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Attitudes of police officers towards syringe access, occupational needle-sticks, and drug use: A qualitative study of one city police department in the United States

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Abstract

Removal of legal barriers to syringe access has been identified as an important part of a comprehensive approach to reducing HIV transmission among injecting drug users (IDUs). Legal barriers include both "law on the books" and "law on the streets," i.e., the actual practices of law enforcement officers. Changes in syringe and drug control policy can be ineffective in reducing such barriers if police continue to treat syringe possession as a crime or evidence of criminal activity. Despite the integral role of police officers in health policy implementation, little is known of their knowledge of, attitudes toward, and enforcement response to harm-minimisation schemes. We conducted qualitative interviews with 14 police officers in an urban police department following decriminalisation of syringe purchase and possession. Significant findings include: respondents were generally misinformed about the law legalising syringe purchase and possession; accurate knowledge of the law did not significantly change self-reported law enforcement behaviour; while anxious about accidental needle sticks and acquiring communicable diseases from IDUs, police officers were not trained or equipped to deal with this occupational risk; respondents were frustrated by systemic failures and structural barriers that perpetuate the cycle of substance abuse and crime, but blamed users for poor life choices. These data suggest a need for more extensive study of police attitudes and behaviours towards drug use and drug users. They also suggest changes in police training and management aimed at addressing concerns and misconceptions of the personnel, and ensuring that the legal harm reduction programs are not compromised by negative police interactions with IDUs.

Keywords: Injecting drug use; Harm reduction; Law enforcement attitudes; Police behaviour; Policy implementation; Qualitative studies; Needle stick injuries

Introduction

Injecting drug users (IDUs) are at significant risk of contracting HIV and other infectious diseases, and of introducing the disease to non-injecting populations (UNAIDS, 2004). Drug injection accounts for nearly one in four new HIV cases, while in some regions (like Asia and Eastern Europe), this mode of transmission has become the single most significant driving force behind the AIDS epidemic (Rhodes et al., 1999; UNAIDS, 2004). In the US, injecting drug use accounts for as many as a third of all adult and half of all paediatric HIV cases, as well as half of new hepatitis C virus (HCV) infections (CDC, 2003).

A growing body of evidence suggests that improved access to clean injection equipment reduces the incidence of blood-borne pathogens, such as HIV and HCV among IDUs, their sexual partners, their children, and other members of the

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community (Gollub, 1999; Hurley, Jolley, & Kaldor, 1997; MacDonald, Law, Kaldor, Hales, & Dore, 2003; Normand, Vlahov, & Moses, 1995; Raboud, Boily, Rajeswaran, O'Shaughnessy, & Schechter, 2003). Laws governing drug use (including laws restricting the purchase or possession of sterile syringes) and the practices of the law enforcement officers who implement those laws influence the feasibility and effectiveness of prevention programs targeted at IDUs (Bluthenthal, 1997; Broadhead, 1999; Burris, Finucane, Gallagher, & Grace, 1996; Collins, Summers, Aragon, & Johnson, 2002; Davis, Burris, Metzger, Becher, & Lynch, 2005; Des Jarlais, McKnight, & Milliken, 2004; Wood et al., 2003). Research has established that legal restrictions on syringe purchase and possession, and the behaviour of law enforcement officers, directly influence willingness of IDUs to obtain, carry and refrain from sharing injection equipment (Aitken, Moore, Higgs, Kelsall, & Kerger, 2002; Blankenship & Koester, 2002; Bluthenthal, Kral, Erringer, & Edlin, 1999; Bluthenthal, Lorvick, Kral, Erringer, & Kahn, 1999; Gleghorn, Jones, Dogherty, Celentano, & Vlahov, 1995; Grund, 2001; Human Rights Watch, 2003c; Klein & Levy, 2003; Koester, 1994; Lin et al., 2004; Maher & Dixon, 1999; Rhodes et al., 2002).

Governments may respond to this problem by changing the law. In the US, 17 states have taken legislative action to ease restrictions on purchase and possession of syringes by IDUs, and/or to authorise syringe exchange programs (SEPs) (Burris, Strathdee, & Vernick, 2003). These changes in the formal law, or "law on the books," do not, however, automatically lead to changes in the behaviour of law enforcement officers, whose activities constitute the "law on the streets" (Burris et al., 2004). Because police officers exercise a great deal of discretion in their work (Maher & Dixon, 1999; Shearing & Ericsson, 1991), law on the streets and law on the books can differ significantly. In places where syringe possession is formally legal, police may use their de facto power to confiscate syringes, or arrest IDUs on other charges, such as possession of a residue of illegal drug in the "legal" syringe. Law enforcement practices inconsistent with official harm reduction policies have been documented in Canada, Australia and the United States (Davis et al., 2005; Doe v. Bridgeport Police Department, 2001; Grund, Hechathorn, Broadhead, & Anthnony, 1995; Human Rights Watch, 2003a,b; Maher & Dixon, 1999; Roe v. City of New York, 2002; Wood et al., 2003).

Needles and syringes also directly affect the occupational health and safety of police officers. A study of police officers in one city found that nearly 30% of respondents had been stuck by a syringe at one point in their career, with over 27% experiencing two or more needle stick injuries (NSI) (Lorentz, Hill, & Samimi, 2000). There is some evidence that syringe access reform can influence NSI among law enforcement officers by making drug users less likely to hide syringes during a police pat-down (Groseclose et al., 1995).

The importance of police in the effective implementation of syringe access policies combined with the occupational risk in handling needles highlight the need for greater efforts to understand police attitudes and behaviour in relation to harm reduction and drug control policy more generally. Such an understanding is key to developing interventions that meet the needs of law enforcement professionals and make them more accepting of harm-reduction initiatives. There has been little study of this subject, however, and the research conducted so far has been confined to the attitudes of higher-level officers (Beyer, Crofts, & Reid, 2002). As a way of addressing this gap, this paper presents the results of interviews with police officers working on the streets of a medium-sized municipality in the U.S. state of Rhode Island.

Methods

Setting and subjects

Historically, the state of Rhode Island's drug paraphernalia law—which included restrictions relating to syringes—was one of the most stringent in the nation: possession of injection equipment was punishable by up to 5 years in prison per syringe. Resulting street scarcity of syringes meant that sharing practices were extremely common among IDUs (Rich et al., 1998). By the mid-1990s, Rhode Island had become one of only 4 US states where over half of all HIV cases could be attributed to injecting drug use (Rich et al., 1999). This served as an impetus for efforts to liberalise the state's syringe possession policies. In 1998, the legislature authorised an SEP and began to fund IDU outreach. In September 2000, the legislature decriminalised personal possession and over-the-counter sales of hypodermic needles.

Our interviews were conducted within a police department serving an ethnically and economically diverse city of just over 70,000. To participate in this study, respondents had to be employed by the department for at least 6 months. Officers and leadership personnel at different levels of the institutional hierarchy were recruited.

Data collection and analysis

A trained ethnographer, Beletsky, conducted a series of 45- to 90-minute interviews between August 2003 and April 2004. Verbal consent was obtained; an oral, closed-ended questionnaire was administered; and a semi-structured interview was conducted using a topic guide. Follow-up and probing questions were used to elucidate and expand on emerging themes after methodology described by Crabtree and Miller (1999). The interview process was pilot-tested with two former police officers. The final version of the interview guide and the study protocol were reviewed and approved by the Institutional Review Board of Brown University.

All but one of the respondents agreed to have the conversation audio-taped. Written notes were taken and used for the untaped interview. Audiotapes were professionally transcribed and the transcripts were verified against the

audio record. Using a qualitative analysis software package, the authors analysed and coded the transcripts. Emergent themes, trends, and frameworks were tallied by Beletsky and Macalino using a grounded hermeneutic approach (Addison, 1999). Identifying information for the department and the participants were changed to assure confidentiality.

Results

Sample

All 14 police officers (about 10% of the department) we recruited agreed to participate. Participants were older (average age: 36), more experienced (average years on the job: 12), and better educated (21% had Master's degrees) compared to non-participants. We attribute this difference to younger officers customarily working late-night shifts, which left them less available for interviews during daytime hours. Half of the respondents were in supervisory or administrative positions (sergeant or captain). The small number of women and minorities in the sample (1 Black male, 1 Hispanic male, 1 White female) is proportional to the representation of these groups in the department. Eight of the participants identified as Catholic, with other Christian denominations accounting for most of the remaining respondents.

Major findings

Three main findings emerged from the data analysis:

1. Respondents were generally unaware or misinformed about the law legalising syringe purchase and possession; knowledge of the law did not significantly change their self-reported behaviour in real street situations.
2. Police officers were anxious about accidental needle sticks and acquiring communicable diseases from IDUs, and officers were not trained nor equipped to deal with this occupational risk.
3. Respondents were frustrated by systemic failures and structural barriers that perpetuate the cycle of substance abuse and crime, while also blaming users for poor life choices.

Knowledge of syringe law and street-level implementation

Officers learn about changes in the law through paper or electronic memos, verbal announcements and, most commonly, by asking questions of peers and supervisors. "The one thing about this job," a detective with 11 years of experience on the force explained, "is you can't know it all, but there's always someone that has an answer to the question." No matter whom we asked, however, knowledge about the recent changes in syringe possession law among officers was poor. Only 7 of 14 officers were aware that a person could now carry injection equipment without a prescription. Some of the officers who were aware that the law had changed did not recognise the difference between the 2000 syringe decriminalisation and prior legislation that authorised syringe possession by SEP clients only. An even smaller proportion of officers (3/14) reported knowing that syringes were now available over-the-counter in Rhode Island pharmacies.

All 14 participants had considerable experience dealing with drug users, reporting spending anywhere from 50 to 90% of their time dealing with crimes or disturbances in some way related to substance abuse problems. Officers who spent more time on the beat interacting with drug users were more likely to be aware of the law change than were those more removed from such interaction. Even those respondents who knew about the change in the law, did not see it as requiring a real change in their work on the street. A supervisor recalled:

> When we first heard about the law change, the cops were like "that's nice, now we're going to let drug addicts go?" And as we thought about it, how often do we actually grab a guy with a needle and syringe and just charge him with that? We probably used discretion on that one anyway. It's the drugs that you charge with. [Captain, 40s]

The law on the books can be conceptualised as a set of tools that officers can choose from to achieve their immediate street-control goals (Burris et al., 2004). Syringe possession law had been one tool that a police officer would use to search or arrest a suspected drug user, but it had never been indispensable:

> Suppose a hammer gets recalled, and now you gotta hit it at a 45 degree angle instead of head on . . . so now it doesn't mean that you can't use that hammer anymore, it just means that you gotta use it differently. [Patrolman, 40s]

Regardless of their knowledge of the law, officers continued to treat syringes as contraband. All but one of those that knew about the law reported that they invariably seized and destroyed injection equipment of suspected IDUs, even if no arrest was made: "if he is an addict, he is not getting it back" [Patrolman, 20s].

Syringe possession, even if treated by the officer as legal in itself, allowed the use of at least two important legal tools. First, drug possession law could be triggered: all but one participant reported that, whenever they recovered a used syringe during a routine search, they would treat that article as evidence and request for it to be tested for drug residue. Importantly, this move would justify the arrest of the IDU pending the test results, though respondents reported that they did not always do so. Second, syringe possession may be treated by a police officer as justification for a search, which in the United States generally requires "probable cause" to suspect illegal activity. Half the respondents viewed the possession of a syringe as virtually always justifying a search, while the other half required additional reasons, such as the

inability of the individual to justify a medical need for syringe use. Ten out of the 14 respondents explicitly mentioned that possession of injection equipment is a sure sign of illegal drug use: "Once I find the needle, it's probable cause for me to go . . . asking more questions" [Sergeant, 40's].

Syringes are not the only markers of drug use used by police. Officers reported using a set of visual, situational, and other cues including poor hygiene, track marks, and geographical location. Many officers also come to know "frequent flyers" in the correctional system—injectors who commit petty crimes and, go briefly to jail and return to the streets to repeat the cycle. By their own account, police officers in this study deal largely with the most visible, criminal, under-treated, and powerfully-addicted strata of the IDU population: homeless users, commercial sex workers, and the mentally-ill, all of whom tend to lack the support networks that keep other users from being brought into the realm of the law enforcement and criminal justice system:

> If they're on a public street . . . it is also about the time of the night that they're there . . . even their height or their size matching people that have been responsible for things in the past . . . We put all of those things together and that gives you the probable cause to search them for your own protection. [Patrolman, 20s]

Needle stick injuries: anxiety and lack of departmental support

The risk of NSI was a source of serious concern to the officers in our sample. Two out of the 14 respondents reported having been stuck by a needle over the course of their career, 9 knew someone who had been stuck, and all but two had heard of someone who had experienced an NSI during a search. The frequency of injuries leads to a high level of anxiety. After a needlestick, "your first thought is, 'Oh, my God, this could be the end of my life.' It's kind of scary" [Patrolman, 20's].

> I'm concerned. I think a lot of guys are concerned. . . . I'd rather see you twenty feet away with a knife then two feet from me and me patting you down and get poked by a needle you said you never had. [Sergeant, 30s]

Some officers also voiced concerns about how an NSI could affect their family relationships:

> One time [my partner] got poked searching a car under a seat. Right away, he started stressing: "Now I gotta' go get checked. Now, I can't touch my wife" . . . so you get to a point where you go: "Is it worth it?" "Is it really, really worth it?" [Patrolman, 20s]

We found no indication that department managers had effectively addressed the high level of anxiety among police officers over disease transmission in the workplace. Most respondents were not well-informed about the HIV, hepatitis, and other infectious diseases and how to minimise their risk. Most reported wearing protective gloves during (most) searches, but two respondents said they do not wear gloves in the field even when conducting pat-down searches. Neither leadership nor street-level staff was aware of specific standard precautions against contracting communicable infections on the job.

Frustration with drug use and drug policy

The officers we interviewed reported a sense of frustration with their work in relation to drug users, doubting their ability to make a difference on the individual or community level: "Sometimes, it's like trying to shovel shit against the tide, it comes back to you dealing with the same people on a daily basis" [Sergeant, 30s]. Themes of cyclical futility appeared in 11 out of 14 (or 79%) of the interviews and the specific phrase "Catch-22" referring to the options of drug users was used by 4 of the officers.

> After being here for seven years, I can say that 80 to 85% of the people are not going to get cured, they're going to just keep going into trouble until either they get locked up forever, or they end up O.D.-ing and dying. [Patrolman, 30s]

> I been on eighteen years in this city, and I've seen no decline at all in people having drugs, using drugs, so we haven't made a difference in almost twenty years, I don't really see us making a difference in another twenty years. [Sergeant, 30s]

> The first couple of times you see it, you think about it and it bothers ya', but then you just get numb . . . It's almost like the movie Groundhog Day: the same thing, over and over and over again. [Sergeant, 30s]

> [The drug addiction cycle] doesn't affect my job, it keeps it busy. The more drug users you have, the busier it is, cause' you got more [petty crime] . . . it's just a revolving door that's just viciously getting bigger, and bigger, and bigger. And nothing's getting done about it. [Detective, 40s]

One of the most common grievances among participants was the apparent failure of the correctional and the criminal justice systems to deter, punish, and correct criminal behaviour. Several respondents felt the current system is especially impotent to deter the "frequent flyers" adept at navigating the courts and prisons, and may using the system to fulfil their basic needs: "Some of them don't have a place to live, they'll do something just to get in [prison], work out, come back . . . it's not a deterrent whatsoever" [Patrolman, 20s].

Most respondents shared the belief that courts failed police officers both because criminals were not adequately punished and because short jail time did not give drug addicts sufficient

time for recovery. Prison overcrowding was another problem, blamed for creating a "revolving door" for the people the police arrested. Lack of investment in the criminal justice system was also criticised:

> A probation system where [drug users] are closely monitored costs a lot of money and that's dollars and cents, and no one wants to spend the money so I'm just going out, and taking my reports. Every day. [Patrolman, 40s]

Nine out of 14 respondents spoke of their frustrations with the gaps in drug treatment:

> [Drug users] need to actually get some type of treatment. . . . Where I send them [for treatment] to doesn't have the resources because it's in a hospital. There's an 'x' amount of beds, but there's twice as many patients waiting for those beds, so that's a problem. I hear it all the time, "I'm on a waiting list." . . . And I'm thinking in the back of my mind, "Okay, so you got to wait for two months, so what are you going to do between now and then? You're going to do heroin . . . You're going to rob people. You're going to steal." And there it is. [Patrolman, 40s]

Participants in our study identified a number of similar concerns about the numerous problems confronting IDUs. These structural issues are presented below with an exemplary quotation from one of the several respondents speaking to the problem:

Housing (9 respondents):

> The whole society right now is a Catch-22, you can't go anywhere and spend less than less than 8–900 dollars a month unless you live in one of those flop-houses that's $25/week and they're drug-ridden. And now you got to go out there in the same old element that you're trying to get out of and you got no hope. Plus they're all having kids; their kids don't have a shot. I've been on the job too long, I'm kind of jaded. [Sergeant, 30s]

Employment (8 respondents):

> Once you get caught stealing, now you've got a record. . . . It's almost impossible to find another job that doesn't deal in some aspect with money, or trustworthiness or something like that . . . so now . . . they can't find jobs anywhere. [Patrolman, 30s]

Social Environment (7 respondents):

> Put it this way: if I'm sober now, I gotta' go find new friends. I'm thirty-one years old, who wants to hang with a recovering drug addict? . . . you're talking about somebody changing their life. You go try to lose ten pounds. [Patrolman, 30s]

Education (2 respondents):

> There's actually an act now . . . if you get caught and you have a drug arrest, you can't get federal money to go to college. So it's kind of a Catch-22 for them . . . if they wanted to better themselves by going to school, they can't afford to pay for it, and they can't get any assistance. [Sergeant, 40s]

The police we interviewed integrated their experiences with drug users into rich accounts of the difficulties drug users face:

> Rehab probably works as far as what I've seen 15–20% of the time. But it's not just the individual; it's their family and all that. A lot of people I deal with, their families turn their back on them. They have no ambition, and as soon as they get cleaned up, they're faced with the reality of not being able to find a job. They move to the boarding houses where you rent a room, you share a bathroom and a kitchen with 14 other people; it's awful. And all of those people are in the same boat you're in, and one person starts using, or one person has been using—you're moving into that environment, now it's there. It's a tough issue; it's a tough thing to kick. [Patrolman, 30s]

> I believe some of the people really do want to stop, but their choices of peers are not going to allow them to; their socio-economic positions. It's like a defence mechanism, escape; and there's not much you can do to help them, because there's nothing I can do to change what they're going to do the rest of their life. [Sergeant, 40s]

> Sometimes it gets frustrating. Sometimes you feel so bad for these people, you know. You look around and go: "You know, these people don't even have a shot." They go in there. They put their time in. They come out. Even if they tried to, they should just get away from the place. Get away from the neighbourhood. Start over. Go somewhere, but they don't. [Patrolman, 30s]

Awareness of social factors did not, however, lead respondents to absolve IDUs of responsibility for drug abuse and criminal behaviour. One patrolman captured the view shared by all the participants: "I don't know how good the services are that are given to them inside or outside, but there's got to be some placing of blame. A person has got to want to change." In the end, our respondents, whatever their views of the social roots of drug use and flaws in the treatment and criminal justice systems, felt that they must make do with the tools they have to deal with the immediate problems within their control:

> Jail is better than no jail because [IDUs] are not on the streets robbing you or me or my wife or my grandmother. That's the only thing that as a police officer I can offer

society, by taking that person and trying to get them off the streets so they can't victimise anybody else for a period of time. [Patrolman, 40s]

Discussion

We have identified several important gaps in the implementation of the Rhode Island syringe deregulation policy. Only half of officers in our sample were aware that syringe possession had been completely legalised. Even officers who knew of the change in law continued to use syringes as probable cause for searches or as evidence of drug possession. Real change in the extent to which IDUs obtain, carry and use sterile injection equipment depends upon what is done to ensure that police officers regulating the IDU "risk environment" (Burris et al., 2004; Rhodes et al., 1999) actually know about, understand and accept the goals of the policy change.

Similarly, federal guidelines and regulations on occupational exposure to blood-borne pathogens did not apparently influence police department managers to address the risk of NSI on the force (Bloodborne Pathogens, 2004; CDC, 1988). Data on needle stick accidents suggest that police officers are several hundred times more likely to experience a NSI than a member of the general public (Lorentz et al., 2000; O'Leary & Green, 2003). While the risk of infection is low, police officers regard the risk as high, believing that "an NSI held the same significance or more than a knife or gunshot wound" (Lorentz et al., 2000). The failure of the departments to provide training and education is unfortunate and may contribute to negative feelings towards IDUs.

Like fear of NSI, officers' attitudes about drug control policy, drug treatment, drug use, and drug users are contextual factors that influence how police officers deal with individual drug users on the streets. Our findings and those of the only similar study we identified (Beyer et al., 2002) indicate the error of assuming that police officers are uniformly doctrinaire, unreflective or close-minded on matters of drug control. 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.

In combination with the literature on policing and harm reduction, this study sets an agenda for both police practice and public health research. The relationship between drug users and police is distorted by misinformation and fear, leading police to use their enforcement discretion in ways that increase risks for drug users without protecting officers from NSI. A variety of measures should be considered to address this problem.

Initial and ongoing police training should include accurate information on the risk of NSI and how to avoid it through use of barrier precautions and better communication with people being searched. Training may also be used to reduce officers' pessimism about drug use by providing information about effective drug use treatment and disease prevention interventions. Adoption of harm reduction as a policy at the department level, as has occurred in some Australian jurisdictions (Midford, Acres, Lenton, Loxley, & Boots, 2002), may enhance the effect of training. The gap between law on the books and law on the street justifies greater efforts by law enforcement and public health managers to monitor practice and use the tools of management (such as standard operating procedures, performance reviews and incentives) to reduce behaviour that interferes with the achievement of public health goals. Collaboration between health and police agencies can provide the occasion for innovations in training, service delivery and health promotion among IDUs and other legally marginalised populations (Aral, Shearing, & Burris, 2002; Burris, in press).

Where SEPs and drug treatment programs are legal on the books, it is clearly essential to take steps to ensure that police agencies understand the value of these programs and how law enforcement behaviour can increase or decrease their effectiveness. Creating the conditions in which injecting drug users face minimal barriers to safe injection may also require changes in law on the books, such as the legalisation of safe injection facilities or changes in drug possession laws or enforcement practices (Burris et al., 2004; MSIC Evaluation Committee, 2003). In the meantime police practice remains a viable and important realm for intervention.

This study also suggests an agenda for further qualitative research to guide public health work among police. Larger studies of police attitudes and practices are needed to test and refine the findings presented here. Thorough exploration of the root narratives in police culture that blame users for addiction and portray prevention and treatment systems as inadequate, and how these narratives influence the exercise of street-level discretion (Shearing & Ericsson, 1991), could effectively inform new approaches to integrating public health and policing.

Conclusion

Policy changes designed to increase IDU access to sterile injection equipment cannot be successfully implemented without the co-operation of the police officers who enforce drug control laws. Policy changes unaccompanied by efforts to secure police co-operation through training, management changes, and monitoring are unlikely to succeed to the desired degree. Collaboration between police and public health agencies has the potential to yield new, more effective methods of reducing risk behaviour and improving access to services.

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