2018). Patterns of substance use and mortality risk in a cohort of 'hard-to-reach' polysubstance users. *Addiction*, *113*(4), 729–739. https://doi.org/10.1111/add.14053

Gjersing, L., & Bretteville-Jensen, A. L. (2014). Gender differences in mortality and risk factors in a 13-year cohort study of street-recruited injecting drug users. *BMC Public Health*, *14*(1), 440. https://doi.org/10.1186/1471-2458-14-440

Gjersing, L., & Helle, M. K. (2021). Injecting alone is more common among men, frequent injectors and polysubstance users in a sample of people who inject drugs. *Substance Use & Misuse*, *56*(41), 2214–2220. https://doi.org/10.1080/10826084.2021.1981388

Grønnestad, T. E., Sagvaag, H., & Lalander, P. (2020). Interaction rituals in an open drug scene. *Nordic Studies on Alcohol and Drugs*, *37*(1), 86–98. https://doi.org/10.1177/1455072519882784

Grundetjern, H., & Sandberg, S. (2012). Dealing with a gendered economy: Female drug dealers and street capital. *European Journal of Criminology*, *9*(6), 621–635. https://doi.org/10.1177/1477370812453103

Hanoa, K., Bilgrei, O. R., & Buvik, K. (2024). Injecting alone: The importance of perceived safety, stigma and pleasure for solitary injecting. *Journal of Drug Issues*, *54*(1), 74–89. https://doi.org/10.1177/00220426231151377

Harocopos, A., Goldsamt, L. A., Kobrak, P., Jost, J. J., & Clatts, M. C. (2009). New injectors and the social context of injection initiation. *International Journal of Drug Policy*, *20*(4), 317–323. https://doi.org/10.1016/j.drugpo.2008.06.003

Ilan, J. (2015). *Understanding street culture: Poverty, crime, youth and cool*. Palgrave Macmillan.

Kirst, M. J. (2009). Social capital and beyond: A qualitative analysis of social contextual and structural influences on drug-use related health behaviors. *Journal of Drug Issues*, *39*(3), 653–676. https://doi.org/10.1177/002204260903900309

Kumar, P. C., McNeely, J., & Latkin, C. A. (2016). 'It's not what you know but who you know': Role of social capital in predicting risky injection drug use behavior in a sample of people who inject drugs in Baltimore city. *Journal of Substance Use*, *21*(6), 620–626. https://doi.org/10.3109/14659891.2015.1122098

Lafferty, L., Rance, J., Dore, G. J., Lloyd, A. R., & Treloar, C. (2021). The role of social capital in facilitating hepatitis C treatment scale-up within a treatment-as-prevention trial in the male prison setting. *Addiction*, *116*(5), 1162–1171. https://doi.org/10.1111/add.15277

Larsson, P. (2021). From medicine to morals, and back again? The changing perceptions of 'the drug problem' in Norway since 1965. In H. Tham (Ed.), *Retreat or entrenchment? Drug policies in the Nordic Countries at a crossroads* (pp. 103–127). Stockholm University Press.

Lovell, A. M. (2002). Risking risk: The influence of types of capital and social networks on the injection practices of drug users. *Social Science & Medicine*, *55*(5), 803–821. https://doi.org/10.1016/S0277-9536(01)00204-0

Madah-Amiri, D., Clausen, T., & Lobmaier, P. (2017). Rapid widespread distribution of intranasal naloxone for overdose prevention. *Drug and Alcohol Dependence*, *173*, 17–23. https://doi.org/10.1016/j.drugalcdep.2016.12.013

Marshall, B. D., Fairbairn, N., Li, K., Wood, E., & Kerr, T. (2008). Physical violence among a prospective cohort of injection drug users: A gender-focused approach. *Drug and Alcohol Dependence*, *97*(3), 237–246. https://doi.org/10.1016/j.drugalcdep.2008.03.028

Mars, S. G., Ondocsin, J., & Ciccarone, D. (2018a). Sold as heroin: Perceptions and use of an evolving drug in Baltimore, MD. *Journal of Psychoactive Drugs*, *50*(2), 167–176. https://doi.org/10.1080/02791072.2017.1394508

Mars, S. G., Ondocsin, J., & Ciccarone, D. (2018b). Toots, tastes and tester shots: User accounts of drug sampling methods for gauging heroin potency. *Harm Reduction Journal*, *15*(1), 1–10. https://doi.org/10.1186/s12954-018-0232-z

Mayock, P. (2005). 'Scripting'risk: Young people and the construction of drug journeys. *Drugs: Education, Prevention & Policy*, *12*(5), 349–368. https://doi.org/10.1080/09687630500183020

McKnight, C., & Des Jarlais, D. (2018). Being "hooked up" during a sharp increase in the availability of illicitly manufactured fentanyl: Adaptations of drug using practices among people who use drugs (PWUD) in New York City. *International Journal of Drug Policy*, *60*, 82–88. https://doi.org/10.1016/j.drugpo.2018.08.004

McNeil, R., Shannon, K., Shaver, L., Kerr, T., & Small, W. (2014). Negotiating place and gendered violence in Canada's largest open drug scene. *International Journal of Drug Policy*, *25*(3), 608–615. https://doi.org/10.1016/j.drugpo.2013.11.006

Moore, D. (2004). Governing street-based injecting drug users: A critique of heroin overdose prevention in Australia. *Social Science & Medicine*, *59*(7), 1547–1557. https://doi.org/10.1016/j.socscimed.2004.01.029

Moore, D., & Dietze, P. (2005). Enabling environments and the reduction of drug-related harm: Re-framing Australian policy and practice. *Drug and Alcohol Review*, *24*(3), 275–284. https://doi.org/10.1080/09595230500170258

Moore, D., & Fraser, S. (2006). Putting at risk what we know: Reflecting on the drug-using subject in harm reduction and its political implications. *Social Science & Medicine*, *62*(12), 3035–3047. https://doi.org/10.1016/j.socscimed.2005.11.067

Nathani, J., Iversen, J., Shying, K., Byrne, J., & Maher, L. (2010). Qualitative accounts of needle and syringe cleaning techniques among people who inject drugs in Sydney, Australia. *Drug and Alcohol Review*, *29*(4), 413–419. https://doi.org/10.1111/j.1465-3362.2009.00165.x

Olsen, A., Banwell, C., Dance, P., & Maher, L. (2012). Positive health beliefs and behaviours in the midst of difficult lives: Women who inject drugs. *International Journal of Drug Policy*, *23*(4), 312–318. https://doi.org/10.1016/j.drugpo.2012.01.003

Ouellet, L. J., Jimenez, A. D., Johnson, W. A., & Wiebel, W. W. (1991). Shooting galleries and HIV disease: Variations in places for injecting illicit drugs. *Crime & Delinquency*, *37*(1), 64–85. https://doi.org/10.1177/0011128791037001006

Rhodes, T. (1997). Risk theory in epidemic times: Sex, drugs and the social organisation of 'risk behaviour'. *Sociology of Health & Illness*, *19*(2), 208–227. https://doi.org/10.1111/1467-9566.ep10934410

Rhodes, T. (2002). The 'risk environment': a framework for understanding and reducing drug-related harm. *International Journal of Drug Policy*, *13*(2), 85–94. https://doi.org/10.1016/S0955-3959(02)00007-5

Rhodes, T. (2009). Risk environments and drug harms: A social science for harm reduction approach. *International Journal of Drug Policy*, *20*(3), 193–201. https://doi.org/10.1016/j.drugpo.2008.10.003

Rhodes, T., Barnard, M., Fountain, J., Hariga, F., Avilés, N. R., Vicente, J., Weber, U., Greenwood, G., & Robertson, K. (2001). *Injecting drug use, risk behaviour and qualitative research in the time of AIDS*. Office for Official Publications of the European Communities EMCDDA.

Rhodes, T., Singer, M., Bourgois, P., Friedman, S. R., & Strathdee, S. A. (2005). The social structural production of HIV risk among injecting drug users. *Social Science & Medicine*, *61*(5), 1026–1044. https://doi.org/10.1016/j.socscimed.2004.12.024

Rhodes, T., Watts, L., Davies, S., Martin, A., Smith, J., Clark, D., Craine, N. & Lyons, M. (2007). Risk, shame and the public injector: A qualitative study of drug injecting in South Wales. *Social Science & Medicine*, *65*(3), 572–585. https://doi.org/10.1016/j.socscimed.2007.03.033

Sandberg, S. (2008a). Black drug dealers in a white welfare state: Cannabis dealing and street capital in Norway. *The British Journal of Criminology*, *48*(5), 604–619. https://doi.org/10.1093/bjc/azn041

Sandberg, S. (2008b). Street capital: Ethnicity and violence on the streets of Oslo. *Theoretical Criminology*, *12*(2), 153–171. https://doi.org/10.1177/1362480608089238

Sandberg, S. (2012). The importance of culture for cannabis markets towards an economic sociology of illegal drug markets. *British Journal of Criminology*, *52*(6), 1133–1151. https://doi.org/10.1093/bjc/azs031

Sandberg, S., & Pedersen, W. (2009). *Street capital: Black cannabis dealers in a white welfare state*. Policy Press.

Sandøy, T. A. (2015). Group solidarity in a hostile milieu: Immigrant experiences in a street-based drug scene. *Drugs: Education, Prevention & Policy*, *22*(3), 232–238. https://doi.org/10.3109/09687637.2014.993921

Shammas, V. L., & Sandberg, S. (2016). Habitus, capital, and conflict: Bringing Bourdieusian field theory to criminology. *Criminology & Criminal Justice*, *16*(2), 195–213. https://doi.org/10.1177/1748895815603774

Skretting, A. (2014). Governmental conceptions of the drug problem: A review of Norwegian governmental papers 1965-2012. *Nordic Studies on Alcohol and Drugs*, *31*(5–6), 569–584. https://doi.org/10.2478/nsad-2014-0047

Smith-Solbakken, M., & Tungland, E. M. (1997). *Narkomiljøet: økonomi, kultur og avhengighet*. Ad Notam Gyldendal.

Strathdee, S. A., Hallett, T. B., Bobrova, N., Rhodes, T., Booth, R., Abdool, R., & Hankins, C. A. (2010). HIV and risk environment for injecting drug users: The past, present, and future. *The Lancet*, *376*(9737), 268–284. https://doi.org/10.1016/S0140-6736(10)60743-X

Strathdee, S. A., Patrick, D. M., Currie, S. L., Cornelisse, P. G., Rekart, M. L., Montaner, J. S., Schechter, M.T. & O'Shaughnessy, M. (1997). Needle exchange is not enough: Lessons from the Vancouver injecting drug use study. *Aids*, *11*(8), F59–F65. https://doi.org/10.1097/00002030-199708000-00001