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**Public opinion and drug policy in Australia: engaging the 'affected community'**

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**Abstract**

Introduction: Policy should be informed by the people it directly affects however the voices of people who use illicit drugs have been marginalised from drug policy debate. In Australia, the majority of survey data regarding attitudes to drug policy is collected at the population level and the opinions of people who inject drugs remain underexplored. This study aimed to investigate how people who inject drugs perceive drug policy in Australia and whether these opinions differ from the broader general population.

Methods: Drug-related policy questions were drawn from the National Drug Strategy Household Survey (NDSHS) and added to the 2011 Illicit Drug Reporting System (IDRS) survey (n=868). The results were analysed for the full IDRS sample, and by recent drug use. IDRS responses were compared to the general population, using the 2010 NDSHS.

Results: There was a high level of support amongst IDRS participants for measures to reduce the problems associated with heroin, but heterogeneity in levels of support for legalisation and penalties for sale/supply across different drug types. Differences between the opinions of the IDRS sample and the NDSHS sample were identified regarding support for harm reduction, treatment, legalisation and penalties for sale/supply.

Discussion: These findings provide a springboard for further investigation of the attitudes of people who use illicit drugs towards drug policy in Australia, and challenge us to conceptualise how the opinions of this community should be solicited, heard and balanced in drug policy processes.

**Key words:** drug policy, public opinion, illicit drugs, consumer participation

**Introduction**

The notion that policy should be informed by the people it most directly affects is an important ethical consideration for public health [1] and policy development [2]. Participation is regarded as a principle of 'good governance' [2, 3] and governments acknowledge that giving the community a voice in policy can better inform policy development, build trust and increase legitimacy [4, 5]. While the value of engagement with specific communities has been discussed in relation to public health domains such as genetic testing [6] and cancer [7], the voices of people who use drugs, and particularly those who inject drugs, have traditionally been marginalised from policy debate. Although there have been efforts to increase the participation of treatment service users in drug treatment service planning and delivery [8, 9], it has been noted that "most of the responses to drug-related overdose, drug-related crime, family breakdown, drug treatment, unemployment, etc., have been developed in isolation to people who use illicit drugs" [10, p.2]. Compared to other areas of public health and social policy where participation is valued, the views of people who use drugs are rarely sought [11, 12] as this community are seen to be 'problematic', 'chaotic' or 'hard to reach' [13]. Despite the illegality of drug use, it is recognised that people who use drugs have a role to play in policy processes. For example, there are a number of government-funded Australian drug user organisations. The stigmatisation and criminalisation of drug use is a complex barrier [14, 15] but should not disqualify people who use drugs from participation [16], especially as the broader criminological literature has demonstrated the need for offenders' views to be heard in policy and practice [e.g. 17, 18]. It is our position that people who use drugs, as citizens, and the community most directly affected by policy responses, should have their views represented in policy deliberation (a position widely held in the international drug policy community [19]).

There are a number of mechanisms by which communities can be engaged in policy deliberation including consultation, partnerships, advocacy and consumer representation. Amongst these mechanisms is survey research which can play an important role by more inclusively communicating the views of a particular community [6]. Surveys can canvass the opinions of a large number of individuals affected by policy, and can make a valuable contribution to policy discussion as "many views can be assessed, not just the views of those who are the 'loudest' or the most politically powerful" [6, p.37]. However in Australia, the majority of survey data regarding attitudes to drug policy are collected at the population level [20] and the voices of people who inject drugs (who represent 1-2% of the Australian population [21]) remain largely marginalised and underexplored. For example, we do not know if people who inject drugs have similar or different views to the

broader population about fundamental drug policy questions such as the role of needle syringe programs, treatment and drug legalisation (issues which have been the subject of heated public debate [e.g. 22, 23, 24, 25]). This has considerable implications, as we know that public opinion can influence policy [26, 27], and the opinions of those with 'lived' experience are, largely, not being heard to inform timely, targeted policy interventions which are seen to be of value [12].

The aim of this study was, firstly, to investigate how people who inject drugs perceive drug policy in Australia and, secondly, to explore whether people who inject drugs have similar or different opinions to the broader general population about drug policy interventions in Australia. In doing so, we hope to provide a starting point for further examination of the opinions of people who use illicit drugs in Australia with a view to generating better understandings of how these voices can, and should, be included in drug policy debate.

**Methods**

The data for this study were derived from two surveys, the 2011 Illicit Drug Reporting System (IDRS) and the 2010 National Drug Strategy Household Survey (NDSHS). The IDRS is an annual, national, face-to-face survey of a sentinel sample of people who inject drugs in Australia [for detailed methodology see 28]. Recruitment occurs through advertisements, needle syringe programs and peer-referral. In 2011, the sample (n=868) were aged 17 to 65 years (mean age, 38 years), 66% were male and 79% were unemployed. The NDSHS is a triennial, national survey which monitors drug use, attitudes and support for drug-related policies in the general population. Participants (n=26,648) aged over 12 years were selected from a national stratified random selection of households. Weighting is used to adjust the data to the profile of the Australian population [for detailed methodology see 29].

The two samples differ substantially in basic demographic characteristics, as would be expected in a comparison of the general population with a sub-population of people who inject drugs. This study compares the data which are most often used to represent public opinion on drug issues in Australia (that is, the NDSHS), with the opinions of people who inject drugs. The broader NDSHS population includes a small proportion of people who inject drugs (in 2010, 0.4% had injected a drug in the previous 12 months [29]), but this sample size is too small to conduct analyses, and does not present a confound to our analysis because of its small size.

Three questions regarding support for drug-related policies were drawn verbatim from the NDSHS [30, p.42-43] and added as supplementary questions to the 2011 IDRS. The questions, with a six-point Likert scale (strongly support; support; neither support nor oppose; oppose; strongly oppose; and don't know), covered support for measures to reduce the problems associated with heroin, support for the personal use of drugs to be made legal and support for increased penalties for the sale or supply of illicit drugs (see Table S1).

Frequency distributions were used to examine support, with responses collapsed into four categories (strongly support/support, neither support nor oppose, oppose/strongly oppose and don't know). The IDRS results were analysed for the full sample, and by respondent characteristics including recent drug use. Pearson's chi-square was used to determine statistical significance between groups, and adjusted residuals were used to analyse which cell differences contributed to the overall chi-square results (an adjusted residual score of greater than 2.0 or below -2.0 indicated that the cell differed significantly).

**Results**

*Support for measures to reduce the problems associated with heroin (IDRS)*

There was a high level of support amongst IDRS participants for all policy measures to reduce the problems associated with heroin (see Table 1). The greatest level of support was for needle syringe programs (96.8%), treatment with methadone and buprenorphine (86.3%) and treatment with drugs other than methadone (82.7%). There was less support for rapid detoxification therapy and naltrexone with approximately one-fifth of participants (23.3% and 19.7% respectively) opposing these measures.

Comparing the IDRS respondents who had used heroin in the last six months with those respondents who had not used heroin recently revealed that the former group were significantly more supportive of methadone/buprenorphine ($\chi^2$ = 24.223, df = 3, p<.0001); treatment with drugs other than methadone ($\chi^2$ = 7.798, df = 3, p<.05); injecting rooms ($\chi^2$ = 10.974, df = 3, p<.012); prescribed heroin trials ($\chi^2$ = 51.331, df = 3, p<.0001); and use of naltrexone ($\chi^2$ = 16.577, df = 3, p<.001), but not significantly more supportive of needle syringe programs nor rapid detoxification measures (p>.05). There were also higher proportions of 'don't know' responses across all interventions from those who had not used heroin recently (see Table S2).

*Support for the personal use of drugs to be made legal (IDRS)*

IDRS participants were asked to what extent they supported or opposed the personal use of drugs being made legal. As shown in Table 1, there was heterogeneity in reported levels of support across different drug types. The highest level of support was for legalisation of cannabis (87.0%), followed by heroin (54.9%). However, over half of IDRS participants opposed legalisation of methamphetamine (58.1%), ecstasy (57.8%) and cocaine (52.0%).

The responses of participants who had used the relevant drug in the last six months were compared to those who had not used the drug recently. As shown in Table 2, in every case there were higher levels of support for legalisation amongst those who had used the relevant drug recently. For example, 90.7% of those who had used cannabis in the last six months supported legalisation of cannabis, compared to 73.3% of those who had not used cannabis recently. Likewise, 48.3% of those who had not used heroin in the last six months opposed legalisation of heroin, compared to 23.7% of recent users.

*Support for increased penalties for the sale or supply of illicit drugs (IDRS)*

IDRS participants were asked to what extent they supported or opposed increased penalties for the sale or supply of illicit drugs. Again, there was heterogeneity in reported levels of support across different drug types (see Table 1). The highest level of opposition was towards increased penalties for sale or supply of cannabis (80.8%). Approximately half opposed increased penalties for the sale or supply of heroin (58.4%), cocaine (50.8%), ecstasy (50.1%) and methamphetamine (49.2%). However, a substantial minority of IDRS participants supported increased penalties. For example, approximately one-third supported increased penalties for the sale or supply of methamphetamine (33.3%) and ecstasy (29.4%).

The responses of participants who had used the relevant drug in the last six months were compared to those who had not used the relevant drug recently (see Table S3). The responses of recent and non-recent users did not differ significantly ($p>.05$), with the exception of heroin ($\chi^2 = 15.279$, $df = 3$, $p<.002$) where recent users offered less support for increased penalties compared to those who had not used heroin recently (21.4% compared to 33.5%, respectively).

*Responses of IDRS participants compared to the NDSHS general population*

We compared the responses of IDRS participants to the responses of NDSHS participants to explore whether people who inject drugs have similar or different opinions to the broader general population about drug policy interventions in Australia.

As shown in Table 1, there were large proportional differences in levels of support between the two samples across most measures to reduce the problems associated with heroin. These differences were evident even in relation to some of the measures most supported by both IDRS participants and NDSHS participants, such as needle syringe programs (IDRS 96.8% support; NDSHS 53.0% support) and methadone (IDRS 86.3% support; NDSHS 48.7% support). However, there was little difference in levels of support between IDRS participants and NDSHS participants for rapid detoxification therapy (IDRS 55.4% support; NDSHS 53.8% support) and naltrexone (IDRS 53.0% support; NDSHS 49.7% support).

Regarding support for the personal use of drugs to be made legal, in contrast to the IDRS sample the majority of NDSHS participants opposed legalisation of all drugs (see Table 1). If we consider the rank ordering of support for legalisation of different drug types, both IDRS and NDSHS participants gave the most support to legalisation of cannabis (IDRS 87.0% support; NDSHS 22.3% support). For the NDSHS sample, the second most supported drug for legalisation was ecstasy (a rank preference not reflected in the IDRS sample where second preference was given to heroin).

Comparing the responses of IDRS participants to NDSHS participants regarding support for increased penalties for sale or supply of illicit drugs, again there were large proportional differences in levels of support between the two samples across all drug types (see Table 1). Approximately three-quarters of the general population supported increased penalties for the sale or supply of heroin (78.9%), methamphetamine (78.5%), cocaine (76.9%) and ecstasy (75.8%). In contrast, increased penalties for sale or supply of these drugs were supported by one-quarter to one-third (26.0% to 33.3%) of IDRS participants. Support for increased penalties amongst the NDSHS sample was slightly lower for cannabis, which reflects the same rank preference as the IDRS sample.

**Discussion**

The findings of this study provide a starting point for understanding how people who inject drugs *themselves* perceive drug policy in Australia, and demonstrate differences between the opinions of this community and the broader general population across key drug policy domains including harm reduction and treatment services, legalisation and penalties for sale or supply.

The high level of support amongst people who inject drugs for all measures to reduce the problems associated with heroin may reflect participants' personal experience and knowledge of these services. The differences in levels of support for different treatment options (for example the higher level of support for methadone as compared to rapid detoxification therapy or naltrexone) warrants

further exploration as it may reflect participants' experience of the efficacy of these treatment options. Such findings have important implications for understanding treatment demand and client preferences. Similarly, the heterogeneity in levels of support for legalisation of different drug types amongst IDRS participants may reflect personal preferences (with cannabis being the most commonly used drug and heroin being the drug of choice for the majority of IDRS participants [28]). However, it is noteworthy that substantial proportions of participants did not support legalisation, despite having used the relevant drug recently (for example one-quarter of recent heroin users opposed heroin legalisation, and approximately half of recent users opposed legalisation for methamphetamine, cocaine and ecstasy). There were not significant differences between those who had and those who had not used the relevant drug type recently when participants were asked about support for increased penalties for sale or supply of illicit drugs (with the exception of heroin).

The comparison between those with direct experience of injecting drug use and the broader general population may simply reflect divergent opinions or may be a function of personal experience and first-hand knowledge. The large proportion of 'don't know' responses (between 22.7% and 34.4%) amongst the general population is noteworthy in this regard. Although the views of the drug using community could be dismissed as self-serving, their attitudes reflect the 'lived' experience of people directly impacted by drug policy.

Comparing the opinions of people who inject drugs with the general population presents challenges for conceptualising how differences in opinion should be balanced in policy deliberation, and raises questions about how the competing voices of different 'publics' should be solicited and heard in policy processes. For example, if we were to consider the opinions of only people who inject drugs, as assessed here, and assume that opinions drive policy, we would implement all harm reduction and treatment interventions, legalise personal use of cannabis and heroin (but not methamphetamine, cocaine and ecstasy) and would not increase penalties for sale or supply. By way of contrast, if drug strategy was based solely on the opinions of the general population we would implement some harm reduction and treatment interventions (but limit treatment with drugs other than methadone, injecting rooms or heroin trials), retain the criminal status of illicit drug use and increase penalties for sale or supply. This characterisation is crude, as it does not take into account the plethora of influences on policy decision-making. Nonetheless it highlights the quandary of how best to conceptualise and reconcile opinions from diverse 'publics' to inform drug policy deliberation.

Seeking and incorporating the perspectives of people who use illicit drugs and acknowledging the important role this group can play in policy discussion is imperative for drug policy despite the

fundamental challenges of balancing divergent views. The role that the community most affected by policy can play in sharing personal experience and knowledge and counterbalancing discriminatory (or uninformed) opinions in policy deliberation is recognised and valued in other policy domains, and held up as an important ethical consideration [1, 6]. Indeed, it has been said that one way of responding to stigma is to involve marginalised individuals in the policy-making process [6]. We argue that it should equally be so in drug policy. The alcohol and other drug field should not shy away from the challenges involved in seeking and integrating the opinions of this community.

There are many challenges in defining a 'community', deciding which voices in that 'community' can be heard and accurately describing their attitudes. For this reason surveys of attitudes should aim for large samples. In this study, we used the IDRS to access a large, national sample of people who inject drugs through established recruitment methods. Nonetheless, the views expressed by IDRS participants in 2011 should not be regarded as representative of all people who inject drugs in Australia. We also acknowledge that surveys are not transparent instruments; surveys contribute to the production and framing of issues, and may generate the similarities and differences they purport to discover [23, 31, 32]. More in-depth, qualitative research is required to better understand the findings of this study. For example, why are people who inject drugs more supportive of legalisation of heroin than methamphetamine? This study also only examined the opinions of people who inject drugs; exploration of the views of people who consume drugs by other means is warranted. Furthermore, it is important to note that surveys are not a substitute for more deliberative public debates and active engagement throughout policy processes [2].

**Conclusion**

The voices of people who inject drugs have been largely missing from discussion of public opinion about drug policy in Australia, which has stymied opportunities for drug policy to be informed by those it most directly affects. The findings of this study demonstrate that there are differences between the attitudes of the general population and people who inject drugs across key drug policy domains. These findings provide a springboard for further investigation of the attitudes of people who use illicit drugs towards drug policy in Australia, and challenge us to conceptualise how the opinions of this community should be solicited, heard and balanced in policy processes. It has been said that "solutions to improving the health and wellbeing of drug users should develop from both a grass-roots level and a top-down strategic level" [13, p.12]. Therefore better understanding how the

voice of the 'affected community' can, and should, be included in drug policy debate in Australia remains an ongoing challenge for the drug policy field.

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## Tables

**Table 1 Support for: measures to reduce the problems associated with heroin; the personal use of drugs to be made legal; and, increased penalties for the sale or supply of illicit drugs, amongst people who inject drugs (IDRS 2011) and the general population (NDSHS 2010) (proportion)**

| Policy support for: | | | Strongly support/ support | Neither support nor oppose | Oppose/ strongly oppose | Don't know enough to say |
|---|---|---|---|---|---|---|
| **Needle and syringe programs** | IDRS | (n=839) | 96.8% | 0.5% | 1.0% | 1.8% |
| | NDSHS | (n=24,898) | 53.0% | 11.6% | 12.8% | 22.7% |
| **Methadone/buprenorphine maintenance** | IDRS | (n=837) | 86.3% | 3.8% | 6.3% | 3.6% |
| | NDSHS | (n=24,827) | 48.7% | 12.6% | 9.0% | 29.8% |
| **Treatment with drugs other than methadone** | IDRS | (n=837) | 82.7% | 5.0% | 4.8% | 7.5% |
| | NDSHS | (n=24,802) | 45.5% | 13.4% | 6.7% | 34.4% |
| **Regulated injecting rooms** | IDRS | (n=836) | 80.5% | 6.2% | 8.6% | 4.7% |
| | NDSHS | (n=24, 904) | 39.8% | 13.6% | 23.9% | 22.7% |
| **Trial of prescribed heroin** | IDRS | (n=834) | 74.6% | 5.5% | 13.1% | 6.8% |
| | NDSHS | (n=24,820) | 25.3% | 13.7% | 33.6% | 27.4% |
| **Rapid detoxification therapy** | IDRS | (n=838) | 55.4% | 9.5% | 23.3% | 11.8% |
| | NDSHS | (n=24,863) | 53.8% | 11.2% | 4.0% | 31.0% |
| **Naltrexone** | IDRS | (n=837) | 53.0% | 11.8% | 19.7% | 15.4% |
| | NDSHS | (n=24,820) | 49.7% | 11.2% | 5.0% | 34.2% |
| **Support for legalisation of the personal use of:** | | | | | | |
| **Cannabis** | IDRS | (n=836) | 87.0% | 3.8% | 8.4% | 0.8% |
| | NDSHS | (n=25,448) | 22.3% | 18.5% | 51.3% | 7.9% |
| **Heroin** | IDRS | (n=835) | 54.9% | 9.9% | 33.1% | 2.2% |
| | NDSHS | (n=25,366) | 5.5% | 4.6% | 81.9% | 8.1% |
| **Methamphetamine** | IDRS | (n=835) | 28.7% | 11.1% | 58.1% | 2.0% |
| | NDSHS | (n=25,341) | 4.6% | 4.7% | 82.5% | 8.2% |
| **Cocaine** | IDRS | (n=835) | 27.3% | 14.6% | 52.0% | 6.1% |
| | NDSHS | (n=25,394) | 5.8% | 5.9% | 80.2% | 8.1% |
| **Ecstasy** | IDRS | (n=834) | 24.9% | 12.1% | 57.8% | 5.2% |
| | NDSHS | (n=25,377) | 6.2% | 6.3% | 79.3% | 8.2% |
| **Support for increased penalties for the sale or supply of:** | | | | | | |
| **Cannabis** | IDRS | (n=833) | 8.8% | 7.4% | 80.8% | 3.0% |
| | NDSHS | (n=25,425) | 56.4% | 17.9% | 18.7% | 6.9% |
| **Heroin** | IDRS | (n=832) | 26.0% | 11.4% | 58.4% | 4.2% |
| | NDSHS | (n=25,393) | 78.9% | 5.7% | 8.4% | 7.1% |
| **Methamphetamine** | IDRS | (n=831) | 33.3% | 13.0% | 49.2% | 4.5% |
| | NDSHS | (n=25,362) | 78.5% | 6.0% | 8.3% | 7.3% |
| **Cocaine** | IDRS | (n=831) | 27.6% | 14.8% | 50.8% | 6.9% |
| | NDSHS | (n=25,404) | 76.9% | 7.0% | 9.0% | 7.1% |
| **Ecstasy** | IDRS | (n=831) | 29.4% | 13.5% | 50.1% | 7.1% |
| | NDSHS | (n=25,389) | 75.8% | 7.6% | 9.6% | 7.2% |

**Table 2 Support for the personal use of drugs to be made legal, by recent use of relevant drug (proportion; adjusted residual) amongst people who inject drugs (IDRS)**

| Support for the personal use of drugs to be made legal: | | Relevant drug used last 6 months | Strongly support/ support | Neither support nor oppose | Oppose/ strongly oppose | Don't know enough to say | *p*-value |
|---|---|---|---|---|---|---|---|
| **Cannabis** | | Yes (n=655) | 90.7% | 2.0% | 6.6% | 0.8% | <.0001 |
| | | | (6.1) | (-5.3) | (-3.6) | (-0.5) | |
| | | No (n=180) | 73.3% | 10.6% | 15.0% | 1.1% | |
| | | | (-6.1) | (5.3) | (3.6) | (0.5) | |
| **Heroin** | | Yes (n=515) | 65.2% | 9.1% | 23.7% | 1.9% | <.0001 |
| | | | (7.7) | (-1.0) | (-7.3) | (-0.5) | |
| | | No (n=319) | 37.9% | 11.3% | 48.3% | 2.5% | |
| | | | (-7.7) | (1.0) | (7.3) | (0.5) | |
| **Cocaine** | | Yes (n=137) | 38.0% | 15.3% | 41.6% | 5.1% | <.015 |
| | | | (3.1) | (0.2) | (-2.6) | (-0.5) | |
| | | No (n=694) | 25.2% | 14.6% | 53.9% | 6.3% | |
| | | | (-3.1) | (-0.2) | (2.6) | (0.5) | |
| **Ecstasy** | | Yes (n=111) | 31.5% | 14.4% | 48.6% | 5.4% | <.199 |
| | | | (1.7) | (0.8) | (-2.1) | (0.1) | |
| | | No (n=720) | 23.9% | 11.8% | 59.2% | 5.1% | |
| | | | (-1.7) | (-0.8) | (2.1) | (-0.1) | |
| **Methamphetamine** | Speed/powder | Yes (n=356) | 32.6% | 10.7% | 54.2% | 2.5% | <.129 |
| | | | (2.1) | (-0.4) | (-1.9) | (0.9) | |
| | | No (n=476) | 25.8% | 11.6% | 60.9% | 1.7% | |
| | | | (-2.1) | (0.4) | (1.9) | (-0.9) | |
| | Base/wax | Yes (n=178) | 36.5% | 11.2% | 49.4% | 2.8% | <.043 |
| | | | (2.6) | (0.0) | (-2.6) | (0.8) | |
| | | No (n=652) | 26.7% | 11.2% | 60.3% | 1.8% | |
| | | | (-2.6) | (0.0) | (2.6) | (-0.8) | |
| | Crystal/ice | Yes (n=375) | 34.7% | 9.3% | 53.6% | 2.4% | <.004 |
| | | | (3.4) | (-1.5) | (-2.4) | (0.7) | |
| | | No (n=457) | 23.9% | 12.7% | 61.7% | 1.8% | |
| | | | (-3.4) | (1.5) | (2.4) | (-0.7) | |

*Note*. Adjusted residual frequencies appear in parentheses below observed percentages.