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ORIGINAL ARTICLE

Police Perceptions of Supervised Consumption Sites (SCSs): A Qualitative Study

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Police are key stakeholders in cities considering supervised consumption site (SCS) implementation. We examine police perceptions of SCSs using data collected between 2008 and 2010. Data from interviews and focus groups conducted with police officers of varied ranks ($n = 18$) in Ottawa and Toronto, Canada, were analyzed using thematic analyses. Participants opposed SCS implementation in their respective cities. The police views we heard invoke values and perspectives on evidence that differ from those used in research. Whether these divergent frameworks are reconcilable is a question for future research. Study limitations are noted. The Ontario HIV Treatment Network funded the study.

Keywords harm reduction, supervised consumption sites, police, law enforcement, illicit drugs, perceptions

INTRODUCTION

Harm reduction is a pragmatic response to illicit drug use that aims to reduce drug-use-related harms and improves the health of individuals and communities (International Harm Reduction Association, 2010). Supervised consumption sites (SCSs) are legally sanctioned facilities where people can inject and, in some sites, smoke illicit drugs under the supervision of trained staff, consistent with a harm reduction approach that recognizes that abstinence from illicit drug use is not always a practical goal (Hedrich, 2004). The primary goals of SCSs include reducing disease transmission, overdose, and public illicit drug use, and improving access to health and social services (Kimber, Dolan, & Wodak, 2005). This article represents a first in-depth empirical examination of a sample of police perceptions of SCSs.

Police are crucial stakeholders in debates about SCS implementation. Some police have supported SCSs in their areas (Hedrich, 2004; Small, Palepu, & Tyndall, 2006). However, law enforcement authorities are also sometimes opposed to SCSs (Canadian Association of Chiefs of Police, 2002; Canadian Police Association, 2007). Although studies document how police sometimes act toward harm reduction programs, there are few investigations of police attitudes and opinions (Beletsky, Macalino, & Burris, 2005; Beyer, Crofts, & Reid, 2002; Rhodes et al., 2006). Studies examining how police interact with needle and syringe programs (NSPs) and the people who frequent these programs report that some policing practices, such as harassment and arrest of NSP clients and confiscation of needles and other drug use equipment, can interfere with access to and use of offered services (Blankenship & Koester, 2002; Bluthenthal, Kral, Lorvick, & Watters, 1997; Davis, Burris, Kraut-Becher, Lynch, & Metzger, 2005; Kerr, Small, & Wood, 2005; Maher & Dixon, 1999; Rhodes et al., 2006; Small, Kerr, Charette, Schechter, & Spittal, 2006). People who use illicit drugs may become less willing to access harm reduction services when they perceive that use of these services may expose them to police scrutiny or harassment (Aitken, Moore, Higgs, Kelsall, & Kerger, 2002). Furthermore, people who inject drugs may be more likely to use non-sterile needles, engage in rushed injecting, and

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be more reluctant to carry clean injection equipment when they are fearful of police intervention (Aitken et al., 2002; Bluthenthal, Lorvick, Kral, Erringer, & Kahn, 1999; Cooper, Moore, Gruskin, & Krieger, 2005; Maher & Dixon, 1999; Pollini et al., 2008; Small, Kerr, et al., 2006). The history of police interactions with other forms of harm reduction programming is relevant to SCSs. Police support or tolerance is needed to ensure that SCS clients will not be harassed or arrested when entering or exiting a site (Fischer & Allard, 2007). Support from police may also take the form of encouraging SCS use. For example, in Vancouver, nearly 17% of SCS clients reported being referred to the site by police (DeBeck et al., 2008).

There are over 90 SCSs operating across the world, predominantly in Europe (Cook, 2010). Nonetheless, most urban centers do not currently have SCSs. SCS use among people who use illicit drugs is associated with a number of health and economic benefits, while the impact on crime and public nuisance is more equivocal (Andresen & Boyd, 2010; Bayoumi & Zaric, 2008; Kerr, Kimber, DeBeck, & Wood, 2007; Kerr, Tyndall, Li, Montaner, & Wood, 2005; Kimber et al., 2008; Marshall, Milloy, Wood, Montaner, & Kerr, 2011; Pinkerton, 2010; Stoltz et al., 2007; Wood, Tyndall, Zhang, Montaner, & Kerr, 2007). The number of robbery and property offences in the vicinity of the Sydney SCS fell between 2001 and 2010 and rates for selected drug offences appeared stable (Fitzgerald, Burgess, & Snowball, 2010). The exception was cocaine use and possession that increased during this period, but also increased across the rest of the city (Fitzgerald et al., 2010). In Vancouver, drug trafficking, assaults, and robbery rates were similar in the year before and the year after the SCS opened; there was also a decrease in the rate of vehicle break-ins (Wood, Tyndall, Lai, Montaner, & Kerr, 2006).

Empirical findings such as the above are not necessarily sufficient to change views on controversial issues, especially when value judgments are involved. Room (2005) writes that the politics of substance use contains many symbols and values, which play important roles in policy-making alongside commitments to evidence-based policy. In a study of how drug policy-makers access research evidence, Ritter (2009) states, "There are many inputs to decision-making–politics, values, opinion–along with research evidence. Research evidence must compete with these other inputs" (p. 73). For some people, the values that inform drug policy debates seem to reflect "deep core beliefs" that involve normative and ontological assumptions about human nature (Sabatier & Weible, 2007). These types of beliefs may not be readily transformable with new empirical evidence, leaving policy change highly challenging (Sabatier & Weible, 2007).

As part of a larger study considering the potential impacts of SCS implementation in two major Canadian cities, Ottawa and Toronto, we consulted with municipal police officers and senior police officials regarding their knowledge and opinions of SCSs. The present study had two objectives. First, we aimed to describe perceptions, attitudes, and values toward SCSs and harm reduction held by police officers and to develop a more nuanced understanding of the sources of these perceptions. Second, we explored the ways police consider and use evidence when discussing harm reduction initiatives.

METHODS

Between December 2008 and January 2010, we conducted 26 one-on-one key informant interviews and 28 focus group discussions. We consulted with multiple stakeholders including police, fire and emergency medical service personnel, city officials, health care providers, residents, business owners, and people who use illicit drugs ($N = 236$; 112 participants in Ottawa and 124 in Toronto). In this article, we report on the 4 interviews (3 in Ottawa and 1 in Toronto) and 2 focus groups (1 in each city, with 7 participants per group) that were conducted with members of the police services ($n = 18$) and below describe only how we recruited police for our study.

We sought approval to participate in the study by requesting to speak with senior police management for the interviews and with police officers of varying ranks (e.g., constables, sergeants) for the focus groups. Participant recruitment was arranged by the two police services; research coordinators were asked to arrange consultations via a police-designated contact person. Initially, the Toronto police-designated contact person advised one of the research coordinators that the police services would not participate because the organization does not support SCSs. The research coordinator explained that the study aims to capture a variety of stakeholder perspectives, and supportive views would not be required to participate. A meeting was requested between the principal investigators and a senior police official in Toronto. At the meeting, the principal investigators discussed the study objectives and why it would be important to include the views of local police. A similar meeting was not requested by or held with the Ottawa police force.

Prior to commencing an interview or focus group, all participants were asked to read and sign a consent form that explicitly asked for permission to tape-record and transcribe the contents of the consultations. After their interviews, several senior police officials were provided with an additional consent form that asked for their permission to have quotes from their interviews attributed to them in any articles, reports, or other publications related to the study. We sought such permission due to the high-profile and public leadership roles of these participants on issues related to illicit drug use. The consent form outlined that the research team would provide the participant with the quotes to be used and the text surrounding the quotes prior to publication. These participants were given the options of having each quote attributed to them or having it de-identified and used without attribution; they were not provided with the options of changing the quote or surrounding text or withdrawing the quote. In the results, we attribute quotes where we received consent for attribution. The study protocol was approved by the research ethics boards at St. Michael's Hospital, the Centre for Addiction and Mental Health, and the University of Toronto.

For the interviews and focus groups, we used a common discussion guide. We asked participants open-ended questions about the perceived use of illicit drugs in the community, the potential benefits and drawbacks of SCSs, where to locate an SCS, design and operational features an SCS should have, how an SCS may impact the health care system and participants' work, and alternative responses to illicit drug use. Key informant interviews were conducted in person or by telephone by a research coordinator or one of the principal investigators. Focus groups were conducted in person with the time and location arranged by the police-designated contact person who was assisting with recruitment. Two research coordinators or a coordinator and one of the principal investigators or a co-investigator moderated each focus group. Immediately following an interview or a focus group, participants were asked to complete a short questionnaire. We offered all participants $25 CAD for participating in the study.

Transcripts were prepared by a professional, confidential transcriptionist and verified for accuracy by one of the research coordinators. All transcripts were uploaded to a qualitative software program (NVivo 8). We followed an iterative analytic procedure (Corbin & Strauss, 2008; Strauss & Corbin, 1998). A subteam composed of one of the principal investigators, a co-investigator, two research coordinators, and a practicum student selected transcripts to review for emergent themes. All subteam members met to discuss and compare coding of transcripts. During these meetings, the subteam developed a common coding structure composed of major themes and subthemes. Once the coding structure was established, all remaining transcripts were coded by one subteam member and coding was verified by another subteam member. Any discrepancies in coding were discussed and resolved by consensus. New themes and any refinements were incorporated into the coding structure as deemed appropriate and as agreed upon by the subteam. Thematic memos were kept to describe, summarize, and analyze the content of each theme. We compared thematic content across and within cities and stakeholder groups to identify any consistencies and discrepancies between and within cities and stakeholder groups. Focus group participants were not individually identified in the transcripts, so we cannot provide proportions of respondents who mentioned a particular theme.

RESULTS

Police in our study were of various ranks and reported years of experience of police service and years of experience working with people who use drugs. Most participants (89%; $n = 16$) were male and the median age of the sample was 43.5 years. Please see Table 1 for characteristics of the participants.

TABLE 1. Characteristics of participants

Sex	
% Male	89 ($n = 16$)
% Female	11 ($n = 2$)
Rank	
% Sergeant or lower	61 ($n = 11$)
% Detective, inspector, or higher	33 ($n = 6$)
% Other	6 ($n = 1$)
Median age (range)	43.5 (28–55)
Median years of police service (range)	19 (2–33)
Median years of working with people who use drugs (range)	14 (5–33)

Underlying Views of Addiction, People Who Use Illicit Drugs, and Preferred Responses to Illicit Drug Use

Police in our study often used the term "addicts"—a term that essentializes people on the basis of their drug use—to refer to drug-dependent individuals that they interact with on the street. Participants framed addiction as an all-consuming state.

> They can't organize their day. They can't have breakfast 'cause their drug is ruling the day. That is their brain. Their brain is geared, "Get up, get high. Get money, get high. Go to sleep." And that is their day, every single day. (Ottawa participant)

Participants said that people who use illicit drugs are caught in an unhealthy lifestyle that is difficult to change. Addiction is conceived, at least in part, as a personal failure, "a personality where you easily fall into addiction" (Toronto participant), and motivation (often noted by participants as absent among street-involved people who use illicit drugs) is viewed as required to break the "cycle of addiction." Police reported that people who use illicit drugs often ask for help to stop taking drugs. A few participants generalized this request for help to all people who use illicit drugs: "And you know what, every single one of those individuals that are addicted to drugs, do not want to continue. They hate their lives, they can't stand it." (Ottawa participant)

Despite describing people who use illicit drugs as wanting help to escape the powerful nature of addiction, the police officers we spoke to voiced skepticism regarding the commitment to enter treatment. Several participants described "addicts" as people who care only about the present and getting high: "They get their drugs. 'I'm in the here and now. I need to do it here and now.'" (Toronto participant) People who use illicit drugs were also characterized as disorganized: "They can't plan the rest of their day, they're not planning the rest of their month or the rest of the year." (Ottawa participant) Police linked this failure to take responsible, future-oriented action to an inability to seek rehabilitation.

Police in our study advocated that treatment for people who use illicit drugs should be encouraged, and sometimes forced, as a benevolent approach that helps to break the addiction cycle.

> But I think, as well, that we should be helping people towards not just remaining in their, their state of addiction, with all of the harms associated to that, but providing them with some means of rehabilitation recovery, to help them be healthier. (Toronto Chief of Police)

> You know, there's that whole issue of you're forcing people for treatment, but I honestly believe that that's what it will take to get a lot of

people back on the right road. A lot of these addicts are not going to willingly go into treatment in the middle of a run of drugs. (Ottawa participant)

The police in Ottawa focused on the need for treatment more often than the police in Toronto. As an Ottawa participant stated, "So our ultimate goal, obviously, is to get them into treatment. At the end of the day, that's what it's all about." The strong pro-treatment sentiment may also reflect the perception of most Ottawa participants that the city lacks sufficient treatment services for the drug-using population.

While endorsing treatment, participants also emphasized the important role of law enforcement for dealing with the criminal behavior associated with illicit drug use: "We go out there. What are we looking for, we're looking for crack users and people committing crime. So when I go out on patrol, that's what I'm looking for." (Ottawa participant) The police in our study often noted that they have extensive experience in their work with the crimes associated with illicit drug use such as theft and solicitation of prostitution, demonstrating their expertise on drug-related issues.

Underlying Views of Harm Reduction

Participants generally do not consider harm reduction to be a viable or effective response to illicit drug use. The dominant view among the police in our study positioned harm reduction as simply enabling illicit drug use. For some, the idea of offering help to someone who is using or has just used illicit drugs is illogical. These participants suggested that people need to be in a clear frame of mind in order to receive help and several employed analogies to make this point.

They're screaming for help. They want help, but they need to be held by the hand, and guided out. If you want to get someone to stop drinking alcohol, you don't go to a bar and talk to him while at the bar after their fifth drink. They'll agree with you: "Yeah, I gotta stop. This is crazy." (Ottawa participant)

Nevertheless, some participants recognized benefits from certain forms of harm reduction such as NSPs, methadone maintenance therapy, and outreach programs.

We have, we adopted a very long time ago a needle exchange program, which I think was a moral thing to do. I wish it worked a little bit better, but I think it's still the right thing to do. By the way, most police services in the country do support such a thing because we believe it to be the moral thing to do. To provide that service, and to provide public education around it. We tried very hard to manage this situation. And the outcomes I think are compelling. (Toronto participant)

Recognition of the utility of certain initiatives such as NSPs appears to contradict and be inconsistent with the assertions that harm reduction is an ineffective response to illicit drug problems. Although mention of "outcomes" suggests an interest in evidence of effectiveness, it was not clear which outcomes would constitute sufficient evidence for the acceptance of harm reduction strategies. Participants varied as to whether they accepted a minor role of harm reduction, recognizing that drug use will continue, or whether they only accepted programs that they believed lead to abstinence.

Again, I am a methadone proponent. But I'm not a proponent of providing them with drugs. So I guess my answer is a little bit of a whole bunch of things, but primarily around providing them opportunities to get off drugs. And if they choose not to, then providing them with the knowledge about what occurs when you don't get off drugs. Not giving them one lane in the middle of the road for impaired drivers, as the joke goes. (Ottawa participant)

We don't want the message to get confused. We are all for looking after the addict through counselling and help, outreach. But I think it has to be an outreach, either some sort of mobile centre, or some ability for these people to get out on the street and meet the addict, instead of bringing the addict to a bad situation. So we're not against helping them, we're all for it. It makes our lives easier. It makes everybody's lives in Toronto easier, and better, and improves everybody's lives and the addicts' lives if we help them. But the consumption portion is not helping anybody, at all, from the bottom of the chain all the way to the top. (Toronto participant)

Further, police indicated that the focus of harm reduction should extend well beyond the individual who uses illicit drugs to include reducing harms for the broader community: "But any initiative that we undertake in the city has to balance and demonstrate harm reduction, not just for the individual drug user, but harm reduction for the community as well." (Toronto Chief of Police) Participants articulated a number of potential harms to the community that would be exacerbated and produced, not reduced, if what they regard as an "extreme" and unacceptable form of harm reduction, such as an SCS, was implemented.

Perspectives on SCSs and Evidence Narratives

The police in our study presented a stance against SCSs that is firm, clear, and unanimous. All participants raised numerous problems that they asserted are associated with SCSs. Two main ways in which the police we spoke to framed their views were identified. First, by referring to values that shape how illicit drug use is problematized, participants reinterpreted or discounted the goals of SCSs. Second, police made claims that appeared to filter evidence and privilege anecdotal reports which suggest that negative outcomes will result from SCS implementation.

Dismissing SCSs Based on Values and Other Goals

The police in our study opposed claims that SCSs reduce harm, promote health, and improve access to services for street-involved people who use illicit drugs. Participants suggested that (1) SCSs do not solve the problem of addiction; (2) SCSs send an ambiguous message about the acceptability of illicit drug use; and (3) SCSs undermine and interfere with law enforcement efforts.

First, the police in our study argued that SCSs do not address addiction but rather offer "just a place" to use illicit drugs, thereby enabling addiction and preventing people from seeking treatment and recovery. Participants in

Ottawa, in particular, strongly upheld the view that the "core issue" is that people need to "get off" illicit drugs.

We're keeping them as addicts, as opposed to trying to get them to be former addicts, where they can, once again contribute, maybe do some of the things that they've always wanted to do, as opposed to being stuck in a vicious circle. Because I just feel personally that any facility that allows them to use would be simply that, a place to use, not fix and reform. Just a place to go and use. (Ottawa participant)

Second, police in both cities reported that SCSs send ambiguous messages regarding the acceptability of illicit drug use, since illicit drugs are exempt from law enforcement inside a site while remaining illegal outside. In their view, illicit drugs ought to remain illegal because these drugs are harmful. The message that illicit drug use is permissible or even acceptable was considered as a dangerous message, especially for youth and other people who are easily influenced: "We don't want to create the impression this is normal behaviour. This is not something we want to encourage." (Ottawa participant) SCSs were considered as inconsistent with anti-drug messaging.

[T]he ambiguous messaging that comes out from a society that says you can't use these drugs, they're against the law, but if you do, we'll provide you a place to do it in. The ambiguity of that, it's a little bit problematic when you're trying to explain to young people about the consequences of illegal drug use. And we are interested in trying to discourage them from that. (Toronto Chief of Police)

Third, participants in both cities also believed that SCSs undermine law enforcement efforts. Several participants reported that an SCS would make illicit drugs "legal" in a given area by providing people who use illicit drugs and dealers with "get out of jail free" cards. The police in our study said that dealers will swiftly take advantage of such opportunities. As one participant noted, "[W]hen we intercept them, they're not drug traffickers; they're users. And then they go inside the supervised injection site. So it's like a safe zone, a de-militarized zone, where they're allowed to use." (Ottawa participant) Some participants added that making illicit drugs and the people involved with illicit drugs exempt from law enforcement inside an SCS will change the nature of police work in such a way that they will no longer be able to do their job effectively.

I can see a defense attorney successfully arguing, "Well, he was on his way to the safe injection site. He was in small possession of . . . he was on his way to the safe injection site." So it went from that to now, the dealers are not being charged . . . so now the police officers, as far as I'm concerned, in that area, are high paid security guards. (Ottawa participant)

The concern would be that we, as a police service, can deal with those people where they are. The difference is when you have that site that's safe, we now can't get in there to deal with that. And that's the concern, is that they can go safely in there and do the drugs without the thought that the police services is going to do anything to them. These other places, we can set up on them, we have ways to deal with them. We have officers on foot. We have other things. And that's the fear, and that's why we can maybe stop it. (Toronto participant)

The police in our study suggested that people who use illicit drugs will be drawn to an SCS and its neighborhood because of the opportunity to be exempt from law enforcement.

I would see an increase in the drug tourists, and I use the word "tourist" as someone that is a drug user in a different area, would come to the City of Ottawa, to use a supervised injection site, not as an area to prevent the spread of HIV and hep C. It would be because of the, it would be like a free zone or a no-zone. (Ottawa participant)

Participants also emphasized that their job is about keeping communities safe. The perception that SCSs will undermine their ability to fulfill their duty led some police to assert that SCSs will bring a series of negative consequences to the community.

I mean our mandate comes, "Protection of life and property." That's for everybody. So that's the person who has the needle left in their yard, or the needle in the park, and prevents their kids from using it. That's the drug users, so we have to look at everybody in the community, and supervised injection sites don't provide a benefit to drug users, even if we say that there's a medical benefit. It doesn't provide that medical benefit without this huge cost in other areas. (Ottawa participant)

Selective Use of Evidence and Privileging Anecdotes

Participants offered claims to challenge assertions made by proponents of SCSs without typically specifying empirical sources. The police in our study seemed to privilege certain types of information, such as anecdotal reports from colleagues, over evidence from research studies. Participants' preference for anecdotal or first-person-based evidence seemed related to distrust of existing empirical evidence about SCSs and skepticism about the objectivity of the researchers who produce such evidence:

You know it's interesting, because when we hear presentations from the health side . . . "Well, the statistics are telling us this, this, and this." They go on the empirical evidence, but there's a whole anecdotal piece that they never disclose and they never discuss. (Ottawa participant)

Those that are involved in the research of it are all already prejudiced. I don't know of anybody that's done research on this whole issue of harm reduction, that wasn't already involved with a network or a coalition of some sort, before getting the funding to do the research. (Ottawa participant)

Participants used this filtering of evidence to assert that (1) SCSs will not reduce rates of disease transmission; (2) SCSs will create new problems for a community or worsen existing problems; and (3) SCSs will have devastating and lasting impacts on local businesses and the community.

Police in our study, particularly in Ottawa, claimed that SCSs will not succeed in reducing illicit drug-use-related risk behaviors associated with HIV transmission and other infections. For some participants, this claim was based on the knowledge founded in research literature. More often, other participants asserted this claim based upon their own expertise gained from working with people who use illicit drugs. Several participants referred to studies

about Vancouver which reported that most illicit drug injections in the city occur outside of the SCS: "[T]he majority of their injections are still taking place outside Insite." (Ottawa participant) This finding was used as evidence that SCSs will not achieve the stated goal of reducing disease transmission. Participants suggested that the people who use illicit drugs that they know cannot be counted on to use an SCS every time they inject illicit drugs: "If they're going to be using six or seven times, maybe ten times, the experience is maybe two or three times, maybe one time, they're actually going to use a supervised injection site." (Ottawa participant) According to participants, SCS clients will need to use the site every time they inject to guarantee the prevention of disease transmission.

Based on their experience of the behaviors of people who use illicit drugs, police asserted that "addicts" want to use whatever drugs they have right away and will not travel to an SCS.

In fact, when a user starts using, they don't think, "Oh, let me see here. Ten seconds later I'm high as a kite on crack." And then they're not going to say, "Oh, let me not share my pipe with my buddy here." They're high. They don't think rationally, they share their pipes and their needles right away. (Ottawa participant)

How great would it be if those ten times [a person injects in a day] they came to our facility [an SCS], used a clean needle, possibly interacted with a health professional, social worker, counsellor, and got some help, and used a clean needle, right? That makes sense. The minute you put it into practice though, and you have a woman performing a sex act for five dollars, so she can buy a crumb of crack cocaine three blocks from the consumption site, and there's someone there with a needle. And she says, "A crumb is not worthwhile going back to the site for, but I'm going to shoot up right here." That's when it breaks down, I think. (Ottawa participant)

Police in both cities worried that SCSs create or worsen the existing illicit drug-related burden for communities, particularly by increasing the congregation of people who use and sell illicit drugs and, thereby, increasing levels of crime, violence, and disorder in the area of a site: "We might now cause a problem!" (Toronto participant) Dealers represented a major concern because they were considered as unscrupulous individuals who "prey" upon others. Again, some participants referenced the knowledge acquired during their police work about people who use illicit drugs and about dealers.

These are the opinions we're giving because we deal with the drug user and the drug world, and we have to give these opinions all the time, because as drug experts in court, we testify constantly, what the trends are, how people are using, how they're dealing, what they're saying to us. So we constantly, constantly interview the drug users on the street, in custody, through informants and that. And the voice that we give is not just the police voice. It's also the drug user and the drug dealer voice. Through our debriefs and being drug experts, recognised by the courts as drug experts, as to what's going on there. So it's very important, because not only are we talking from the enforcement point or what the citizens are saying to us, we're also talking about what the addicts are telling us and what the drug dealers are telling us. (Toronto participant)

Several Ottawa participants emphasized anecdotal reports that they have acquired from police colleagues who work in and around Vancouver's Downtown Eastside or from firsthand experience visiting the city to suggest that crime and disorder have remained high or became worse after the SCS opened.

When we look at Insite, and again, there's a lot of sort of public disorder and crime issues associated with the drug use in that area. And it's certainly fair to say that a lot of those issues were there prior to Insite. But Insite has not really made any impact on those issues. (Ottawa participant)

So what I've seen in Vancouver does not, from my perspective, deal with those issues. There's more needles on the street there than I see here. There's more addicts lying around the streets, shooting up on the streets than I ever see here. (Ottawa participant)

Finally, the police in our study asserted that an SCS would leave a devastating, long-term imprint on local businesses and the community wherever a site is located. Ottawa participants again used on the ground stories about Vancouver: "[A]gain we see in the Downtown Eastside of Vancouver, where a business district is now being replaced by pawn shops and cash advance businesses, which really thrive on and exploit this population, these populations." (Ottawa participant) For these participants, such reports suggested that SCSs will stigmatize their surrounding communities: "You're going to attract a huge amount of population that are using, exclusively drugs. So you're basically going to infect one area of the city." (Ottawa participant) Police in both Toronto and Ottawa seemed to share these concerns, though participants in Ottawa mentioned them slightly more frequently.

Certainly when we speak to the people on the ground there, the cost associated, and all the residual crime that comes from that, it's taken a ghetto and made it even more ghettoized. People will often argue, "Well, you know, it was already a bad area." Well, that bad area's gotten even worse. And it's slowly being pushed out. And the police are having to spend inordinate amounts of money just trying to contain it. And that's certainly one of the great frustrations. (Ottawa participant)

Some participants asserted that their communities do not support or want an SCS and recommended that decision-makers listen to *all* stakeholders, not just those who support this type of harm reduction intervention.

We are seen as a voice for residents. They do look to us for leadership on this issue. That's why it's very important that we're part of the table because, you know, the discussion we're having now is the discussion we have every day when we're out on the road, talking to the businesses, talking to communities, talking to the addicts, talking to the shelters. We do, in a way, represent a large segment of the population, and a large segment that are completely opposed to this. (Ottawa participant)

A few police in our study noted that there might be some potential public health benefits of SCSs; however, even these participants maintained their opposition to SCS implementation in their respective cities. Several participants emphasized an expectation that the research team

clearly and accurately reports their opposition to SCSs in any publications related to this study.

DISCUSSION

We consulted police in two Canadian cities about their perspectives on SCSs, where people are allowed to use illicit drugs. Our participants strongly asserted that SCSs represent an ineffective response to problems associated with illicit drug use. They argued that SCSs do not address addiction, send ambiguous messages regarding the acceptability of illicit drug use, and interfere with law enforcement efforts. Instead, police suggested that an appropriate response to illicit drug use includes treatment and rehabilitation, consistent anti-drug messaging, and law enforcement to keep communities safe. Participants also asserted that SCSs will not reduce disease transmission, but will exacerbate crime and have destructive, long-lasting effects on local businesses and residents.

Although the police in our study unanimously considered SCSs to be detrimental, some participants, including officers from a range of ranks, expressed support for other harm reduction strategies such as NSPs and methadone maintenance. Historically, police have not always supported such initiatives (Fischer, 2003; Strike, Myers, & Millson, 2004), suggesting that some views on harm reduction may be changeable over time. The debate about SCSs may represent another chapter in an evolution of changing police perspectives on harm reduction. In some European cities where SCS implementation was preceded by periods of lengthy discussions between divergent interest groups including law enforcement and public health services, police have accepted SCSs as having a role to play in reducing open drug scenes (Hedrich, 2004). From this study, we cannot determine whether gradual acceptance of harm reduction interventions is due to the accumulation of empirical evidence, endorsement by authoritative international bodies such as the World Health Organization, accumulated local experience, or other factors. Longitudinal studies of attitudes toward SCSs among police departments may present a valuable future research priority.

The objectives that the police in our study identified as important for an SCS are distinct from objectives promoted by many public health authorities. Hathaway and Tousaw (2008) note that critics of the Vancouver SCS seek to shift the discussion of efficacy from its intended outcomes to proving reduced rates of illicit drug use and addiction. These authors note that, "This distortion of the issue sets safe injection up for failure, deflecting attention away from the real objectives and harm reduction markers of success" (Hathaway & Tousaw, 2008, pp. 12–13). In our study, police espoused values that endorsed abstinence as the only solution to addiction, leaving little room for supervised illicit drug use as a public health response to the problems of disease transmission and overdose morbidity and mortality.

The police perspective on evidence differs from that used in research. When making some arguments that dismiss SCSs, the police stated their beliefs like "facts" (e.g., an SCS sends the message that illicit drug use is acceptable) without providing supporting empirical evidence. The police we spoke to tended to cite selective evidence about the impact on communities and privilege anecdotal reports as proof. For instance, participants referred to the frequency of drug use inside and outside the Vancouver SCS, direct encounters with people who use illicit drugs, and stories provided by colleagues. Furthermore, our participants saw themselves as experts when it comes to illicit drug problems. In a qualitative study of police officer attitudes toward syringe access, Beletsky et al. (2005) comment, "Police are in a better position than most to see the complexities of drug use and control, directly observing and sometimes bearing the individual and social harms they entail" (p. 272). This may explain why participants' own experiences on the street and the words of colleagues may hold greater currency than findings from empirical studies.

Our findings have important implications for debates about SCS implementation. Those who argue for SCS implementation on the basis of research findings alone may seem naïve. SCS proponents should recognize that research evidence, even if it meets rigorous academic standards, might be insufficient to sway opinions among those who hold a firm view of addiction as a moral failure. Proponents should remember that the design of evaluation studies and the selection of outcomes also reflect choices regarding the most valuable indicators of success. Researchers operating within a harm reduction framework also endorse a set of values (cf. Hathaway & Tousaw, 2008; Keane, 2003). Whether these divergent value frameworks can be reconciled remains an unanswered question. If they are reconcilable, the design and evaluation of an SCS will require broad consultation, including with police forces, and consensus on defining efficacy should be possible. In contrast, if reconciliation is elusive, the debate about SCS implementation becomes much more political and conflict becomes more likely. In this circumstance, efforts to implement SCSs may focus on building support with stakeholders who are more amenable to SCS goals.

Study's Limitations

There are several limitations to this study. The police in our sample represent a small group of participants who were recruited and selected by police-designated contacts. It is not possible to determine how representative the views expressed by police officers in our study are of other police in Ottawa and Toronto. Furthermore, social desirability bias might have constrained the willingness of some participants—who may possibly hold personal views at variance with their occupational views—to express themselves openly. The perspectives of police in our study may also not be generalizable to police in other locations, particularly in jurisdictions where SCSs are already situated. Finally, we defined SCSs as facilities that permit both injection and smoking of illicit drugs and used the term "SCS" throughout our questions. We might have elicited different responses had we asked questions about supervised injection and smoking sites separately.

CONCLUSIONS

Overall, the police participants in our study expressed a firm, anti-drug perspective that dismissed SCSs as an option for reducing the harms associated with illicit drug use. Our participants stated a clear preference for approaches, such as treatment, that aim to rehabilitate people who use illicit drugs and law enforcement. However, drug treatment success rates vary considerably (Anglin, Hser, & Grella, 1997), and increasing evidence shows numerous limitations associated with law enforcement as a method of addressing illicit drug use (Drucker, 1999; Reuter & Pollack, 2006). Alternative initiatives, including SCSs, are promoted by harm reduction advocates for people who are not yet willing or able to discontinue using illicit drugs. Yet SCSs cannot operate effectively without the cooperation and, preferably, acceptance from local police. This provides public health researchers with reason to examine further how to elicit police support for SCSs. In Vancouver, some police openly support the SCS and have played an important role in bringing about the "culture change" that was needed to establish the site (Small, Palepu, et al., 2006). There are reports that criminal justice personnel including police have, at least privately, supported initiatives such as prescription heroin and SCSs (Beyer et al., 2002). Police officers have also reported frustrations with the ability of the criminal justice system to deal effectively with people who use illicit drugs (Beletsky et al., 2005). Therefore, engendering support for SCS implementation among police may be an attainable goal.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the article.

RÉSUMÉ

Perceptions policières des sites de consommation supervisée (SCS): étude qualitative. Les policiers sont des intervenants clés dans les villes qui contemplent la mise en place de sites de consommation supervisée (SCS). Nous explorons les perceptions policières des SCS à l'aide de données recueillies entre 2008 et 2010. Les données tirées d'entrevues et de groupes de discussion ayant eu lieu avec des agents de police de divers grades ($n = 18$) à Ottawa et Toronto (Canada) ont été soumises à des analyses thématiques. Les participants s'opposaient à la mise en oeuvre de SCS dans leurs villes respectives. Les opinions policières exprimées invoquaient des valeurs et des points de vue sur les preuves qui différaient de ceux adoptés dans la recherche en santé. Des études futures devront déterminer si ces cadres de référence divergents peuvent être réconciliés. Nous prenons note des limites de l'étude, financée par l'Ontario HIV Treatment Network.

RESUMEN

Las percepciones de la policía sobre las salas de consumo supervisado: un estudio cualitativo. La policía es una parte interesada en las ciudades que están considerando la implementación de salas de consumo supervisado. Usando datos recolectados entre el 2008 y el 2010, se examinaron las percepciones que la policía tiene de las salas de consumo supervisado. Se hizo un análisis temático de los datos de entrevistas y grupos de enfoque con policías de varios rangos ($n = 18$) que se llevaron a cabo en Ottawa y Toronto, Canadá. Los participantes se oponían a la implementación de salas de consumo supervisado en sus respectivas ciudades. Las opiniones de los policías invocan valores y perspectivas sobre la evidencia que son diferentes a las que se utilizan en la investigación. La reconciliación de estos marcos divergentes es una cuestión para futuras investigaciones. Se reconocen las limitaciones del estudio. El Ontario HIV Treatment Network financió este estudio.

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GLOSSARY

HIV: Human immunodeficiency virus, the virus that causes acquired immune deficiency syndrome (AIDS).

Insite: The supervised injection facility located in Vancouver, British Columbia, Canada.

Needle and syringe program (NSP): NSPs help to reduce the risk of HIV and hepatitis transmissions by increasing access to sterile needles and syringes, removing used needles from circulation in the community, and educating clients about the risk of reusing injection equipment.

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