International Journal of Drug Policy 64 (2019) 40–46

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Research Paper

"It's about bloody time": Perceptions of people who use drugs regarding drug law reform

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ARTICLE INFO

Keywords:
People who use drugs
Drug law reform
Drug laws
Drug policy
Qualitative
Consumer participation

ABSTRACT

Background: In Australia and elsewhere, the impacts of drug prohibition have sparked a critical dialogue about the state of current drug laws. While a range of 'experts' have offered their opinion and participation in these deliberations, the voices of the affected community have largely been excluded. This study aimed to gather the opinions and preferences of people who use drugs about the current or alternative models of drug laws, in addition to how they think drug laws could be changed Author Conflict of Interest Declaration.

Methods: In March 2018, four focus groups (n = 37) were conducted with people who were in receipt of social welfare services in Sydney, Australia, where participants were encouraged to share their views about the current drug laws, drug law reform options, and important messages to politicians. Several themes were identified through a thematic analysis.

Results: Models of drug law reform were often understood and expressed in language and constructs different to those commonly used by researchers. Opinions were diverse and there was no consensus on a preferred model, although discussions flowed around decriminalisation, legalisation, and a medical/prescription model; the latter being the preferred approach. Participants shared pessimistic views of the drug laws ever changing, and argued that public opinion would need to adjust for reform to succeed. Furthermore, they argued that the views of the affected community are vital to any drug law reform campaign.

Conclusions: Participants affinity towards a medical/prescription approach to drug regulation was an unexpected finding. This study serves as an important example of the opinions and experiential knowledge of the affected community and this knowledge could be solicited alongside other forms of 'expertise' in drug law reform campaigns.

Introduction

Worldwide, the drug laws are at a critical juncture. In Australia and internationally, concerns have been raised over laws addressing drug use and possession, pointing to the failures of drug prohibition (Eastwood, Fox, & Rosmarin, 2016; Gotsis, Angus, & Roth, 2016; New Zealand Drug Foundation, 2017; Weatherburn, 2014; Wodak, 2014). The prevailing approach of prohibition, with its criminal framing, has been increasingly deliberated on the grounds of ineffectiveness and human rights violations (Eastwood et al., 2016; Gotsis et al., 2016; Weatherburn, 2014; Wodak, 2014). While the decriminalisation of drugs has been strongly supported by the Australian public (Gotsis et al., 2016; Lancaster, Ritter, & Stafford, 2013) drug law reform continues to be challenging to define and govern in the face of moralised and sensationalised arguments of "drug problems" (Global Commission on Drug Policy, 2011; Hughes, 2006). Furthermore, approaches to these debates are most often fixed between the 'experts' – politicians, law enforcement, public health practitioners, academics, and civil leaders – while lay public opinions are often excluded (Lancaster, Ritter, & Diprose, 2018). A range of opinions play an important role in determining and informing political deliberations and processes, and the experiences of the affected community – people who use drugs (PWUD) – are often not incorporated in these deliberations (Ritter, Lancaster, & Diprose, 2018).

Involving PWUD in governance can be viewed in terms of theories of public participation. One of the central arguments of participation theory is that it is democratic: participation provides an opportunity for citizens to articulate their interests and values. Public participation theories claim that accountability and transparency of governments are enhanced while addressing issues of representation, power and

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https://doi.org/10.1016/j.drugpo.2018.12.006

authority (Quick & Bryson, 2016; Young, 2002). This approach has also been promoted as a way to advance social justice, enhance understanding of public problems, explore equitable solutions, and create plans and projects of higher quality and relevance.

From this lens, PWUD and others that are directly impacted by the drug laws can be seen as important stakeholders to the discourses and decisions that affect them. PWUD provide important insight into their dynamic lived experience, the local context of drug use, and the impact of drug policies within this context, and this process promotes accountability, diversity, and ethical standards (Cornwall & Gaventa, 2000; Gaventa, 2004; Greer et al., 2016; Tritter & McCallum, 2006). The concept of participation in decision-making has become commonplace in some areas of healthcare such as mental health, disability and cancer treatment (Brett et al., 2014). Research in participation in public health intervention development has shown its benefits such as empowerment, physical and social health, increased social capital and neighborhood cohesion (Attree et al., 2011; Popay et al., 2007; Wallerstein & Duran, 2006). However, some have pointed out that participation in drug policymaking with PWUD has lagged behind (Rance & Treloar, 2015), despite over three decades of calls to increase the uptake of consumer participation as a best practice to policymaking (Crawford et al., 2002; Greer et al., 2018, 2016; Tritter & McCallum, 2006).

Research has pointed out the impacts of *not* including the affected community in drug policy reform. For instance, in 2014 several regulatory reforms in British Columbia, Canada resulted in changes to methadone maintenance treatment to a ten-times more concentrated methadone formulation ('Methadose') and restrictions in pharmacy delivery services (Greer, Amlani, & Buxton, 2016; McNeil et al., 2015). While some methadone patient groups were involved in developing community posters about the change, policy reforms and materials given to methadone patients were uninformed by patients themselves (Greer, Amlani et al., 2016, 2016). Research on the influence and impacts of regulatory frameworks on the lives of people on methadone have shown disrupted treatment engagement and considerable health and social harms, including increased and widespread withdrawal symptoms, worsening pain and increased injection heroin use (Greer, Amlani et al., 2016; McNeil et al., 2015). These studies and others underscore the need to consider unintended effects of not involving all relevant stakeholders in the planning and implementation of new policies.

There is a small yet growing body of literature that documents the voices of PWUD in drug policy efforts globally. Of the literature that exists, studies have quantitatively investigated correlates of attitudes towards drug law models (Darke & Torok, 2013) and the heterogeneity of opinions about drug policies among people with different drug use histories (Lancaster, Sutherland, & Ritter, 2014). Lancaster et al. (2013) measured opinions of the drug laws between people who inject drugs and the general public, and later qualitatively examined PWUDs opinions as to why publics hold particular views about drug policies (Lancaster, Santana, Madden, & Ritter, 2015).

However, to date, no study has conducted a qualitative investigation of the opinions and preferences regarding drug laws among PWUD, nor examined their perspectives specific to drug law reform campaigns. The aim of this study was to investigate how PWUD understand drug laws, their views about how drug laws could be improved (including alternative models, and their opinions of campaigns for drug law reform in Australia). Documenting the voices of the affected community is important as it provides insight into what PWUD think about drug law and policy development, as well as how the opinions of PWUD can be heard and balanced in drug law reform and policy processes – particularly as pushes for drug law reform move forward.

Methods

A qualitative approach was taken to investigate the affected community's perspectives of the drug laws, drug law reform, and reform campaigns. The population of interest was people directly affected by drug laws. Drug use experience (past or present) was not a strict eligibility criterion so we could elucidate perspectives from close affiliates of PWUD (e.g. partners, friends, dealers) who may or may not use drugs themselves, but who could nonetheless have closely witnessed or been impacted by drug laws. Information about drug use histories were not explicitly asked but drugs and drug use were topics often raised by participants.

Researchers from the University of New South Wales held four focus groups in March, 2018 with people who were in receipt of social welfare services in Sydney. Advertisements for the focus groups were placed at these services two weeks prior to the groups, and service staff recruited participants via word of mouth. Participants were eligible for the study if they: 1) spoke English; 2) were over 18 years old, and; 3) were interested in talking about drug laws. Participants were offered $40 AUD cash for out-of-pocket reimbursement, and refreshments were provided. The focus groups were 60–90 min in duration. After informed consent, the group was facilitated using a semi-structured question guide. Questions included: "what do you think about the current drug laws"; "What would you like to see changed about the drug laws"; and "How would changes to the drug laws impact you?" In the focus groups, researchers did not seek to define any terms at the start, and attempted to elicit the participants own terminology. Later in the focus groups, terms used to describe drug laws and policies were clarified by the facilitator to enable more specific discussion (i.e. "earlier you used the term decriminalisation. Let's talk a little bit about decriminalisation, which is different from legalisation, and different from the prescription model. Decriminalisation means that the use and possession of these drugs is not a criminal offence but supply is still a criminal offence. What do you think about the decriminalisation of heroin?"). Participants were encouraged to each share freely. These discussions were audio-recorded and later transcribed verbatim. Field notes were also taken. Ethics approval was obtained from the Human Research Ethics Committee at the University of New South Wales (approval # HC17998).

A total of 37 individuals participated in the focus groups (with a maximum of ten participants per group). The focus groups were conducted in downtown Sydney at a harm reduction site (n = 10; n = 9; n = 10) and in an outer suburb of Sydney in a recovery setting (n = 8). Having more than one setting for the focus groups allowed for a diverse range of views. For the analysis undertaken here, all focus group data were merged, to enable an understanding of themes arising across the full sample. Participants were not asked for quantitative demographic or drug use information (to retain a sense that their opinion, irrespective of their details, was being valued). Of the 37participants, 36 spontaneously shared their recent illicit drug use history during the discussions. Participants mostly identified opioids as their drug of choice, although poly drug use permeated.

Before analysing the data, transcriptions were cleaned – all names were replaced with pseudonyms (herein) and other identifying information was removed to preserve anonymity. Data were coded and sorted using NVivo using a thematic analytic approach. A thematic approach enables a comprehensive understanding of qualitative data by identifying, analyzing, organizing, describing, and reporting themes with an applied focus (Braun & Clarke, 2006; Nowell, Norris, White, & Moules, 2017). The steps used in the analysis were similar to those outlined by Nowell et al. (2017) which enhances rigour in a thematic analytic approach. Preliminary themes were inductively and collaboratively developed between the researchers (AG & AR), and later expanded upon using a constant comparison technique. Several broad themes had emerged through debriefing, journaling, and meetings, which were used to develop initial categories. These broad categories were then collaboratively synthesized and expanded to create hierarchies of concepts and themes. From this process, an exhaustive list of subthemes and codes was created and reviewed, which was used to

code and sort the data in NVivo. The final themes, theme names, and respective quotes were reviewed and discussed in detail. Throughout this process, the researchers debriefed often, reflecting on interpretations and reactions to the data (Lincoln & Guba, 1985; Nowell et al., 2017). The final themes and supporting quotes were reviewed by the researchers; differences were discussed and resolved by agreement.

Results

Three main themes were identified from the focus group data: 1. the language used to describe drug law reform; 2. perspectives of the models of drug laws, including decriminalisation, legalisation, and the medical or prescription model (a "helping" model); and 3. perspectives on changing the drug laws.

The language of drug law reform

In academic settings, there is a particular set of terms and language that pertain to drug law reform, including terms such as decriminalisation, legalisation, regulation, threshold quantities, and so on. This was not a language shared by focus group participants. For instance, decriminalisation was never discussed in terms of '*de jure*' law, and participants rarely used the term '*de facto*' using it only when describing police discretion experiences and after the researcher used the term. '*Thresholds*' was also not used by participants. Instead, this term was synonymous with "*amounts*" (of drugs), typically described as grams or ounces.

Other technical terms or concepts not mentioned by participants were administrative fines, cautioning, paraphernalia, and diversion (as in police diversion programs). Other concepts such as the idea of cultivation was understood as "grow[ing] a couple of plants" (Adam, focus group (FG) 4) for personal use. Synthetic drugs were often described as "manmade" or "hard drugs," and described as being made by "cooks" or "manufactured in the backyard" (Jerry, FG2).

Researchers' definitions of 'legalisation' and 'decriminalisation' were not the same as the participants' own definitions. Some understood legalisation as synonymous with decriminalisation. For instance, researchers asked what participants thought about legalisation and Cassie (FG2) responded:

> So, if you legalise it and you take away the criminality, therefore you don't have that red flag… because it's decriminalised and it hasn't got that dark side to it.

Later in FG2, when someone asked how people could access drugs under decriminalisation, Noah responded: "Through the government, magically." Others also thought decriminalisation meant increased availability. For instance, when talking about decriminalisation in Portugal, John (FG1) attributed the change to increased drug availability: "there's data on [decriminalisation]… so the increased availability of drugs doesn't lead to an increase in use."

Legalisation was also understood to refer to drugs being available through the medical system. For instance, by asking "what do you think of legalising all drugs?" participants spoke about "get[ting] on a program, like methadone" (Rachel, FG2) through their doctor, and did not talk about legalisation in terms of a legal regulated drug market. In nearly all cases, participants' dialogue around legalisation always referred back to the medical system:

> John: …I reckon every drug should be legalised but – like if heroin should be legalised but have a clinic to go and have your heroin and whatever (FG1)
> Karl: …if they did regulate it [heroin], it's like they legalise methadone, and once you get on a program, it will reduce the crime, so if you are going to do that, maybe a lot cheaper, if there is a program…. (FG2)

There were also different understandings of the current status of illegal drugs - notably, cannabis. When asked about perspectives on the legalisation of cannabis, Jules and Karl both declared "it's [already] happened," and Ben (FG3) stated that people are "[already] us[ing] it for legal purposes".

Models of drug law reform

Discussion flowed around three main models of drug law reform: decriminalisation; legalisation; and a medical/prescription model. First, it was clear that the models applied specifically to certain drug types. For example, legalisation for cannabis was roundly supported, but not for crystal methamphetamine ('ice'). Participants used words such as "soft" or "natural" to describe cannabis and "hard," "heavy," or "manmade" to describe other drugs including ecstasy, cocaine and ice. Some participants voiced that drug laws should be different based on these classifications.

Opinions of the law reform options across drugs were often based on participants' perceptions of a drug's effect and its helping or harming potential. Perspectives of drug reform shifted instantly once methamphetamine or 'ice' was in question, and views of 'ice' as harmful were intense and vividly described. Participants thought that 'ice' was "evil shit" (William, FG4), "insidious" (Adam, FG4), "a scourge on society… the worst drug on earth" (Dylan, FG3) compared to other drugs.

> Natalie: But different drugs do different things to you… You know, [with heroin] you're more likely to sit at home and you know? Like ice, ice physically changes you. (FG1)

We noted that the intense opposition to crystal methamphetamine was largely among people who used opioids. One participant (who had self-identified as a person who uses 'ice') vigorously challenged the harsh perceptions of 'ice':

> Jerry: See this is where I get really frustrated when people say it [ice] is the worst drug on the plant… but they prefer to use like heroin and whatever and this and that. It's still a drug. (FG1)

Perspectives on decriminalisation

After general discussion, the facilitator turned the discussion to specific law reform models starting with decriminalisation, and ensured that participants had a shared understanding of the model under discussion at that point (decriminalisation as the removal of criminal penalties for use/possession). Over time, distinctions between the models became more clear. As noted by one:

> Kirk: we're talking about decriminalisation for possession and use. We're not saying it's going to be legalised. They're still going to be pinching dealers …going after the importers and stuff like that…. It's still going to be illegal to go and score it, but if you're caught with it, you're not charged. You know, that's what decriminalisation is. It's not willy nilly everybody can use drugs; it's just making life for us a lot easier. (FG1)

Decriminalisation was supported by most, although not all participants offered an opinion. Cannabis decriminalisation was described as a change that needed to happen "ASAP" (Kate, FG4) and statements regarding reform were to the point. Some even thought it was not worth talking about and were quick to move the discussion elsewhere: "forget the cannabis" (Cat, FG4).

Participants recognised that with decriminalisation there would be a shift in law enforcement towards more discretionary power among police, which concerned participants. This concern was reinforced because currently in Australia, the diverse forms of decriminalisation largely rely on police discretion. Participants were less concerned about how this shift would influence their own availability or use of drugs, but brought it up in reference to drug market resilience. Some noted that decriminalisation would not remove the "problems" they associated with drug use, and that dealers and drug markets would endure.

Others pointed out that decriminalisation would not "take away all those other issues" (Richard, FG3), and emphasised the need for enhanced access to treatment and other health services. The potential revenue gain by diverting money away from the criminal justice system was discussed, with the suggestion that revenues could be put towards increased access to such services.

Conversations about decriminalisation revealed that law enforcement under this model produced an environment of uncertainty for participants. This uncertain environment was described as a "*grey area*" by participants across the focus groups. The grey area of decriminalisation, they thought, was what fostered discretionary police power: "They'll just use it as discretion" Graham (FG1) said. When talking about the decriminalisation model, Graham (FG1) exclaimed: "The last thing you need is police discretion. Please." Some associated this grey area of decriminalisation with giving power to the police: "They can't be charged, but that doesn't stop the police from still interrogating them around the corner. They still do it." (Paul, FG3). Dave (FG1) expanded this concept saying:

> …there is becoming this sort of grey area… I mean, because you have got this, sort of, de facto – where the laws haven't changed but police don't necessarily charge somebody, you end up where it's like if they don't like you one day, you get charged. You know, one person gets off. The next person gets charged.

The notion of the grey area was reinforced by participants who voiced the need for well-defined parameters in drug laws. One way to alleviate the uncertainty would be to outline clear boundaries, such as a "fair amount [of drugs]" (Graham, FG1). Dave elaborates this desire to have clear definitions:

> Dave: …we want to get some clear legislation. Things that make it clear what we can and can't do, you know, and some of that needs to be done. (FG1)

In this sense, participants expressed an appreciation of the important difference between *de facto* decriminalisation (where discretion remains, and is the prevailing model in Australia for cannabis) and *de jure* decriminalisation (where use/possess is removed from the criminal law entirely).

Perspectives on legalisation

When introducing legalisation there were mixed perspectives and these views varied considerably by drug type. There was strong support for cannabis legalisation and strong opposition for crystal methamphetamine legalisation in all groups. For those who held generally negative views of legalisation, opposition was based on a fear of availability and lack of control of certain drugs. Conversely, support for legalisation was often contingent on the regulation or controls being put in place: "You've got to have some sort of regulation" (Matt, FG2). When asked if one group supported legalisation, several participants responded "only" or "maybe with regulations". These regulations may include age or quantity limits, as noted by Adam: "Age they are at, and quantity." (FG4).

When discussing legalisation, the drug market was always a topic of discussion. Some thought legalisation would have no impact on the black market, while others thought legalisation would eliminate it. Other impacts were also discussed. When considering a legalisation model for heroin, some were uncomfortable with the potential harms: "…because, you always need a little bit more" (William, FG4) and "there is going to be too many ODs. People will be OD-ing left right and centre" (Angie, FG4). At both points in this particular conversation (and others), participants turned back to the heroin prescription program.

Perspectives on medical/prescription model

The prevailing and preferred model among participants in all focus groups was a medical or prescription model of drug availability for personal use. Participants were quick to suggest changing the drug laws "for medicinal purposes" (Angie, FG4), without being prompted. There were three prominent medical models introduced by participants: 1) cannabis as a treatment for illness; 2) heroin as a treatment for drug dependence; and 3) availability of drugs through a prescription or physician without reference to illness or treatment.

For the first of these three, access to cannabis through the medical system was seen to alleviate multiple illnesses including cancer, epilepsy, seizures, and ADHD.

> Richard: The medical uses as well… children having seizures where they're having eight to ten seizures a day and when they're using the cannabis… they stop. (FG3)

During one group held in a recovery setting (FG3), Richard and Paul also discussed how cannabis can be used "the right way" (Paul) if through the medical system:

> Richard: Say, medical. Like pot with a script… you feel epilepsy... the research from what we

see on the news and stuff - the news guys would know that it can be used in a medical way and it helps heaps of people.

In contrast to cannabis, participants described but did not use the phrase 'heroin assisted treatment.' Instead, they spoke about the heroin prescription model by describing approaches in other countries or as an alternative to "rotten methadone" (Dani, FG4). Descriptions of a heroin assisted treatment model were spoken about with hopefulness and as an antidote to methadone: "the worst drug" (Kate, FG4). In one focus group (FG4), heroin prescription was described as an opportunity to manage drug dependence and potentially quit drug use altogether.

A third model for consideration was the availability of drugs through a prescription or physician, but not for medical purposes. In this model, drugs would be available through the medical system but not for treatment of drug dependence or an illness. Regulation under this prescription model was important. For example:

> And when you go to pick it up, you can only pick up so much for that period of time, so whether they go through it in one day or within a month. Like, this time next month and you can't pick up until this time next month. So, if they sell it or that's gone then they can't pick up their next lot for.. (Richard, FG3).

In contrast, Laura (FG1) voiced her concerns about this third prescription model:

> Does that means the younger generation that's growing up today, does that mean they can get hold of whatever's out there now or will be out there, whatever? They can just go and go to the chemist or whatever or somewhere and pick it up and go, "Okay, I can just walk down the street and do it or have a shot".

A helping model

Conversations about access to drugs through the medical system brought a strong sense of hope and humanity. Participants often organised their support for the medicalisation of drugs by framing it in terms of *helping*. Participants thought drugs offered through medical streams could positively change lives. Some participants who held relatively negative perspectives of drug law reform shifted their views when reframed as a solution that could "help" others. Paul (FG3) said: "if my kids were sick or something and needed - like, I'd be growing it…" and Dylan, who originally opposed legalisation, responded: "I second that; I'd do exactly the same thing. If they were sick and needed it."

Similarly, participants framed access to heroin in terms of helping themselves and others. Participants thought this model would alleviate many of the problems they were experiencing with methadone, and

suggested that people would "get sick of coming in," (Adam, FG4) and eventually stop using heroin altogether. However, an alternate view from Noah (FG2) was that the medical model merely supplants the current power over the illicit market with control through the medical fraternity:

> …I thought that changing the focus away from criminal sanctions to having things managed by health professionals was an answer, but I am strongly disagreeing with that these days[…] because having your life managed by a judiciary, or having your life managed by health professionals, can be just as bad.

Perspectives on change

It'll never happen

Despite not asking participants *if* reform would happen, many had the opinion that drug laws would never change. This pessimism was evident across models; some said "[the government] will never decriminalise" (Graham, FG1), or "it's not going to happen" (Chad, FG4) and another said "I don't think you're going to see legalisation of drug use in any of our lifetimes" (Noah, FG2).

Participants offered various reasons for this pessimism. First, participants thought PWUD were a group treated differently from others in society. Some of these perspectives were rooted in the marginalisation and social exclusion that PWUD face. For example, when probed about what they thought would happen with the drug laws, Kirk (FG1) said: "nobody likes us because we were junkies, you know?" and another woman stated that society thinks "you're nothing but a junkie" (Laura, FG1). Because people were labelled as "junkies" there was a sense that governments would not care about or change the laws for the interests of PWUD. One woman reinforced this sense of marginalisation when she repeated:

> Cassie: there's two laws, isn't there? There's one for the rich and one for the poor, let's be honest. The jails aren't full of people – doctors (FG2).

Another man, William (FG4), declared:

> They won't legalise … this group of government don't give a shit. Governments don't give a shit. We're the human garbage, basically.

Others thought that governments had vested interests in maintaining prohibition and the criminal justice system. Some discussed these interests as an industry that generates money and jobs through various systems of policing, government, corruption, and the judicial system.

Changing public opinion

In acknowledging participants doubts of law reform, the group was led into a conversation about what would need to happen, 'in theory' to change the laws. For them, the public was uninformed: "The public wouldn't accept [drug law reform] because they don't understand enough about it" (Martin, FG1). Changing public opinion was also seen as a key part of law reform campaigns: "there has got to be a lot of education for the general public" (Kirk, FG1). Participants voiced that gaining public support was a key ingredient in order to change the political climate for law reform. Graham said: "You've got to educate the people that aren't using the drugs. That's the biggest thing, otherwise it won't work." (FG1).

In another group, one participant iterated that the government was a political entity whose interest was to gain public or voter support, and that this is may be where law reform advocates should focus their efforts. When discussing the possibility of reform, Richard (FG3) explained: "[…] they're scared of making that step to want to legalise it, because of voters".

Others supported this view that PWUD were a minority of the 'public,' or that their voices were not part of this public. Some believed that until public opinion shifted, nothing would change. In different ways, participants voiced that the first step to drug law reform was to change public opinion about how they view drugs and PWUD; until then, they thought law change would not be supported. A staged approach was also regarded as a good idea: "Not legalisation… Not initially. It needs to be built up…step by step." (Ryan, FG1).

The role of people who use drugs

The voices of PWUD were viewed as a vital part of any drug law reform campaign. As stated by one participant "it's about bloody time…" (Cat, FG2) referring to the researchers coming to talk to PWUD about the drug laws. She continued:

> … that you guys or the powers that be sit down with a few of us addicts that have still got a competent brain happening - working and discuss exactly this. I just think it's about time.

Many participants felt strongly about and saw the value in "talk [ing] to a bunch of people like us," (Angie, FG4), having the voices of PWUD heard and incorporated into decisions that affect them. When asked about how governments should go about designing drug laws, one participant responded:

> Ben: … if they speak to more people and do things on it they'll find out what the issues are and what reasons instead of just, okay, you're a user; we're going to do this and that. (FG3)

Participants understood that they had a unique perspective on the realities of drug use, describing these views as almost a form of expertise – a lived knowledge – that was rooted in the realities of their everyday lives. To them, campaigns to change the laws have "to come from experience" (Chad, FG4).

Talking to PWUD and actually learning about their experiences was important to most. Donald (FG1) said: "If they want to talk about us, get to know us first. Get on the street and see what's going on first, before you're going to be talking about it." Participants highlighted that this reality is not experienced by many of the people making decisions about PWUDs lives.

Noah (FG2) noted that even if PWUD were engaged and asked to share their voice, it would not mean their opinions would necessarily be incorporated: "You think so? We had these discussions two years ago." Others highlighted that one reason for this disconnect was that PWUD have historically been marginalised and silenced: "Saying that, the voice of an addict or - ex-addict doesn't get respected enough because they feel like our views aren't worthy of a decent conversation or taken seriously" (Richard, FG3).

Discussion

This study qualitatively demonstrates the diverse views on drug law reform models among people who are directly affected by the drug laws, revealing a diversity of understandings of the language and concepts of drug law models. Through this exploration, participants provided insight into why they supported certain drug laws and reform approaches, illustrating several issues that were important to them. By learning what matters most to the affected community, drug law reform, campaigns, and deliberations can be enriched by these insights. Furthermore, inclusive approaches have the potential to address the pervasive and robust stigma and marginalisation experienced by PWUD in society that, as was shown in this study, perseveres.

PWUD in this study showed that there is support for the decriminalisation of drugs, but that support for drug policy reform goes beyond this "first step." Three frameworks were explored by participants: decriminalisation, legalisation, and three variations of the medical/prescription approach. Although no consensus for support of any model was sought (nor established), the discussions showed the diversity of opinions that exists among and between PWUD. These findings are consistent with previous research (Darke & Torok, 2013; Lancaster

et al., 2014, 2015). Others have found significant heterogeneity of opinions of drug policy interventions based on drug use history, indicating that stigma and discrimination may exist between people with different experiences of drugs (Lancaster et al., 2014). Lancaster et al. further investigated why PWUD were not universally supportive of drug law reform and, similar to our findings, found distinctions made between the relative harms of crystal methamphetamine and heroin justified PWUD opinions about drug policies. Our findings add that views of the potential helpfulness of medicalising particular drugs, like the potential alleviation of illness from cannabis or alternative opioid substitution therapies, provide a basis for their support of drug law reform. Interestingly, participants held the view that the 'public' was not supportive of drug law reform. However, research has shown the majority of the Australian general public are in support of decriminalisation (Lancaster et al., 2013). This finding may point to the internalised stigma and marginalisation that PWUD face, as well as highlighting the lack of a shared language around models of law reform.

One model that was especially supported on the basis of helpfulness was drug regulation through the medical system. Affinity and support towards this model was an unexpected finding. However, as pointed out by one participant (Noah), transferring power and control from the judiciary to the medical system "can be just as bad," although this was a view not shared widely in the focus group. One explanation for this may be the medical system is known and familiar, thus participants could easily conceptualize and articulate details around this approach. Previous research has found that familiarity reduces ambiguity and influences beliefs and decision-making in policy (Cairney & Oliver, 2017). Participants were also wary and distrustful of the government's involvement, so medicalisation may have been the better alternative.

However, over the past decade or so, the medical model has been largely ignored in drug law deliberations. This is likely caused by a number of factors: there are different versions of the medical/prescription model (as noted by participants themselves) so it is not a singular idea; the health professionals researching and providing heroin assisted treatment have not aligned that work (a medical intervention) with drug law reform; and other 'prescription' models of drug availability that are not connected to a health intervention have not been strongly supported. Yet the participants in this research saw a medical/prescription model as most preferred. Participants mainly supported models that either addressed drug dependence (e.g. heroin prescription) or alleviated illness (e.g. cannabis prescription). The recent changes to medical cannabis laws in Australia, along with the extensive international coverage of 'medical marijuana' are likely contributing factors to this zeitgeist. Other jurisdictions provide evidence that a robust medical drug system, such as the medical cannabis industry in Colorado, has provided an infrastructure and cultural shift to support future drug law reform (Canadian Center on Substance Abuse, 2015; Transform, 2017).

The diversity of opinions from PWUD and findings in this study also pose challenges for drug law campaigning and priority setting. With such diverse opinions, how does one establish reform priorities that are sensitive to this community? How do we reconcile different opinions or views that do not align with our own or with research evidence? Considering the privilege and power researchers, academics, and politicians alike automatically bear in policy decision-making, these are not easy but important questions to answer. One option is to focus on how people come to understand drug laws and reform and the deeper meaning behind their support. For instance, participants' concern over reform that was based in the interests of business and government suggest that drug law reform campaigns need to be more closely aligned to social justice goals regardless of the model they advocate for. Furthermore, people engaging in participatory processes must examine their assumptions and goals of participation otherwise it may result in "tokenism" (Greer, Amlani et al., 2016; Arnstein, 1969). Participatory goals go beyond information gathering; rather, they aim to change the discourse of drug use and PWUD, as well as be empowering (Lancaster, Seear, Treloar, & Ritter, 2017, 2018).

An important part of any drug policy campaign is addressing the stigmatisation of drugs and discrimination of PWUD that is ever-present in society (Drug Law Reform, 2015; New Zealand Drug Foundation, 2017). These findings support the notion that including PWUD in decisions that affect them has the potential to mitigate stigma and marginalisation of this group (Greer, Amlani et al., 2016; Lancaster et al., 2015). Participants in our study highlighted that participation with PWUD happens too infrequently. Meaningful inclusion of PWUD in decision making addresses stigma by building capacity and promoting the opportunity for empowerment (Greer, Luchenski et al., 2016). Furthermore, drawing on the voices of PWUD brings attention to and adds to the conversation about the way in which knowledge and 'expertise' becomes defined and privileged in drug policy processes (Lancaster et al., 2018; Ritter, 2015)

In addition to examining perceptions of drug law models, this study aimed to understand PWUD views of drug policy reform campaigns. A general level of pessimism was noted. However, participants gave important insights into what they thought of different models of the drug laws and how these terms are conceptualised. As we have shown in this study, the language and concepts that are used in academic settings are not always translatable or understood among the affected community. As such, the development of a shared language of reform may be a crucial first step for reformers.

While this project was able to draw on the experiential knowledge of PWUD, our results have limitations. First, as with most qualitative research, our sample was not representative of all people affected by drug policies, notably those who do not access social welfare services. In addition, the focus group settings may have influenced the results. We attempted to hold the focus groups at a range of service locations but, due to limited staff resources, were narrowed to two locations (a medical harm reduction (n = 3 sites) and recovery (n = 1 site) service). Analyses were not conducted separately for the two sites, due to our aim of exploring diversity of opinions, but we note that the settings themselves may partially explain participants' opinions, for example the affinity towards the medical model. Finally, while focus groups provide an opportunity to build rapport among participants and create an inclusive and safe space for conversation, the breadth and depth of topics discussed was limited due to time and the group setting. Individual interviews, by virtue of more time and privacy, would elucidate a more in-depth look into individual PWUD perspectives.

This study adds to a small but growing body of research that attempts to understand how PWUD perceive drug laws and law reform. It also serves as an example of the rich knowledge that can be gathered by engaging with the affected community. Current approaches to policy decision making favor particular 'expertise' and assume that the 'experts' understand the context and implications of their decisions (Ritter, 2015). However, the dynamic experiences of the local context of drug use, and the impact of those contexts, can only be truly understood by gathering the experiential knowledge, or 'expertise' of PWUD. Without engaging the affected community in decisions that affect their lives, governments, academics, and advocates alike risk promoting drug policy reform that is not relevant or meaningful to PWUD themselves.

Author conflict of interest declaration

We wish to confirm that there are no known conflicts of interest associated with this publication and there has been no significant financial support for this work that could have influenced its outcome.

Acknowledgements

This work was supported by the Canadian Institutes of Health Research Michael Smith Foreign Study Supplement and University of New South Wales Drug Policy Modelling Program.

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