



The Case for a Health Focused Response to Drug Use in Tasmania's Legal System

COMMUNITY
LEGAL CENTRES
TASMANIA

The Case for a Health Focused Response to Drug Use in Tasmania's Legal System

COMMUNITY
LEGAL CENTRES
TASMANIA

Community Legal Centres Tasmania is the peak body representing the interests of nine community legal centres located throughout Tasmania. We are a member-based, independent, not-for-profit and incorporated organisation that advocates for law reform on a range of public interest matters aimed at improving access to justice, reducing discrimination and protecting and promoting human rights.

Community Legal Centres Tasmania would like to thank those organisations and persons who provided assistance and the anonymous referees for their valuable comments. Funding for this report was made available through a grant from the Solicitors' Guarantee Fund.

This report was prepared by Benedict Bartl, a policy officer and lawyer with Community Legal Centres Tasmania.

Contents

Executive Summary	iv
1 The War on Drugs	1
1.1 Introduction	1
2 Illicit Drugs in Australia.....	3
2.1 Use	3
2.2 Price and Availability	4
2.3 The Use of Illicit Drugs in Tasmania	5
2.4 Illicit Drugs and the Law in Tasmania.....	5
2.5 Illicit Drugs and the Law: Australian and Tasmanian statistics.....	6
2.6 The Magistrates Court.....	8
2.7 The Supreme Court	9
3 Australia's International Obligations.....	12
4 Harm Minimisation and Australia's de-facto Decriminalisation Model.....	15
4.1 Diversion.....	16
4.1.1 Police Drug Diversion	17
4.1.2 Court Mandated Diversion	19
5 What are the Options for Reform?	21
5.1 Regulation	21
5.2 Depenalisation.....	21
5.3 Decriminalisation.....	21
5.3.1 The Portuguese Model.....	22
5.3.2 What conclusions can Tasmania draw from the Portuguese model?	27
Summary	28
Appendix A: <i>Illicit Drug Reform in Tasmania: A Cost Benefit Analysis</i>	29

Executive Summary

- More than 8 million Australians (42 per cent) aged 14 years or over have consumed illicit drugs in their lifetime and almost 3 million (15 per cent) have done so in the last 12 months.
- Cannabis is the most frequently used illicit drug in Australia with an estimated 35 per cent of Australians having used cannabis in their lifetime and 10 per cent having used cannabis in the last twelve months. Other commonly used drugs include ecstasy, cocaine and methamphetamine.
- The last decade has seen the number of illicit drug seizures increase by 91.7 per cent; the weight of illicit drugs seized increase by 263.1 per cent; and the number of national illicit drug arrests increase by 70.5 per cent.
- Australian governments spend more than \$1 billion each year on law enforcement and other supply control measures, yet the price of illicit drugs has fallen over the last decade and illicit drugs are relatively easy to obtain.
- More than 130,000 people are arrested each year in Australia for drug-related offences including more than 1100 in Tasmania. More than 80 per cent of all arrests are made against persons who have been charged with use, possession or administering a drug for their own use.
- Almost half of all offenders sentenced to a minor drug-related offence in Tasmania receive a fine. However, almost 15 per cent of offenders sentenced for minor drug offences are sentenced to a term of imprisonment, including suspended sentences.
- Recognition that we cannot arrest our way out of illegal drug use is already acknowledged in State and Commonwealth support for a number of diversion programs offered by the police and courts in Tasmania. Both Police Drug Diversion and Court Mandated Diversion are confirmation that — at least for some offenders — personal drug use should be treated as a health rather than a criminal justice issue.
- In 2001, Portugal decriminalised the possession of small quantities of all drugs and has reorientated personal drug use as a public health rather than a law enforcement issue. Portugal's decriminalisation model provides some guidance as to the likely impact in Tasmania.
- A report prepared by Dr Paul Blacklow, an economist at the University of Tasmania, estimates the total cost of illicit drug use in Tasmania in 2015–16 at \$301.73 million (see Appendix A).
- Blacklow's analysis finds that the total cost of illicit drug use in Tasmania under decriminalisation would be \$273.6 million, a financial saving of \$28.13 million.
- More significantly, the reorientation of personal drug use as a public health issue will see a reduction in crimes involving the use or threat of violence, a reduction in drug-related death and disease and a reduction in drug-related ambulance call-outs, emergency admissions and hospitalisations.

1 The War on Drugs

1.1 Introduction

The war on drugs has failed. Like the prohibition on alcohol in the United States almost one hundred years ago, the continuing war on illicit drugs cannot succeed. Despite the considerable resources that have been directed towards the criminalisation of drug use, there has been no curtailment of either the supply or the consumption of illicit drugs. Indeed, only last year the Australian Crime Commission noted that the number of seizures, the weight of drugs confiscated and the number of arrests being made were at their highest recorded levels.

In Australia, around four in ten adults will use an illegal drug in their lifetime and almost 3 million Australians aged 14 years and over have used an illegal drug in the last 12 months. Moreover, surveys of drug markets consistently point to illicit drugs being readily available at the same time as prices are dropping. For example, a study published in the *British Medical Journal* found that when inflation-adjusted and purity-adjusted prices were considered, the price of cocaine had decreased 14 per cent and heroin and cannabis had both decreased 49 per cent between 2000 and 2010.

For the vast majority of the Australian population who have consumed illicit drugs, the experience was, and is, enjoyable. For many such people, illicit drug use was linked to an experimental or rebellious phase during their youth and the consumption of such substances later subsided due to risk aversion, health concerns or as familial or employment responsibilities became more demanding. For others, drug use was, and continues to be, recreational, with drugs being consumed after work, on weekends and on occasions of celebration. For some, drug use is an addiction, a condition to be endured by any means possible, including resorting to crime.

For the rebellious or curious teenager, the hedonistic adult and the impaired addict, the war on drugs has failed them. The failure is evident in the limited effectiveness of our current prohibitionist response, including the ease with which illicit drugs are accessed and the sanctioning of otherwise law-abiding citizens. And the failure is exacerbated in the detriment caused to both the consumer and the wider community including drug overdoses and other health-related harms, crime and the growth of criminal networks.

Increasingly, this view is being recognised at a local, regional and global level as Australian States and Territories, governments around the world and even the agencies of the United Nations acknowledge that personal drug use demands a health rather than a criminal response.

By drawing on the experiences of both Australian and overseas examples, this paper demonstrates that a health-focused response to personal drug use has the potential to save lives, reduce problematic drug use and save millions of dollars in failed law-enforcement strategies.

This paper begins with an outline of the extent of drug use in Australia, setting out the high number of persons who consume and have consumed illicit drugs. The paper then critically analyses the significant expenditure by State and Commonwealth governments on illicit drugs, particularly supply control measures such as law enforcement and border protection and considers its effectiveness when contrasted with availability and price. The second part of the paper outlines the law enforcement response to illicit drugs, including more than one hundred thousand Australians charged each year with drug-related offences, with more than one thousand in Tasmania. The report then goes on to note our obligations as a signatory to international conventions and sets out Australia's quiet shift in focus from law enforcement to

diversion. Finally, the paper reviews the decriminalisation model adopted by Portugal more than fifteen years ago, concluding that the adoption of a similar model has the potential to reduce drug use amongst young adults who are most at risk, reduce drug-related deaths by eroding social stigma and increasing investment in treatment, and reduce problematic drug use.

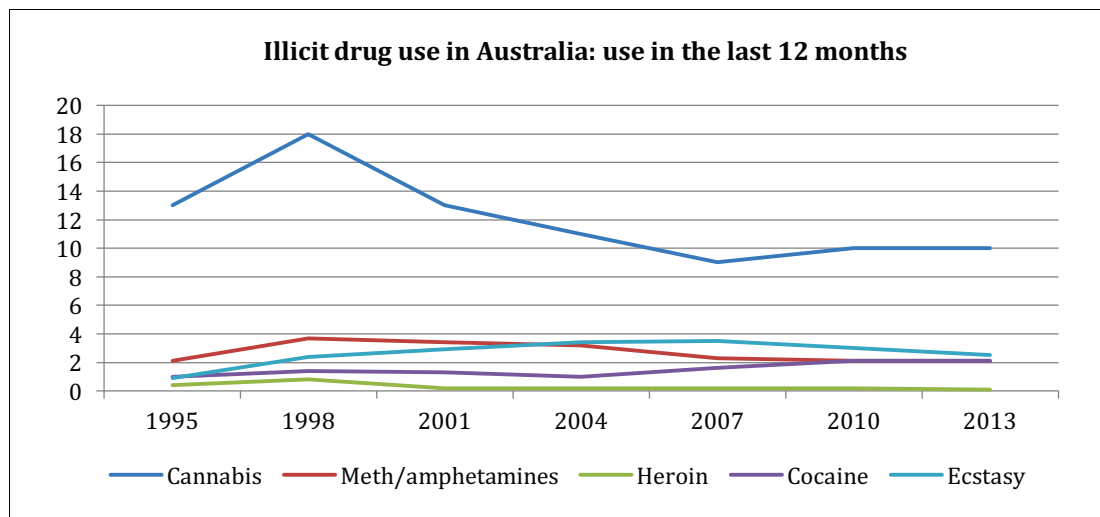
2 Illicit Drugs in Australia

According to the most recent data from the Australian Crime Commission (ACC), Australia is awash with illicit drugs. The Commission reports that during 2014–15 law enforcement agencies reported 105,862 illicit drug seizures with a combined weight of 23.5 tonnes and 133,926 arrests.¹ As the Chief Executive Officer of the ACC summarised in his annual report to the Australian Government, “over the last decade the number of illicit drug seizures has increased 91.7 per cent; the weight of national illicit drugs seized has increased 263.1 per cent; [and] the number of national illicit drug arrests has increased 70.5 per cent”.²

At the same time, the extent of drug use in the Australian population is difficult to measure because of the stigma and potential risk of prosecution associated with illegal drug use. The most reliable source of information about the prevalence of drug use in Australia is the National Drug Strategy Household Survey (the “Survey”), which, in 2013, surveyed almost 23,000 people aged 14 years or older on their drug use as well as their attitudes and opinions about illicit drugs. The Survey found that about 8 million Australians (42 per cent) aged 14 years or over had ever illicitly used drugs, including the misuse of pharmaceuticals. The Survey also found that almost 3 million (15 per cent) had done so in the last 12 months.³

2.1 Use

Cannabis is the most frequently used illicit drug in Australia with an estimated 35 per cent of Australians (or 6.6 million persons aged 14 or over) having used cannabis in their lifetime and 10 per cent (or around 1.9 million) having used cannabis during the previous year, as the following graph highlights:⁴



¹ Australian Crime Commission, *2014-15 Illicit Drug Data Report* at 2. As found at <https://www.acic.gov.au/publications/intelligence-products/illicit-drug-data-report> (Accessed 10 June 2017).

² Ibid 3. Also see Australian Crime Commission, *2013-14 Illicit Drug Data Report* at 2 in which it was noted that the number of seizures, the weight of drugs confiscated and the number of arrests being made were at their highest recorded levels.

³ Australian Institute of Health and Welfare (AIHW), *National Drug Strategy Household Survey* detailed report 2013 (2014), Drug statistics series no. 28. Cat. no. PHE 183. Canberra: AIHW at 49. As found at <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129549848> (Accessed 10 June 2017).

⁴ Ibid 58. This data compares to about 12 per cent of adults who reported ever having used cannabis in 1973.

The second most commonly used illicit drug according to the Survey is ecstasy with 10.9 per cent of Australians (or 2.1 million) ever having used ecstasy and 2.5 per cent (or around 500,000) of the population having used it during the previous year.

The Survey further found that 8.1 per cent of Australians (1.5 million) had used cocaine in their lifetime with about 2.1 per cent (400,000) of the population having used it during the previous year. While the use of drugs such as cannabis, ecstasy and methamphetamines has generally declined since 2004, the proportion of people using cocaine has been increasing since 2004. This is particularly so among those aged between 20–29 and 30–39 with cocaine use currently at the highest levels ever recorded in Australia.

Finally, the Survey found that seven per cent of Australians (1.3 million) had used methamphetamines in their lifetime and 2.1 per cent (400,000) of the population had used them during the previous year. Methamphetamine comes in a number of forms including powder/pills (colloquially known as “speed”), a sticky paste (“base”) or crystal methamphetamine (“ice”).⁵ Whilst the media is quick to portray methamphetamine use as a “scourge” or “pandemic”,⁶ use has *declined* since its peak at 3.7 per cent in 1998 but remained stable at 2.1 per cent between 2010 and 2013. Nevertheless, it is clear that there has been a change in use with consumers preferring the more powerful acting ice to either speed or base.⁷

2.2 Price and Availability

It is incontrovertible that the bulk of government expenditure on illicit drugs is spent on supply control measures including law enforcement. For example, in the most recent analysis of government spending, Ritter, McLeod and Shanahan revealed that in 2009–2010 Australian governments spent approximately \$1.7 billion on combatting the use of illicit drugs; 64 per cent of this expenditure was on law enforcement and the remainder was directed towards drug treatment, harm reduction and prevention.⁸

With almost two-thirds of all State and national government expenditure on illicit drugs being spent on supply control measures, the effectiveness of this approach should be evident in the research: it should show a lack of availability and, as a result, higher prices. However, a large number of studies have consistently demonstrated that efforts to reduce the illicit drug trade have had little effect on the price and availability of illegal drugs. For example, the National Drug Strategy Household Survey found that around four in ten Australians have consumed illicit drugs, suggesting that they remain relatively easy to access. Moreover, the research demonstrates that the price of illicit drugs has been falling over the last decade. A longitudinal study monitoring the price and purity of illicit drugs from the United States, Europe and Australia published in the *British Medical Journal* concluded that inflation-adjusted and purity-adjusted prices of heroin, cocaine and cannabis had dropped in all three jurisdictions. With

⁵ Methamphetamine is an abbreviation of methylamphetamine. Throughout this paper both terms are used interchangeably.

⁶ S Martin, ‘Ice scourge taking over indigenous communities’, *The Australian*, 15 October 2015; K Moor, ‘Australia warned its ice problem is reaching pandemic proportions’, *Herald Sun*, 30 April 2014.

⁷ AIHW, Op cit 7. For example, the Survey observes that the reported use of speed decreased from 51 per cent in 2010 to 29 per cent in 2013 while the reported use of ice increased from 22 per cent in 2010 to 50 per cent in 2013.

⁸ A Ritter, R McLeod & M Shanahan, *Government drug policy expenditure in Australia – 2009/10*, (2013) DPMP Monograph Series No. 24. Sydney: National Drug and Alcohol Research Centre. Also see T J Moore, *What is Australia’s ‘drug budget’? The policy mix of illicit drug-related government spending in Australia*, (2005) DPMP Monograph Series No. 01. Fitzroy: Turning Point Alcohol and Drug Centre.

specific reference to Australia, the authors noted that despite ever increasing seizures “the average inflation-adjusted price of cocaine decreased 14 per cent, while the inflation-adjusted price of heroin and cannabis both decreased 49 per cent between 2000 and 2010”.⁹

In 2014–15, the ACC noted a record number of illicit drug seizures. In the same year, annual research produced by the National Drug and Alcohol Research Centre and published in *Australian Drug Trends 2016: Findings from the Illicit Drug Reporting System* noted that cannabis, methamphetamine, cocaine and heroin were generally considered “easy” or “very easy” to obtain and that this has remained stable for some time.¹⁰

2.3 The Use of Illicit Drugs in Tasmania

In Tasmania, around 15.1 per cent of the population aged 14 years and over has used illicit drugs in the previous 12 months according to the most recent National Drug Strategy Household Survey.¹¹ The Survey found that Tasmania had the second highest rate of recent cannabis use at 11.8 per cent, the second highest rate of recent methamphetamine use at 3.0 per cent and the equal second highest rate of recent ecstasy use at 2.9 per cent.¹² Compared to other Australian jurisdictions, Tasmania has low availability of cocaine and heroin, although the dearth of heroin has resulted in greater misuse of prescription opioids such as oxycodone and morphine.¹³

2.4 Illicit Drugs and the Law in Tasmania

In Tasmania, the *Poisons Act 1971* and *Misuse of Drugs Act 2001* prohibit the cultivation, production, manufacture, trafficking, selling, supplying, use or possession of controlled drugs, plants and precursors.¹⁴ Section 3(3) of the *Poisons Act 1971* sets out that a person will be deemed to be in “possession” of a controlled substance¹⁵ if it is found on them or at their premises unless they can prove that they had no knowledge of the substance.¹⁶ Harsh sentences of up to 21 years imprisonment can be imposed for more serious indictable offences such as trafficking, cultivating or manufacturing controlled substances and up to two years imprisonment for offences including possession and use.¹⁷ As well, unlike the criminal law more generally, the onus of proof has been reversed meaning that the accused bears the onus of proof

⁹ D Werb, T Kerr, B Nosyk, S Strathdee, J Montaner & E Wood, *The temporal relationship between drug supply indicators: an audit of international government surveillance systems* (2013) BMJ Open, 3, e003077, doi:10.1136/bmjopen-2013-003077. Also see G Farrell, ‘Routine activities and drug trafficking: the case of the Netherlands’ (1998) 9(1) *International Journal of Drug Policy* 21–32.

¹⁰ J Stafford, C Breen & L Burns, *Australian Drug Trends 2016: Findings from the Illicit Drug Reporting System (IDRS)* (2016) National Drug and Alcohol Research Centre, University of New South Wales, Australia.

¹¹ AIHW, Op cit Table 7.9 of the ‘Supplementary Tables’ under ‘State and Territory tables’.

¹² Ibid, Table 7.12 of the ‘Supplementary Tables’ under ‘State and Territory tables’.

¹³ National Drug and Alcohol Research Centre, *A Review of Opioid Prescribing in Tasmania: A Blueprint for the Future* (2012) Sydney: University of New South Wales.

¹⁴ More than 300 controlled drugs, plants and precursors are described in Schedule 2-4 of the *Misuse of Drugs Act 2001* (Tas).

¹⁵ A ‘controlled substance’ is defined as a controlled drug, controlled plant or controlled precursor: section 3 of the *Misuse of Drugs Act 2001* (Tas).

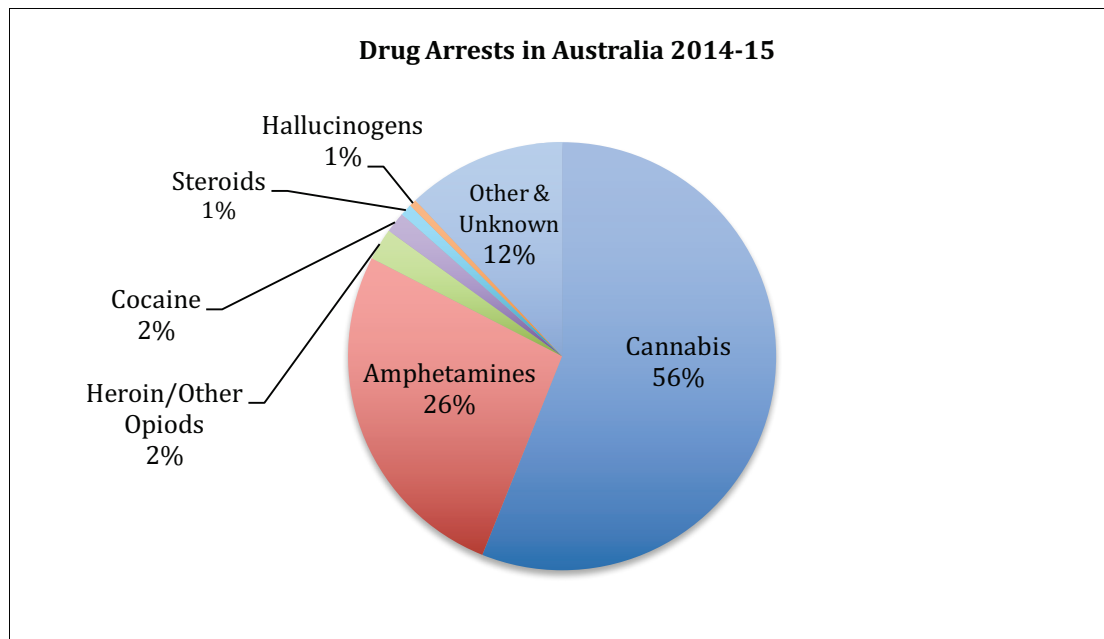
¹⁶ See also ss 3 and 3(3) of the *Misuse of Drugs Act 2001* (Tas) for the same definitions of both “controlled substance” and “possession”. See also the cases of *Arnold v Stringer* [2004] TASSC 13; *Alison v Lowe* [1988] Tas R 21; *Lowe v Goodluck* [1985] TASSC 9.

¹⁷ Sections 22–25 of the *Misuse of Drugs Act 2001* (Tas). Similar “controlled drug” offences as well as specific offences of importing or exporting border controlled plants/drugs are also contained in Chapter 9 of the *Criminal Code Act 1995* (Cth).

in establishing that possession of a certain threshold quantity was not intended to be sold.¹⁸ In short, possession of a certain threshold quantity is a trafficking offence unless the consumer can prove otherwise.

2.5 Illicit Drugs and the Law: Australian and Tasmanian statistics

The number of persons charged with drug-related offences in Australia, and more specifically in Tasmania, is difficult to accurately measure due to the different recording and counting rules applied by the various reporting bodies. For consistency this report relies on the national data provided by the ACC. This data demonstrates that the overwhelming majority of drug-related arrests¹⁹ in Australia are for cannabis. For example, in 2014–15 there were 133,926 arrests for drug-related offences of which 75,105 were for cannabis and 35,468 for amphetamines:²⁰



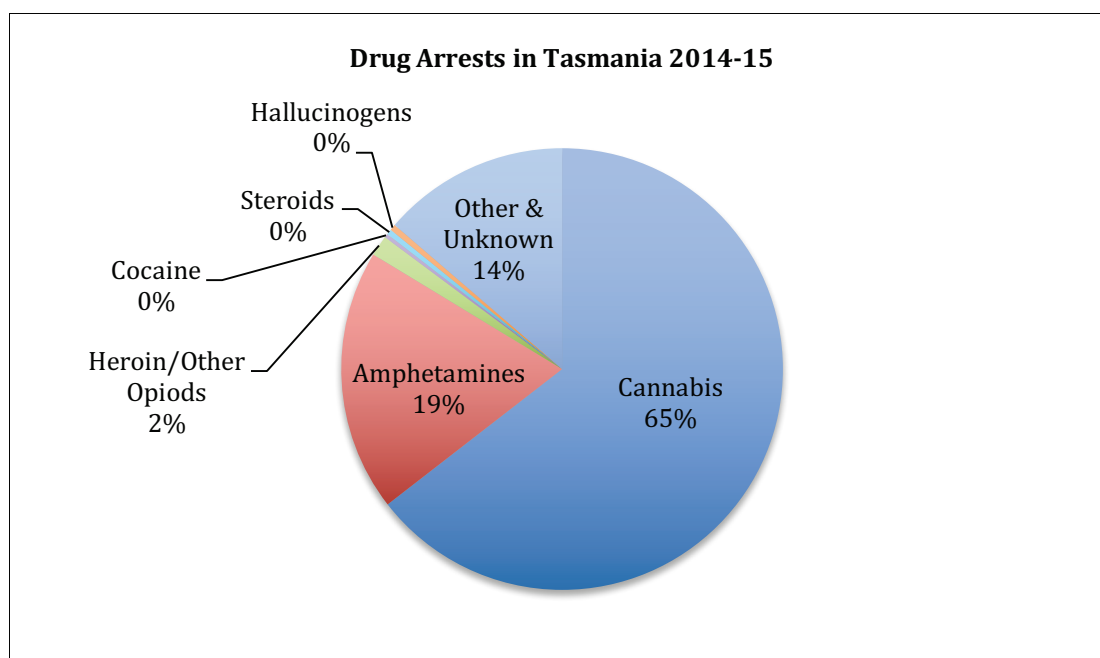
In comparison with the Australia-wide data, Tasmania differs in a number of respects including the higher percentage of cannabis and “other and unknown” drug-related arrests, the lower percentage of amphetamine arrests and the small number of cocaine, steroid and hallucinogen arrests:²¹

¹⁸ Sections 6(2), 7(2) and 12(2) of the *Misuse of Drugs Act 2001* (Tas).

¹⁹ In its explanatory note the Australian Crime Commission defines “arrest” as incorporating recorded law enforcement action against a person for suspected unlawful involvement in illicit drugs. It incorporates enforcement action by way of arrest, summons, diversion program, cannabis expiation notice (South Australia), simple cannabis offence notice (Australian Capital Territory), drug infringement notice (Northern Territory), “notice to appear” (Queensland) and cannabis intervention requirement (Western Australia). Some charges may have been subsequently dropped or the defendant may have been found not guilty. Australian Crime Commission, Op cit at 183.

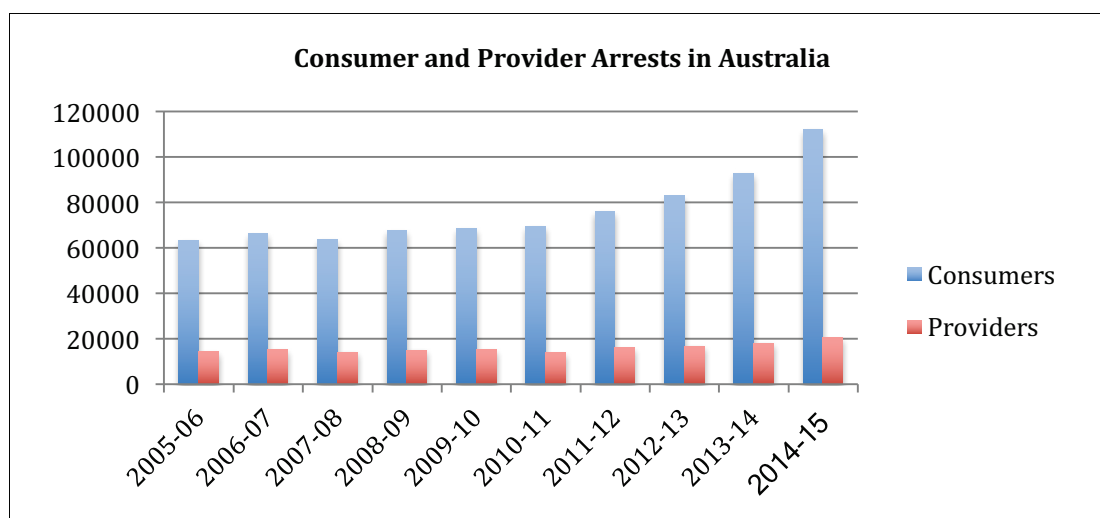
²⁰ Ibid, Figures 30, 41, 53, 67, 72, 76 and 91.

²¹ Ibid, Tables 11, 14, 20, 26, 30, 32 and 37.



In their analysis of illicit-drug arrests, the ACC distinguishes between “consumers” who have been charged with use, possession or administering a drug for their own use and “providers” who are charged with supplying drugs and are charged with offences such as importation, trafficking, selling, cultivation and manufacture.²²

According to the most recent ACC data, “the number of national illicit drug arrests has increased 70.5 per cent over the last decade, from 78,533 in 2005–06 to a record 133,926 in 2014–15.”²³ At the same time, as the graph below illustrates, the increase has been primarily against consumers with an 81 per cent increase in consumer arrests.²⁴

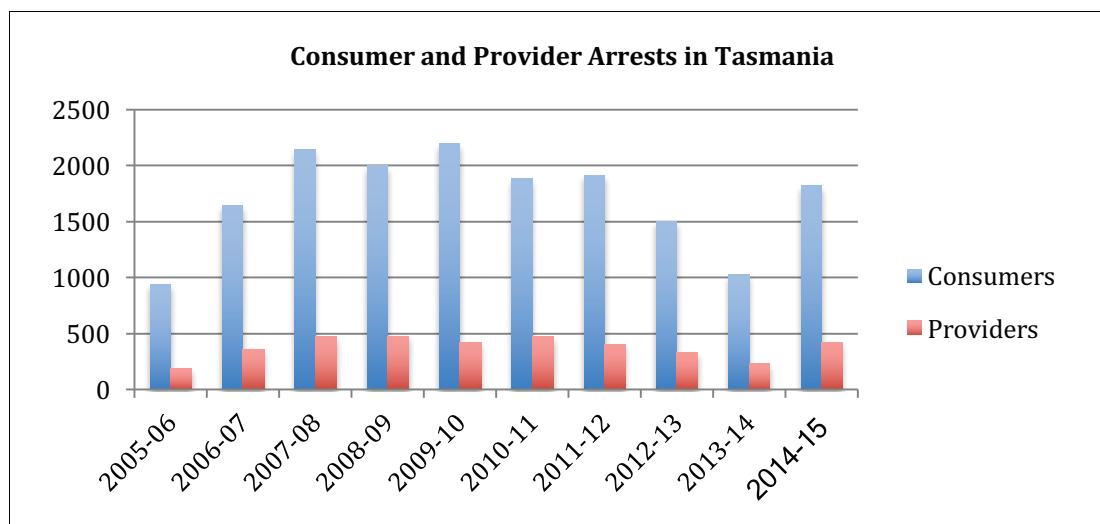


²² Ibid, 178.

²³ Ibid, 6.

²⁴ Ibid, 186.

Similarly, the Tasmanian specific ACC data demonstrates that around 80 per cent of all drug arrests over the last decade have been made against persons who have been charged with use, possession or administering a drug for their own use.²⁵ It is also worth noting that whilst consumer drug arrests have fluctuated over the last decade there has been a 92 per cent increase between the 2005–06 and 2014–15 data.



2.6 The Magistrates Court

Research published by the Magistrates Court of Tasmania demonstrates that, on average, around 1000 Tasmanians per annum over the last decade have been charged with drug-related offences. There was a peak of 1442 in 2010–11, a gradual decline over the following three years before once again rising in 2014–15.²⁶

Magistrates Court of Tasmania		
Year	No. of Illicit Drug Cases (adults)	No. of Illicit Drug Cases (Youth Justice)
2005–06	999	39
2006–07	1093	40
2007–08	1307	71
2008–09	1280	89
2009–10	1228	101
2010–11	1442	86
2011–12	1283	66
2012–13	965	31
2013–14	886	28
2014–15	1036	31

²⁵ Ibid, Table 41.

²⁶ The data was found in Annual Reports published by the Magistrates Court in 2014–15, 2010–11 and 2006–07. The Annual Reports can be accessed at http://www.magistratescourt.tas.gov.au/about_us/publications (Accessed 10 June 2017). It should be noted that some caution should be taken with this data as it includes all persons who were charged with a drug-related offence. It is likely that in some cases the charges were withdrawn or that someone was subsequently found innocent at trial.

More detailed information about persons charged with illicit drug-related offences in the Magistrates Court is available from the Tasmanian Sentencing Advisory Council's (SAC) website²⁷ which provides data on the number of offenders convicted for drug-related offences.

The SAC data demonstrates that the overwhelming majority of drug-related offences in the Magistrates Court involve consumers who have been convicted of possession, use, or cultivation offences. Whilst the SAC statistics do not provide any information on the type of drug for which the sentence was imposed, the Australian Crime Commission observes that 65 per cent of all arrests in Tasmania are for cannabis possession (see above) and cannabis accounted for 73 per cent of all seizures in Tasmania in 2014–15.²⁸

Whilst the data demonstrates that almost half of all offenders sentenced for a drug-related offence receive a fine,²⁹ it is concerning that almost 15 per cent of offenders sentenced for minor drug offences are sentenced to a term of imprisonment, including fully and partially suspended sentences. Between 2010–15, 544 offenders were sentenced to imprisonment for minor drug offences of which 80 per cent received a fully suspended sentence, 13 per cent imprisonment and seven per cent to a partially suspended sentence.³⁰

Importantly, the data provided by both the Magistrates Court and the SAC is only able to capture those offenders convicted of a drug-related offence. The data is unable to provide any guidance on the number of offenders sentenced for other offending but where the cause is an underlying drug problem. If the evidence from the Supreme Court is any guide (see below) then the total number of offenders being sentenced for drug-related *crime* rather than merely drug-related *offences* is likely to be significantly higher.

2.7 The Supreme Court

In the Supreme Court where more serious indictable offences are prosecuted, all sentences handed down are available on the *Sentencing Database*. The database provides an outline of the offence for which the offender is being sentenced for all cases heard in Tasmania since 2008.³¹ A review of the database reveals that between 2008–15 around 68 Tasmanians were sentenced each year for drug-related offences with a peak of 89 in 2009 and 2011 and a gradual decline thereafter.

²⁷ See Sentencing Advisory Council Statistics <<http://www.sentencingcouncil.tas.gov.au/statistics>> (Accessed 10 June 2017).

²⁸ Australian Crime Commission, Op cit, Table 51.

²⁹ In raw numbers, 1997 of the 4090 offenders who were sentenced between 2010–15 for a drug offence under the *Misuse of Drugs Act 2001* (Tas) received a fine.

³⁰ In raw numbers of the 544 offenders sentenced to imprisonment between 2010–15 for a drug offence under the *Misuse of Drugs Act 2001* (Tas), 432 were sentenced to a fully suspended sentence, 73 sentenced to imprisonment and 37 sentenced to a partially suspended sentence.

³¹ The sentencing comments are available at <http://catalogues.lawlibrary.tas.gov.au/textbase/SentSearch.htm> (Accessed 10 June 2017).

Supreme Court of Tasmania	
Year	No. of offenders sentenced for drug-related offences
2008	84
2009	89
2010	72
2011	89
2012	58
2013	52
2014	52
2015	49
2016	62
Total	607

However, the data fails to capture the full extent of offenders with a demonstrable drug use problem. Problematic drug consumers may be sentenced for a wide variety of offences many of which are not drug offences — for example offenders who commit an armed robbery in an attempt to source funds for their habit. A more complete picture of the link between problematic drug use and crime is demonstrated through an understanding of the underlying cause of the offending rather than focusing narrowly on the type of offence; an explanation that is likely to be made clear during the offender's hearing or plea in mitigation and highlighted in the sentencing comments of the Supreme Court judge.

The Comments on Passing Sentence, as they are sometimes called, are delivered by the sentencing judge in open court when passing sentence and generally state the offence(s) for which the offender has been convicted, the objective circumstances of the offence and the subjective circumstances of the offender.³² An analysis of the sentencing comments reveals that there are a significant number of offenders in Tasmania whose offending behaviour is inextricably linked to their problematic drug use. As the Table below demonstrates, on average more than 120 sentences are handed down each year in the Supreme Court for offenders with problematic drug use.

Supreme Court of Tasmania		
Year	No. of offenders sentenced with an acknowledged drug-problem	No. of offences committed
2008	104	392
2009	123	336
2010	120	383
2011	156	392
2012	125	415
2013	115	319
2014	132	305
2015	117	303
2016	140	355
Total	1132	3200

³² An electronic database of the sentencing comments is available at <http://catalogues.lawlibrary.tas.gov.au/textbase/SentSearch.htm> (Accessed 10 June 2017).

Our review of Tasmania's Magistrates and Supreme courts demonstrates that there is on average at least 1100 Tasmanians being charged, prosecuted and sentenced each year for drug offences or where the offending behaviour can be traced back to their problematic drug use. It must be emphasised however that this figure is likely to be much higher given that our research into the underlying causes of offending was limited to the Supreme Court.

With Australia's law enforcement approach to drug use having failed to curtail either supply or demand as well as resulting in a large number of non-violent offenders being charged, prosecuted and sentenced, a different approach is needed. Increasingly, this view is being recognised at a local, regional and global level as Australian States and Territories, governments around the world and even the agencies of the United Nations acknowledge that personal drug use demands a health rather than a criminal response. A good example is the World Health Organisation, which in 2014 called for the decriminalisation of personal drug use in a report focused on HIV prevention.³³

³³ World Health Organisation, Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (July 2014). As found at http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1 (Accessed 10 June 2017). Also see the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health who in a submission about drug laws observed that "less restrictive approaches to drug control, including decriminalisation or de-penalisation, should be considered to effectively prevent risky behaviour by people who use drugs and to reduce the harmful effects associated with drug use": A Grover, *Submission to the Committee against Torture regarding drug control laws*, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (October 2012). As found at <http://www.ohchr.org/Documents/Issues/Health/drugPolicyLaw.pdf> (Accessed 26 June 2015).

3 Australia's International Obligations

Australia is a signatory to three United Nations conventions that seek to control drug use. These conventions are:

- The *Single Convention on Narcotic Drugs 1961*;³⁴
- The *Convention on Psychotropic Substances 1971*; and
- The *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988*.

The “bedrock” of the international effort to control drug use³⁵ is the *Single Convention* which expressly provides that signatories are “to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs”.³⁶ Article 36 of the *Single Convention* also stipulates the penalties to be imposed, noting:

(a) Subject to its constitutional limitations, each Party shall adopt such measures as will ensure that cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation of drugs contrary to the provisions of this Convention, and any other action which in the opinion of such Party may be contrary to the provisions of this Convention, shall be punishable offences when committed intentionally, and that serious offences shall be liable to adequate punishment particularly by imprisonment or other penalties of deprivation of liberty.

(b) Notwithstanding the preceding subparagraph, when abusers of drugs have committed such offences, the Parties may provide, either as an alternative to conviction or punishment or in addition to conviction or punishment, that such abusers shall undergo measures of treatment, education, after-care, rehabilitation and social reintegration in conformity with paragraph 1 of article 38.³⁷

The failure to include “use” in the list of prohibited conduct was not an oversight but rather a deliberate exclusion according to the official United Nations commentary:

It will be noted that paragraph 1 does not refer to ‘use’. As has been pointed out elsewhere, article 36 is intended to fight the illicit traffic and unauthorised consumption of drugs by addicts does not constitute ‘illicit traffic’.³⁸

This point is reiterated in further commentary by the United Nations:

There can be no doubt that Governments may refrain from imposing imprisonment in cases of possession of drugs held for personal consumption without legal authority. Possession of drugs for distribution without such authority must, on the other hand, be made punishable ‘by imprisonment or other penalties of deprivation of liberty’ [emphasis added].³⁹

³⁴ The *Single Convention* was amended by the 1972 Protocol.

³⁵ D Bewley-Taylor, ‘Challenging the UN drug control conventions: problems and possibilities’ (2003) 14 *International Journal of Drug Policy* at 171–9.

³⁶ *Single Convention on Narcotic Drugs 1961* art 4.

³⁷ *Ibid* art 36.

³⁸ United Nations (UN) (1973), ‘Commentary on the Single Convention on Narcotic Drugs 1961’, New York at 428, [7].

³⁹ *Ibid*, 113,[23].

As a result, it is clear that the *Single Convention* seeks to differentiate between personal use and trafficking. In the case of personal use, the United Nations allows Parties the discretion to impose a penalty of their choosing whilst for possession amounting to a trafficable amount signatories are required to impose imprisonment and other “deprivation of liberty” sanctions.

Following Australia's adoption of the *Convention on Psychotropic Substances 1971* the range of drugs subject to international control was significantly broadened to include synthetic behaviour- and mood-altering drugs including amphetamines and LSD. Most recently, Australia ratified the *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988*, which gave effect to “comprehensive measures against drug trafficking, including provisions on money laundering, asset seizure, agreements on mutual legal assistance and the diversion of precursor chemicals”.⁴⁰

Whilst the *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* is primarily concerned with drug trafficking, article 3(2) stipulates that signatories are to make the possession of drugs for personal consumption a criminal offence:

Subject to its constitutional principles and the basic concepts of its legal system, each Party shall adopt such measures as may be necessary to establish as a criminal offence under its domestic law, when committed intentionally, the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention.

Whilst the *Convention* significantly broadens the scope of prohibition to include “personal consumption”, article 3(4) goes on to note that Parties may choose to divert offenders away from the criminal justice system:

(a) Each Party shall make the commission of the offences established in accordance with paragraph 1 of this article liable to sanctions which take in to account the grave nature of these offences, such as imprisonment or other forms of deprivation of liberty, pecuniary sanctions and confiscation.

(b) The Parties may provide, in addition to conviction or punishment, for an offence established in accordance with paragraph 1 of this article, that the offender shall undergo measures such as treatment, education, aftercare, rehabilitation or social reintegration.

(c) Notwithstanding the preceding subparagraphs, in appropriate cases of a minor nature, the Parties may provide, as alternatives to conviction or punishment, measures such as education, rehabilitation or social reintegration, as well as, when the offender is a drug abuser, treatment and aftercare.

(d) The Parties may provide, either as an alternative to conviction or punishment, or in addition to conviction or punishment of an offence established in accordance with paragraph 2 of this article, measures for the treatment, education, aftercare, rehabilitation or social reintegration of the offender.

In short, whilst Parties are required to criminalise the illicit possession, cultivation and purchase of drugs, the *Convention* does not require Parties to impose a punishment of any kind for personal use. Indeed, according to the United Nations, “paragraph 2 does not require drug consumption to be established as a punishable offence”.⁴¹

⁴⁰ D Bewley-Taylor, Op cit 172.

⁴¹ United Nations, ‘Commentary on the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988’, New York (1988) at paragraph 3.95. As found at

In other words, whilst the *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* requires Parties to prohibit the use of drugs, it also provides them with the discretion to determine the type of sanction (either criminal or administrative) to be imposed. This view was shared by both the Commonwealth Department of Justice and the then Minister for Foreign Affairs Gareth Evans who noted that the decriminalisation of personal use or possession is not a breach of Australia's international obligations.⁴²

As this analysis demonstrates, Tasmania would be acting consistently with Australia's obligations under all three United Nations conventions if it were to decriminalise personal drug use, as long as drug use remained prohibited.⁴³

http://www.unodc.org/documents/treaties/organized_crime/Drug%20Convention/Commentary_on_the_united_nations_convention_1988_E.pdf (Accessed 10 June 2017). Also see article 4 and 36 of the 1961 Convention and articles 5 and 22 of the 1971 Convention.

⁴² S Morgan, 'Policy Initiatives and Drug Law Reform – The Law Society of New South Wales' (1994) 94(3) *Drugs in Society* 31 at 32.

⁴³ G Greenwald, 'Drug Decriminalisation in Portugal: Lessons for creating fair and successful drug policies' (2009) Cato Institute: Washington DC at 7; Australia21 'Alternatives to Prohibition: Illicit Drugs: how we can stop killing and criminalising young Australians' (2012) Report No 2 at 5, 23.

4 Harm Minimisation and Australia's de-facto Decriminalisation Model

Whilst decriminalisation of personal drug use may seem like a radical proposal, in reality a de facto decriminalisation model is already in place — at least for some offenders — with criminal sanctions replaced with a health-focussed response.

As noted above, Australia has ratified a number of international conventions concerned with drug use and possession. However, Australia's federalist system of government means that laws governing drug use and possession remain largely a State and Territory responsibility. Whilst governments of all persuasions continue to publicly proclaim Australia's war against drugs,⁴⁴ there has been growing recognition that personal drug use should be treated as a health rather than a criminal justice issue.

The shift towards a more humane policy began in 1985 with the Commonwealth and all States and Territories signing on to a National Drug Strategy (NDS).⁴⁵ The overarching principle of the NDS was harm minimisation with the then Health Minister, Neal Blewett describing the aim as: "[not] to eliminate drugs, or drug abuse, or remove entirely the harmful effects of drugs, merely 'to minimise' the effects of the abuse of drugs on a society permeated by drugs".⁴⁶

To this day, harm minimisation remains the overarching principle of the NDS with the *National Drug Strategy 2010—2015* outlining that the principle encompasses "the three equally important pillars of demand reduction, supply reduction and harm reduction... in a balanced way".⁴⁷ These pillars are defined in the *National Drug Strategy 2010-2015* as:⁴⁸

- **Demand reduction** means strategies and actions which prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community.
- **Supply reduction** means strategies and actions which prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs.
- **Harm reduction** means strategies and actions that primarily reduce the adverse health, social and economic consequences of the use of drugs.

⁴⁴ For example, Prime Minister Abbott's declaration "We are ensuring that the war on drugs is fought as fiercely as we humanly can. It's not a war we will ever finally win. The war on drugs is a war you can lose – you may not ever win it, but you've always got to fight it": M Colvin, 'Australia losing its war against drugs', *PM Program* 29 April 2014. As found at <http://www.abc.net.au/pm/content/2014/s3994435.htm> (Accessed 10 June 2017).

⁴⁵ From 1985 to 1998 this was known as the National Campaign Against Drug Abuse (NCADA) which was followed by the National Drug Strategic Framework from 1998–99 to 2002–03. For more detail see A Ritter, K Lancaster, K Grech & P Reuter, *An Assessment of Illicit Drug Policy in Australia (1985 to 2010) Themes and Trends* (2011), DPMP Monograph Series No. 21. Sydney: National Drug and Alcohol Research Centre 9–10.

⁴⁶ N Blewett, *National Campaign Against Drug Abuse: Assumptions, arguments and aspirations* (1987) Monograph Series No. 1, Canberra: Australian Government Publishing Service.

⁴⁷ Ministerial Council on Drug Strategy, *National Drug Strategy 2010—2015* (2011) Canberra: Commonwealth of Australia.

⁴⁸ The *Tasmanian Drug Strategy 2013–2018* notes its "connection" to the *National Drug Strategy 2010–15* noting that the NDS has "guided the establishment of the key concepts, principles, direction and priorities" of the Tasmanian approach: Interagency Working Group on Drugs, *Tasmanian Drug Strategy 2013-2018* (April 2013) at 6.

In other words, the official government policy at a Federal, State and Territory level tacitly acknowledges that drug use exists which cannot be fully eradicated by legislative action and which, in the interests of public health, calls for measures that will reduce or minimise the risk to the individual and to society.

Harm minimisation models have been put into practice around Australia. Issuing cautions, along with other diversionary responses intended to divert individuals away from the criminal justice system are practiced by law enforcement agencies in all States and Territories, particularly for drug offences involving youth and non-violent offenders.⁴⁹ Additionally, most States and Territories have introduced court-based diversion programs, often referred to as drug courts, in an attempt to address the factors underpinning the offending behaviour.

4.1 Diversion

Drug diversion strategies seek to redirect offenders away from the criminal justice system. Whilst diversion has traditionally been a strategy adopted prior to offenders being charged with a criminal offence, the term is nowadays used more broadly to include both police and court drug diversion programs. The police has long practiced diversion, although in an informal and ad hoc manner, with offenders usually issued with a caution or warning. The first jurisdiction to introduce a more systematic approach to cautioning was South Australia⁵⁰ and whilst some other jurisdictions have followed,⁵¹ it was only in April 1999 that a national response was established with the Commonwealth and all States and Territories signing of the *Council of Australian Government – Illicit Drug Diversion Initiative (IDDI)*.⁵²

One of the key aims of the IDDI was to reduce drug use, crime and negative social impacts through the creation of early intervention programs that diverted drug users away from the criminal justice system and into drug education and treatment programs. The IDDI received significant Commonwealth funding for the establishment of diversionary programs by both the police and the courts in every State and Territory including Tasmania.

Diversion continues to remain one of the most widely implemented harm minimisation measures, with a 2008 review finding that 51 programs were in operation throughout Australia.⁵³

A comprehensive evaluation of police drug diversion undertaken by the *Australian Institute of Criminology* in 2008 found that there was a high rate of compliance with the required education

⁴⁹ S Morrison & M Burdon, *The role of police in the diversion of minor alcohol and drug-related offenders*, (2000) National Campaign Against Drug Abuse, Monograph Series: Monograph No. 40. Canberra: Department of Health and Aged Care.

⁵⁰ South Australia introduced two diversion programs in the 1980s. The Drug Assessment and Aid Panels introduced in 1984 provided assessment and treatment for users of illicit drugs (excluding cannabis) prior to sentencing in court. Whilst the Cannabis Expiation Notice Scheme introduced in 1987 penalised cannabis users with fines (expiation notices) as an alternative to prosecution in court.

⁵¹ For example, New South Wales introduced a specialist drug court and in 1998 Victoria introduced the Court Referral and Evaluation for Drug Intervention and Treatment (CREDIT) bail scheme. As found in C Hughes & A Ritter, *A summary of diversion programs for drug and drug-related offenders in Australia* (2008) DPMP Monograph Series No. 16. Sydney: National Drug and Alcohol Research Centre at 4.

⁵² Ibid 4.

⁵³ Ibid 4.

or treatment programs and the majority of participants who were referred to diversion not re-offending in the 12–18 months after being cautioned.⁵⁴

Further, there has only been one Australian study examining the cost-effectiveness of diversion. This study reviewed the introduction of the NSW Cannabis Cautioning Scheme, which gave police the discretion to formally caution rather than charge adults suspected of minor cannabis offences. The study found that in the scheme's first three years of operation, a total of 9235 cautions had been issued and estimated that the scheme had saved 18,000 police hours or \$400,000 as a result of not having to charge offenders, prepare matters for court or attend hearings.⁵⁵ The study also found significant cost efficiencies for the courts with estimated savings of at least \$800,000 and possibly more than \$1,000,000.⁵⁶

In Tasmania, there are two diversion programs in operation, the Police Drug Diversion program and the Court Mandated Diversion scheme.

4.1.1 Police Drug Diversion

The Police Drug Diversion program is unique in Australia because of its ability to target both cannabis and other illicit drugs. Whereas other States and Territories have implemented more restrictive programs that allow police to divert persons found using or possessing cannabis exclusively, the Tasmanian program enables a range of responses to drug users found with any illicit drug.⁵⁷

The program, which commenced in March 2000, grants police officers the discretion to caution both adult and young offenders without prosecution. The program is available for low level and/or first time users of cannabis and other illicit drugs. Licit drugs used illicitly are also covered under the program. The program adopts a three-tiered approach:

- *1st Level Diversion: Cannabis Caution* is available where the offender is found in possession of cannabis. The offender is cautioned and advised that if they commit further offences of a similar nature they may be prosecuted.
- *2nd Level Diversion: Brief Intervention* occurs on a second cannabis offence. The offender is issued with a Drug Diversion Notice and is required to attend a brief face-to-face intervention with a health professional. Failure to attend may result in offender being charged and prosecuted in court.
- *3rd Level Diversion: Assessment and Treatment* takes place where an offender is found in possession of cannabis for the third time or found in possession of any other illicit drug or licit drug used illicitly. The offender must contact the relevant alcohol and drug service within three working days or is charged and prosecuted in court. The offender is assessed in order to match them with an appropriate treatment intervention. Compliance with the treatment plan will result in no further action being taken.⁵⁸

⁵⁴ J Payne, M Kwiatkowski & J Wundersitz, *Police drug diversion: a study of criminal offending outcomes* (2008) Research and Public Policy Series Report 97. Canberra: Australian Institute of Criminology.

⁵⁵ J Baker & D Goh, *The Cannabis Cautioning Scheme three years on: An implementation and outcome evaluation* (2004) NSW Bureau of Crime Statistics and Research, Sydney at 35–6.

⁵⁶ Ibid at 37.

⁵⁷ A complete list of the police drug diversion programs currently available in Australian jurisdictions is available here: <https://ncpic.org.au/professionals/publications/aic-bulletins/police-drug-diversion-in-australia/> (Accessed 8 May 2015).

⁵⁸ Jason Payne, Max Kwiatkowski & Joy Wundersitz, Op cit 7.

Under this scheme offenders may be referred to diversion if apprehended on three occasions in the previous 10 years. Additionally, there is no maximum allowable quantity of illicit drug although the police officer must be satisfied that the illicit drug found on the offender was for personal use only.⁵⁹

According to the most recent data published by the National Drug and Alcohol Research Centre, there were on average more than 1000 cautions and diversions in each of the years between 2003–04 and 2010–11 after which persons under the age of 18 were no longer included for reporting purposes.⁶⁰

Year	No. cautions/diversions	No. diverted to health intervention
2003–04	1398	179
2004–05	1330	365
2005–06	1158	236
2006–07	1361	369
2007–08	1681	634
2008–09	1528	536
2009–10	1609	615
2010–11	1132	413
2011–12	869	397
2012–13	778	260
2013–14	690	205
2014–15	648	216

A report published by the Australian Institute of Health and Welfare in 2008 found that 18.6 per cent of persons subject to diversion between 2003–06 were required to undertake either a brief intervention or assessment and treatment.⁶¹ A majority of persons (51.4 per cent) required to undertake a brief intervention or assessment were aged between 18–25, 21.4 per cent were aged between 36–45, and 12.9 per cent between 26–35 years old.⁶² The ability of the Tasmanian program to divert all types of drug use to diversion has led one Australia-wide review of diversionary programs to conclude that the Tasmanian program enables “a more individually tailored and streamlined program than the traditional police drug diversion scheme”.⁶³

Although there have been criticisms of police diversion in the past including the lack of resourcing for treatment and assessment, the arbitrary nature of police discretion and the lack

⁵⁹ Ibid 7.

⁶⁰ A Peacock, M Humphries & R Bruno, *Tasmanian Drug Trends 2015 Findings from the Illicit Drug Reporting System (IDRS)* (2015) Australian Drug Trends Series No. 149. National Drug and Alcohol Research Centre, University of New South Wales, Australia at 151.

⁶¹ Australian Institute of Health and Welfare, *The effectiveness of the Illicit Drug Diversion Initiative in rural and remote Australia* (2008) Drug statistics series no. 19. Cat. no. PHE 96. Canberra: AIHW at 65.

⁶² Ibid 70. Data was not collected by the Department of Health and Human Services for offenders who received a 1st Level Diversion Cannabis Caution. As well, the data is only for 2005–06.

⁶³ C Hughes & A Ritter, *Op cit* 17.

of training provided to police officers,⁶⁴ the anecdotal evidence of those employed in the alcohol and other drug sector is that despite these deficiencies the system appears to be working.⁶⁵

4.1.2 Court Mandated Diversion

In July 2007, Tasmania introduced a court-based drug diversion program known as Court Mandated Diversion (CMD). Its aim was “to break the drug-crime cycle by involving offenders in treatment and rehabilitation programs and providing alternative pathways for offenders through increasing their access to drug, alcohol, or other welfare services”.⁶⁶ Whilst CMD began as a 12-month pilot program, it has remained as a sentencing option in Tasmania's Magistrates Courts ever since.

CMD is available to both adult and juvenile offenders with a demonstrable history of drug use who plead guilty to committing non-violent offences. Offenders are sentenced to a drug treatment order that includes treatment for illicit drug use and may require attendance at “vocational, educational, employment, rehabilitation or other programs specified in the order”.⁶⁷

Unlike other forms of diversion such as police cautioning, where offenders are diverted away from the criminal justice system, in CMD and other court diversion programs for drug offenders offered throughout Australia, judicial officers are actively involved in the treatment and monitoring of the offender in an attempt to address the factors underpinning the offending behaviour.

A review of the CMD Program for the Department of Justice in November 2008, found that less than half of the 157 offenders who had commenced the program had undertaken any previous drug treatment leading the authors to conclude that “CMD has been their first ever opportunity to confront their need for treatment and to gain support to deal with their addiction related issues... and is, in itself, a significant achievement”.⁶⁸ The review also found that 56.7 per cent of participants had not reappeared in court after their involvement in the program, a figure commensurate with other court-based drug diversion programs.⁶⁹

Importantly, studies have been carried out comparing persons sentenced to CMD with persons who have not undertaken the program. An evaluation of the NSW Drug Court for example, found that when participants in the Drug Court were matched with offenders sentenced to more conventional sentences, Drug Court participants regardless of whether they remained in treatment or were removed from the program, were 17 per cent less likely to be reconvicted for any offence, 30 per cent less likely to be reconvicted for a violent offence and 38 per cent less likely to be reconvicted for a drug offence at any point during the follow-up period (which averaged 35 months).⁷⁰ And, when only those Drug Court participants who had completed the program were compared, they were found to be 37 per cent less likely to be reconvicted of any

⁶⁴ A Kellow, R Hall, M Richman, M Alessandrini, M Bower, R Julian, R White, *Enhancing the Implementation and Management of Drug Diversion Strategies in Australian Law Enforcement Agencies: Final Report* (2006) National Drug Law Enforcement Research Fund, Commonwealth of Australia at 36, 40, 52 and 56.

⁶⁵ Discussions were held with Sarah Charlton, Chief Executive Officer of Holyoake Tasmania Inc in 2017 and Jann Smith, the then Chief Executive Officer of the Alcohol, Tobacco and other Drugs Council Tasmania Inc in 2016.

⁶⁶ Department of Justice, *Tasmania's Court Mandated Drug Diversion Program Evaluation Report* (2008) at 7. It should be noted that the report was commissioned by the Department of Justice and written by ‘Success Works’.

⁶⁷ Sections 7, 27G and 27H of the *Sentencing Act 1997* (Tas).

⁶⁸ Department of Justice, Op cit 68.

⁶⁹ Ibid 107, 115–116.

⁷⁰ D Weatherburn, C Jones, L Snowball & J Hua, *The NSW Drug Court: A re-evaluation of its effectiveness* (2008) 121 *NSW Bureau of Crime and Statistics and Research* at 9.

offence, 65 per cent less likely to be reconvicted of an offence against the person, 35 per cent less likely to be reconvicted of a property offence and 58 per cent less likely to be reconvicted of a drug offence.⁷¹

Despite its proven ability to rehabilitate, the CMD program in Tasmania was, until very recently,⁷² limited to offenders sentenced in the Magistrates Court and is capped at 80 participants.⁷³ These limitations have resulted in strongly worded criticism from judges of the Supreme Court. For example, in sentencing a young offender in 2015, Chief Justice Blow noted that:

You have had a drug problem. You committed these offences as a result of that drug problem. Your counsel has told me that you wanted to get involved in the Court Mandated Diversion program and that you were not able to do so because there was not a place and there is no longer a waiting list. I think it is very unfortunate that the authorities do not have the funding to make available as many places as are needed for these programs. We would be a lot better off if more people were able to undertake them and be rehabilitated by means of these programs.⁷⁴

⁷¹ Ibid 11.

⁷² Section 27B of the *Sentencing Act 1997* (Tas) was proclaimed and came into effect on 8 February 2017. See *Proclamation under the Sentencing Amendment Act 2016*.

⁷³ Sentencing Advisory Council, *Phasing out of Suspended Sentences* (2016) Final Report No 6 at 46. The Report notes that this includes those subject to a CMD order and those being assessed for suitability.

⁷⁴ Chief Justice Blow in his sentencing remarks delivered in *State of Tasmania v Joshua John Atkinson* (6 February 2015). Also see Justice Tennant's comments *State of Tasmania v Andrew Paul Kelleher* (18 November 2015) where she observes, 'This is a case where the court mandated drug program available in the Magistrates Court might have been of some assistance to you. You were not eligible when sentenced in that court because, at the time of your sentence in July, you had these potential Supreme Court matters still outstanding. I have no power to access that program for you'.

5 What are the Options for Reform?

Whilst the National Drug Strategy adopts harm minimisation as its overarching policy and endorses a balanced approach in reducing supply, demand and harm, the reality is that the majority of government funding is still allocated to law enforcement measures.⁷⁵ For example, a review carried out in 2008 estimated that \$1.3 billion was expended on direct drug policy interventions of which the majority was spent on law enforcement (55 per cent) followed by prevention (23 per cent) treatment (17 per cent) harm reduction (3 per cent) and other (1 per cent).⁷⁶

However, if it is acknowledged that we cannot arrest our way out of illegal drug use, then options for reform need to be considered. Broadly, there are three alternative models: regulation, decriminalisation and depenalisation.

5.1 Regulation

Regulation is the removal of all criminal and administrative sanctions for the production, distribution and use of drugs. Regulation would see drugs sold at licensed premises. The sale, production or distribution of drugs outside of the regulatory system would remain a criminal offence. The regulatory model is currently applied in Australia to a number of drugs including tobacco, alcohol and prescription medicines.

5.2 Depenalisation

Depenalisation maintains the legislative prohibition on drug use and possession but in practice criminal sanctions are not imposed. This approach is exemplified by the Netherlands, where minor cannabis offences are not enforced. Diversionary programs in operation throughout Australia are essentially a form of depenalisation, although the type of offence (drug type) and offender (age, prior offences) differ depending upon the program in place. It is also arguable that a depenalisation model is already applied in Tasmania for persons found in possession of cannabis for medical reasons, although this is at the discretion of the police, prosecution and Director of Public Prosecutions.⁷⁷

5.3 Decriminalisation

Decriminalisation is the removal of criminal sanctions for possession of small quantities of illegal drugs for personal use. In its place, administrative or civil sanctions are imposed. Decriminalisation models for personal drug use have been introduced in a number of countries including Portugal. In Australia, decriminalisation is in place for minor cannabis use, possession and cultivation offences in South Australia, Western Australia, the Northern Territory and the

⁷⁵ A Ritter, K Lancaster, Katrina Grech & Peter Reuter, *Op cit* 9–10.

⁷⁶ T Moore, 'The size and mix of government spending on illicit drug policy in Australia' (2008) 27(4) *Drug and Alcohol Review* 404 at 408.

⁷⁷ For example, in response to a query about the ongoing prosecution of persons who possess cannabis for medicinal reasons, the State Government responded that "the decision of Tasmania Police to prosecute occurs on a case-by-case basis, informed by advice of Tasmania Police Prosecution Services and the Director of Public Prosecutions as required": Michael Ferguson representing Rene Hidding, Minister for Police, Fire and Emergency Management, Tasmanian Parliament, *Hansard*, House of Assembly 28 April 2016.

Australian Capital Territory. In these jurisdictions, so long as the prescribed fine is paid, no criminal proceedings are commenced.

5.3.1 The Portuguese Model

On 1 July 2001, new laws came into effect throughout Portugal decriminalising the purchase, possession and consumption of all illicit drugs for personal use. As a result of this legislative reform, instead of criminal penalties, persons found in possession of small amounts of illicit drugs are subject to administrative penalties including fines or are referred to treatment.

Whilst opponents of the reform predicted that drug use would increase exponentially and Portugal would become a drug haven for addicts and recreational drug users,⁷⁸ analysis of the effect of the reforms has found that whilst there has been a small increase in reported illicit drug use among adults this has been offset by reduced drug abuse amongst adolescents and problematic drug users. Moreover, significant resources have been able to be re-allocated to drug treatment with concomitant reductions in HIV infections, drug-related deaths and addiction.⁷⁹

Before turning to the intricacies of the Portuguese model, it is important to note from the outset that the reform forms only one part of a much larger reorientation of personal drug use as a public health rather than law enforcement issue. This shift in policy was precipitated by high levels of problematic drug use in Portugal in the late 1980s and throughout the 1990s which led to high levels of drug-related social problems including the spread of infectious diseases.⁸⁰

In an attempt to find solutions the government appointed a "Commission for the National Strategy to Fight against Drugs" which recommended wide-ranging reform to drug policy including international cooperation, prevention, treatment, harm reduction, prisons and drugs, rehabilitation, supply reduction and money laundering. Amongst its many proposed reforms, the Commission recommended the decriminalisation of personal drug use.⁸¹

The report was supported by Government and ultimately became the National Strategy for the Fight Against Drugs, which was adopted in 1999.⁸² The National Strategy remains to this day the foundation of Portugal's drug policy with an ambitious aim of doubling investment in areas such as an extension of harm reduction interventions, improving access to treatment including as an alternative to prison and developing treatment and harm reduction in prisons.⁸³ In summary, whilst the decriminalisation of drug use in Portugal has attracted significant media attention, as the European Monitoring Centre for Drugs and Drug Addiction has highlighted it is "one element of a larger policy change" in which drug use has increasingly been seen as a health issue⁸⁴ and where the emphasis is on education, early intervention and treatment.

⁷⁸ G Tremlett, 'Lisbon takes drug use off the charge sheet', *The Guardian* 20 July 2001. As found at <http://www.theguardian.com/world/2001/jul/20/drugsandalcohol.uk> (Accessed 1 May 2015).

⁷⁹ C Hughes and A Stevens, 'What can we learn from the Portuguese decriminalization of illicit drugs?' (2010) 50 *British Journal of Criminology*, 999.

⁸⁰ In 1999 for example, Portugal had the highest rate of drug-related AIDS in the European Union and the second highest prevalence of HIV amongst injecting drug users. *Ibid* 1001.

⁸¹ European Monitoring Centre for Drugs and Drug Addiction (2011), 'Drug policy profiles — Portugal' at 15.

⁸² *Ibid* 15.

⁸³ *Ibid* 15–16.

⁸⁴ See, for example, Decree Law 183/2001 which came into effect on 21 June 2001 and seeks to regulate harm reduction interventions, as well as drop-in centres for drug addicts, refuges and shelters, mobile centres for the

How Portugal's decriminalisation law operates

Portugal's decriminalisation laws apply to the purchase, possession and consumption of all illicit drugs. Article 2(1) of *Decree-Law 30/2000* ("the Act") relevantly provides that:

The consumption, acquisition and possession for one's own consumption of plants, substances or preparations listed in the tables referred to in the preceding article constitute an administrative offence.⁸⁵

The Act lists a table of all "plants, substances or preparations" that were formerly prohibited and goes on to define personal use in article 2(2) as a quantity "not exceeding the quantity required for an average individual consumption during a period of 10 days".⁸⁶ No distinction is made between the types of drug or whether the possession or consumption was in private or in public. The effect of this law is that whilst the purchase, possession and consumption of illicit drugs remain prohibited, decriminalisation means that infractions are dealt with as administrative violations rather than as offences in the criminal justice system.⁸⁷

Under the Portuguese model, police officers who observe drug use or possession do not arrest offenders but instead confiscate the drug and issue an infraction notice. Within 72 hours of the issuance of the notice, the offender is required to report to the Commission for the Dissuasion of Drug Addiction ("the Commission"), a government body with the power to assess the offender's level of use, provide information and education materials on drug use and also, in appropriate circumstances, impose administrative infraction notices.⁸⁸ If the Commission finds evidence of drug trafficking, the matter will be referred to prosecution and dealt with under the criminal justice system.

Each Commission consists of three members: one commissioner with a legal background and two commissioners with backgrounds in health or social work.⁸⁹ In determining the sanction that should be imposed, the Commission is required to consider a wide range of factors including the seriousness of the act, the type of drug consumed, whether consumption was in public or private and whether the usage was recreational or problematic.⁹⁰ The offender has the right to request that a therapist of their choosing take part and the offender can also request that a medical examination be undertaken to assist the Commission in its determination. Minors are subject to the same laws but are able to have a legal representative present.⁹¹

prevention of infectious diseases, methadone and buprenorphine substitution programs, syringe exchange schemes, contact and information units and street workers. Ibid 18.

⁸⁵ Decree-Law 30/2000 (*Decreto-Lei n.º 30/2000*, de 29 de novembro 2000).

⁸⁶ The average quantity sufficient for 10 days' personal usage includes one gram of heroin, two grams of cocaine, 25 grams of cannabis leaves and one gram of MDMA and amphetamines. Amounts are listed in a table appended to Portugal's Decree-Law 30/2000. The amounts are available at A Domosławski, *Drug Policy in Portugal: The Benefits of Decriminalizing Drug Use* (2011) Open Society Foundations: Global Drug Policy Program at 51. As found at <https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf> (Accessed 10 June 2017).

⁸⁷ Drug trafficking remains a criminal offence subject to imprisonment.

⁸⁸ All 18 of Portugal's administrative districts have at least one commission with larger districts such as Lisbon comprising more than one commission.

⁸⁹ Article 7 of the Decree-Law 30/2000. The Ministry of Justice makes the legal appointment whilst the Health Minister and the government's coordinator of drug policy make the other two appointments.

⁹⁰ Article 15(4) of the Decree-Law 30/2000.

⁹¹ Article 3 of the Decree-Law 30/2000.

Penalties that may be imposed include fines as well as non-pecuniary penalties and warnings.⁹² Non-pecuniary penalties available to the Commission include suspension of practicing certificates for professionals such as doctors and lawyers, a ban on “high risk” venues such as nightclubs, suspension of a driver or firearm licence, a ban on associating with particular individuals, a community service order and a prohibition on travel abroad.⁹³ Fines are a penalty of last resort meaning that in practice, unless there are repeated infractions, a fine will not be imposed.

For recreational users with no prior offences, the Commission must “provisionally suspend proceedings” meaning that no sanction is imposed.⁹⁴ Only where recreational users have repeated infractions will fines or other non-pecuniary penalties be imposed.

For persons with a drug addiction, the Commission may “provisionally suspend proceedings” where the offender, with or without prior offences, “agrees to undergo treatment”.⁹⁵ The Commission may also impose sanctions but then suspend the sanctions on the condition that the person undertakes treatment.⁹⁶ In practice, the Commission will rarely order that an offender undertake treatment as “the Commissions’ aim is for people to enter treatment voluntarily; they do not attempt to force them to do so”.⁹⁷

Importantly, the Commission contributes to the de-stigmatisation of drug use. In part this is achieved by the deliberate separation of the Commission from the criminal justice system and its determination of guilt. Instead, the Commission emphasises respect for the offender and focuses on the rehabilitation of the offender. Proceedings before the Commission remain strictly confidential and hearings are deliberately informal with members dressing informally and all parties sitting on the same level.

Whilst a large number of sanctions are available to the Commission, the vast majority are suspended with no sanction being imposed. For example, in 2010 the European Monitoring Centre for Drugs and Drug Addiction reported that 81 per cent of all cases that came before the Commission were suspended. This is perhaps unsurprising given that 76 per cent of all infraction notices were issued to persons in possession of cannabis and that 93 per cent of all cases involved only one drug.⁹⁸

A major review of Portugal’s decriminalisation reforms was published in 2010 in the *British Journal of Criminology*.⁹⁹ The review analysed a large number of evaluative reports including Portugal’s Institute for Drugs and Drug Addiction (*Instituto da Droga e da Toxicodependência*) as well as undertaking a number of interviews with key informants. The review, which was published almost a decade after the decriminalisation reforms were introduced, found that Portugal had experienced:

⁹² Articles 15 and 17 of the Decree-Law 30/2000. Fines that can be imposed are between 25 euros and the minimum national wage.

⁹³ Article 17 of the Decree-Law 30/2000.

⁹⁴ Article 11(1) of the Decree-Law 30/2000.

⁹⁵ Article 11(2) and (3) of the Decree-Law 30/2000.

⁹⁶ Article 14 of the Decree-Law 30/2000.

⁹⁷ Artur Domosławski, *Op cit* 30.

⁹⁸ European Monitoring Centre for Drugs and Drug Addiction, 2012 National Report (2011 data) to the EMCDDA by the Reitox National Focus Point, ‘Portugal’ – New Developments, Trends and in-depth information on selected issues.

⁹⁹ C Hughes and Alex Stevens, ‘What can we learn from the Portuguese decriminalization of illicit drugs?’ (2010) 50 *British Journal of Criminology*, 999–1022.

- small increases in reported illicit drug use amongst adults;
- reduced illicit drug use among problematic drug users and adolescents, at least since 2003;
- reduced burden of drug offenders on the criminal justice system;
- increased uptake of drug treatment;
- reduction in opiate-related deaths and infectious diseases;
- increases in the amounts of drugs seized by the authorities;
- reductions in the retail prices of drugs.¹⁰⁰

However, as the authors were at pains to point out, decriminalisation was only one part of a broader drug strategy which significantly expanded education, treatment and other services for drug users leading the authors to conclude that,

the Portuguese evidence suggests that combining the removal of criminal penalties with the use of alternative therapeutic responses to dependent drug users offers several advantages. It can reduce the burden of drug law enforcement on the criminal justice system, while also reducing problematic drug use.¹⁰¹

A ‘resounding success’ or a ‘disastrous failure’?

The reforms have been the subject of considerable international attention with a number of reports drawing wildly contrasting conclusions. At one extreme, some commentators have described the reform as a “disastrous failure that should not be followed by anyone” whilst at the other extreme, the reforms have been heralded as a “resounding success”.¹⁰² In their critique of the two most divergent accounts of the Portuguese reforms, Hughes and Stevens compare and contrast the three most contested claims asserted in the respective reports, namely the increase in drug use, the increase in drug-related deaths and rates of drug use in comparison to other European countries.

Drug Use in Portugal

The first point of difference between reports that found positive outcomes and those that did not, was whether drug use had indeed increased in the years following the reform. After reviewing the data relied on in the conflicting reports as well as reviewing other data, Hughes and Stevens found that “recent and current drug use in Portugal indicate minimal if any changes between 2001 and 2007”.¹⁰³ The authors also noted that “recent and current drug use *declined* among those aged 15–24, the population who were most at risk of initiation and long-term engagement”¹⁰⁴ and concluded that “[t]he available evidence thus gives grounds for arguing that

¹⁰⁰ Ibid 1017.

¹⁰¹ Ibid 1018.

¹⁰² The Association for a Drug Free Portugal (Associação para uma Portugal Livre de Drogas) described the reforms as a “disastrous failure” whilst the Cato Institute a progressive United States think-tank labelled the reforms a “resounding success”. Both reports are critiqued in C Hughes & Alex Stevens, ‘A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs’ (2012) 31(5) *Drug and Alcohol Review* 101.

¹⁰³ Ibid 105.

¹⁰⁴ Ibid.

while there was some growth in the scale of drug use in post-reform Portugal, there was an overall positive net benefit for the Portuguese community".¹⁰⁵

Drug-related Deaths in Portugal

The second contested claim was whether the reforms had led to a decrease in the number of drug-related deaths. This was a significant issue as one of the most important considerations in implementing the reforms was the desire to reduce the almost 400 drug-related deaths that had occurred in the year preceding the reforms.¹⁰⁶ Whilst the pro-decriminalisation report reported a decrease to 290 drug-related deaths between 2001–06, the prohibitionist report observed that in 2006–07 there had been a 45 per cent increase from 216 to 314 deceased individuals testing positive for drugs.

In their analysis, Hughes and Stevens found that as well as focusing on different years, the data used by the two reports relied on contrasting definitions of drug-related death. Hughes and Stevens found that the better definition was restricted to doctors' assessments of the cause of death rather than positive toxicological tests (i.e. traces of drugs found in deceased persons).¹⁰⁷ Whilst Hughes and Stevens ultimately determined that drug-related deaths had decreased since 2001,¹⁰⁸ they emphasised that the most plausible explanation for the decrease in drug-related deaths was that "a key goal of the reform had been to reduce social stigma and thereby facilitate access to Portuguese drug treatment and harm reduction services".¹⁰⁹ In other words, it was the focus on drug use as a public health issue rather than a criminal justice issue that gave impetus to significant investment in treatment and other harm minimisation measures.

Comparing Drug-Use in Portugal with other European Countries

The final contention Hughes and Stevens responded to was drug use in Portugal in comparison to that in other European countries. Again, both reports relied on different sets of data with the pro-reform report focused on the prevalence of drug use whilst the contra report focused on the prevalence of problematic drug-use. Hughes and Stevens analysis found that rather than comparing Portugal with the rest of Europe, both reports should have instead focused on Spain and Italy, two countries with similar geography and drug situations. When this was done the data demonstrated that in relation to drug use there were similar increases in all three nations for lifetime and recent drug use for cannabis and cocaine; for school children lifetime prevalence increased in all three countries between 1999 to 2003 before dropping in 2007, and, significantly, that Portugal was the only nation to exhibit declines in problematic drug use. Finally, with regard to drug-related deaths, Hughes and Stevens reported that "post-reform Portugal is performing — longitudinally — similarly or slightly better than most European countries".¹¹⁰

In summary, Hughes and Stevens attribute much of the confusion generated by the two diametrically opposed views to the selective use of evidence by the authors meaning that different datasets were utilised in reaching their respective conclusions.¹¹¹

¹⁰⁵ Ibid.

¹⁰⁶ Ibid 106.

¹⁰⁷ Ibid 107.

¹⁰⁸ Ibid 108.

¹⁰⁹ Ibid.

¹¹⁰ Ibid 109.

¹¹¹ Ibid.

Utilising more scientifically valid research methods, Hughes and Stevens found that overall there had been minimal change in drug use between 2001–07, but importantly, that drug use had decreased amongst the population most at risk of long-term use; the increase in harm reduction services and reduction of social stigma had facilitated access to services that had in turn decreased drug-related deaths; and finally, that a comparison with comparable countries in the region demonstrated that Portugal was the only nation to exhibit declines in problematic drug use. All of this led Hughes and Stevens to conclude that:¹¹²

Considered analysis of the two most divergent accounts reveals that the Portuguese reform warrants neither the praise nor the condemnation of being a ‘resounding success’ or a ‘disastrous failure’, and that these divergent policy conclusions were derived from selective use of the evidence base that belie the nuanced, albeit largely positive, implications from this reform.

5.3.2 What conclusions can Tasmania draw from the Portuguese model?

Portugal’s reorientation of personal drug use as requiring a public health rather than law enforcement response provides some guidance as to the likely impact in Tasmania. In an attempt to measure the cost of Tasmania’s current law enforcement approach as well as the costs of moving to a Portuguese model, we commissioned Dr Paul Blacklow, an economist at the University of Tasmania to prepare a report estimating the cost of illicit drug use in Tasmania, the effects of Portugal’s decriminalisation model and the cost of illicit drug use including improved rehabilitation services in Tasmania under decriminalisation.

Blacklow’s report, which is attached as Appendix A, estimates that the current crime and justice related costs including the arrest and sentencing of offenders as well as the impact on victims was \$130.13 million in 2015–16. The report also analyses the cost of death and disease caused by illicit drug use including Hepatitis B and Hepatitis C, liver disease and HIV/AIDS. Blacklow estimates the current cost of death and disease caused by illicit drug use to be \$127.48 million. Finally, the report analyses the health and road accident costs estimating the cost at \$39.14 million and \$4.98 million respectively. In summary, Blacklow’s report finds that the total cost of illicit drug use in Tasmania in 2015–16 was \$301.73 million.

Significantly, Blacklow’s analysis finds that if Tasmania were to adopt the Portuguese model and its public health focus, the total cost of illicit drug use in Tasmania under decriminalisation would be \$273.6 million, a financial saving of \$28.13 million. Whilst cost savings are a worthwhile policy objective, more significant is the reduction in drug-related death and disease, the reduction in drug-related ambulance call-outs, emergency admissions and hospitalisations and the reduction in crimes involving the use or threat of violence such as murder, physical or sexual assaults and armed robberies.

¹¹² Ibid 111.

Summary

In summary, this paper has set out to prove that Australia's drug strategy has failed. We have demonstrated that despite more than \$1 billion being spent each year on law enforcement and other supply control measures, the strategy has not worked with the price of illicit drugs having decreased and consumers repeatedly noting that access to illicit drugs is relatively easy. At the same time the Australian Government continues to publish data observing ever increasing numbers of seizures, weight of drugs confiscated and number of arrests.

Portugal's reorientation of drug use as a public health issue is a policy reform that should be introduced in Tasmania. If the Portuguese experience provides any guidance, it is that decriminalisation and the prioritisation of personal drug use as an issue of public health will reduce crime and problematic drug use whilst saving lives and millions of dollars in failed law-enforcement strategies.

Appendix A:

Illicit Drug Reform in Tasmania A Cost Benefit Analysis

Dr Paul Blacklow

**TASMANIAN SCHOOL OF
BUSINESS & ECONOMICS**



**UNIVERSITY *of*
TASMANIA**

Illicit Drug Reform in Tasmania A Cost Benefit Analysis

A report submitted by:

**Tasmanian School Of Business and Economics (TSBE)
University of Tasmania (UTAS)
ABN 30 764 374 782
Dr Paul Blacklow**

For:

**Ben Bartl
Policy Officer
Community Legal Centres Tasmania
ABN 94 997 472 863
Ben_Bartl@clc.net.au**

DISCLAIMER

The identification of risk factors and their estimated contribution to default rates are statistical estimation based on the sample data provided by the client. The risk factor estimation is thus subject to the assumptions of the statistical model, sampling variability and the quality of the data. The University of Tasmania recommends that readers read the methodology section and note the assumptions and exercise their own skill and care with respect to their use.

While all due care has been taken by the staff in compiling this report the University of Tasmania is not responsible or liable for any losses arising from the use of or reliance on this information. The University of Tasmania does not represent, warrant, undertake or guarantee that the information in the report is correct, accurate, complete or non-misleading; that the use of guidance in the report will lead to any particular outcome or result; or in particular, that by using the guidance in the report you will necessarily reduce default rates.

EXECUTIVE SUMMARY

⇒ This report estimates that the:

- Total Cost of Illicit Drug Use in Tasmania in 2015-16 **under the current law is \$301.7 million.**
- Total Cost of Illicit Drug Use in Tasmania in 2015-16 **under decriminalisation is 273.6 million.**
- Decriminalisation of Illicit Drug Use in Tasmania in 2015-16 would save **\$28.0 million or 10.3%** of the 2015-16 cost.

CONTENTS

Executive Summary	1
Contents.....	2
Tables	3
The Proposal	4
1 Introduction	5
1.1 Illicit Drugs.....	5
1.2 Illicit Drug Use in Australia compared to the World	6
1.3 Illicit Drug Use in Australia.....	7
1.4 Illicit Drug Use in Tasmania.....	8
2 Methodology	10
2.1 Neoclassical Economics, Market failures and Cost Benefit Analysis.....	10
2.1.1 Private versus Social Benefits and Costs	10
2.1.2 Private and Social Cost Benefit Analysis	11
2.1.3 Cost and Benefits Excluded in this Study	11
2.1.4 Tangible Costs and Intangible Costs	11
2.2 Loss of Life	12
2.3 Inflating Estimates for 2015-16.....	14
2.4 Cost Components of Illicit Drug Use	14
2.4.1 (C) Crime.....	14
2.4.2 (D) Death and Disease	18
2.4.3 (H) Health	20
2.4.4 (R) Road Accidents	23
2.5 Effects of Illicit Drug Decriminalisation on Use and Costs.....	24
2.5.1 Illicit Drugs Use under Decriminalisation	24
2.5.2 (C) Drug Related Crime under Decriminalisation	26
2.5.3 (D) Drug Related Deaths and Disease under Decriminalisation.....	27
2.5.4 (H) Drug Related Health Costs under Decriminalisation	27
2.5.5 (R) Drug Related Road Accidents under Decriminalisation.....	28
3 Results.....	29
3.1 (C) Crime Costs of Illicit Drugs in Tasmania 2015-16	29
3.2 (D) Death and Disease Costs of Illicit Drugs in Tasmania 2015-16.....	30
3.3 (H) Health Costs of Illicit Drugs in Tasmania 2015-16.....	31
3.4 (R) Road Accidents Costs of Illicit Drugs in Tasmania 2015-16	31
3.5 Total Costs of Illicit Drugs in Tasmania 2015-16.....	32
4 Conclusion.....	33
5 References	35

TABLES

Table 1 Australia's and other Comparable Countries Illicit Drug Use in 2011	6
Table 2 Illicit Drug Use in the Previous Year by State/Territory and Australia 2013.....	9
Table 3 Social Proportion of Loss of Life Costs by Disease.....	13
Table 4 Growth in Broad Expenditure CPI Components Hobart 2011 to 2015-16	14
Table 5 Self-reported Substance Attributable Charges from DUMA 2009	15
Table 6 Proportion of Crime due to Illicit Drug Use	16
Table 7 Crime Cost Components of Illicit Drug Use	16
Table 8 Victim Costs of Crime 2015-16 and Under-Reporting Multipliers	17
Table 9 Deaths and DALYS due to Illicit Drug Use in Australia 2011.	19
Table 10 Deaths and DALYS due to Illicit Drug Use in Tasmania 2011	20
Table 11 Health Cost Components of Illicit Drug Use.....	21
Table 12 Total Crashes and those caused by Illicit Drugs by Severity Tasmania 2015-16	23
Table 13 Drug Use in Portugal aged 15–64, by Drug Type, 2001 and 2007	25
Table 14 Victims of Crime per 100,000 Drug Users Prior to and After Decriminalisation	27
Table 15 Crime Costs of Illicit Drugs in Tasmania - Current and Decriminalisation.....	29
Table 16 Death/Disease Costs of Illicit Drugs in Tasmania - Current and Decriminalisation	30
Table 17 Health Costs of Illicit Drugs in Tasmania - Current and Decriminalisation	31
Table 18 Road Costs of Illicit Drugs in Tasmania - Current and Decriminalisation	31
Table 19 Total Costs of Illicit Drugs in Tasmania - Current and Decriminalisation	32

THE PROPOSAL

The investigators will provide a brief report to the client outlining the methodology used and estimates of the:

- A. cost of illicit drug use Tasmania in 2015-16;
- B. the effects of decriminalisation on illicit drug use; and
- C. the cost of illicit drug use Tasmania in 2015-16 under decriminalisation.

Deliverables

A brief report providing the methodology and estimates of the costs of illicit drug use in Tasmania in 2015-16, the effects of decriminalisation and the cost of illicit drug use Tasmania in 2015-16 under decriminalisation.

1 INTRODUCTION

This project will estimate the costs of illicit drug use in Tasmania in 2015-16, the effects of decriminalisation and what that cost would be if the use of illicit drugs was decriminalised. In the following section 1.1, it briefly outlines what are considered illicit drug in Australia and Tasmania. In section 1.2, illicit drug use in Australia compared to the rest of the world is examined. Sections 1.3 and 1.4 examine recent illicit drug use in Australia and Tasmania. Chapter 2 provides the data sources and explains the methodology and assumptions used to construct the estimate of the cost of illicit drug use in Tasmania in 2015-16. In particular, in section 2.1 it outlines the approach of neoclassical economics to cost-benefit analysis and the approach used in this limited study. Section 2.2 discusses methods used in the past and in this study to value the loss of life. In section 2.4 the data sources for each of the four cost categories considered in this study: Crime, Death and Disease, Health and Road Accidents are given. The effects of decriminalisation upon the incidence of the various cost components are discussed in section 2.5 and the assumptions made listed. The estimates of the cost of illicit drug use in Tasmania under the current law in 2015-16 and under decriminalisation are presented in chapter 3. The costs under the current law and decriminalisation are presented for each cost component Crime in section 3.1, Death and Disease in section 3.2, Health in section 3.3, Road Accidents in section 3.4 and summarised in Section 3.5. Section 4 concludes the report.

1.1 Illicit Drugs

Illicit drugs are drugs whose use is prohibited by law or the illegal or inappropriate use of pharmaceutical drugs and other substances. In Australia and Tasmania illegal drugs include cannabis, ecstasy, meth/amphetamine, illegal opiates, cocaine, heroin, ketamine and GHB (gamma-hydroxybutyrate) and synthetic cannabinoids. The most commonly used pharmaceutical drugs for non-medical reasons are opiates, benzodiazepines and steroids. Other substances used inappropriately include inhaling petrol, glue and other fumes and the consumption of certain plants or animals. Sometimes the term illicit drugs, is used to refer to only illegal drugs excluding the misuse of pharmaceutical drugs and other substances.

While this study focuses on illegal drugs, it includes the misuse of pharmaceutical drugs and other substances, since many statistics are only available for this broader definition. The misuse of pharmaceutical drugs and other substances is relatively low compared to the use of illegal drugs.

1.2 Illicit Drug Use in Australia compared to the World

According to United Nations Office on Drugs and Crime (UNODC), illicit drug use in Australia, together with the Czech Republic, New Zealand, Canada, Italy, US and Scotland appears to be the highest amongst OECD countries¹. Australia's use of illicit drugs is double the average of Western Europe.

Table 1 Australia's and other Comparable Countries Illicit Drug Use in 2011

Selected Countries	% of the population aged 15-64 who have used in the last 12 months				
	Cannabis	Ecstasy	Amphetamine	Cocaine	Opiates
Australia	10.6	4.2	2.7	1.9	0.4
Austria	3.5	0.5	0.5	0.9	0.4
Belgium	5.0	1.1	0.9	1.2	n.a.
Canada	13.6	1.7	1.5	1.9	0.5
Czech Republic	15.2	3.6	1.7	0.7	0.4
Denmark	5.5	0.4	1.2	1.4	0.6
England and Wales	7.9	1.8	1.1	3.0	0.8
France	8.6	0.5	0.2	0.6	0.5
Germany	4.7	0.4	0.5	0.7	0.2
New Zealand	14.6	2.6	2.1	0.6	1.1
Northern Ireland	7.2	1.8	1.0	1.9	0.1
Portugal	3.6	0.4	0.2	0.6	0.5
Republic of Ireland	6.3	1.2	0.4	1.7	0.5
Scotland	8.4	2.5	1.4	3.9	1.5
United States	12.5	1.0	1.3	2.6	0.6

Source: United Nations Office on Drugs and Crime (UNODC), <https://data.unodc.org>, Drug Indicators, Annual Prevalence by region

Notes: The data relate to different years, and comparisons should be treated with caution. For more details on the methods and sources, readers are referred to World drug report 2010 (UNODC 2010).

In particular, Australia's use of ecstasy and meth/amphetamine appears to be the highest in the world. Australia's use of meth/amphetamine appears to be the highest in the world at 2.1% of the population and quintuple the usage rate for Europe and 1/3 higher than North America. Australia's use of ecstasy appears to be the highest in the world at 3.0% and is quintuple the usage rate in Europe and quadruple that of North America. It is important to be cautious when

¹ United Nations Office on Drugs and Crime (UNODC), <https://data.unodc.org>, Drug Indicators, Annual Prevalence by region.

making such comparisons because of differences in methodology in the household surveys used to generate these figures.

1.3 Illicit Drug Use in Australia

The Australian Institute of Health and Welfare (AIHW) conducts the National Drug Strategy Household Survey (NDSHS) every three years. The 2013 survey was the 11th and the latest for which results are available, with results from the 2016 NDSHS to be released in mid-late 2017. The AIHW reports from the surveys that 60% of people aged 14 years or older had never tried an illicit drug and that this figure has been stable for the last decade. The proportion aged 14 years and older who had used an illicit drug in the last 12 months in 2013 was 15% or 2.9 million people. The most common drug used both recently and over their lifetime was cannabis, used by 10.2% and 35% respectively of people aged 14 and over. The NDSHS found many illicit drug users also used more than one illicit drug, most commonly with cannabis. Of all illicit drugs, community tolerance has increased for cannabis use, while people in Australia still consider heroin to be the drug most associated with a drug problem.

The proportion of Australians using illicit drugs has been rising since 2007, when the NDSHS estimated that 13.4% used an illicit drug in the previous year and in 2010 it estimated the proportion was 14.7%. The significant rise from 2007 to 2010 was largely attributed to an increase in the use of cannabis, cocaine, pharmaceuticals and hallucinogens and a decline in the use of ecstasy as result of its reduced supply over the period.

While the proportion of Australian recently using illicit drugs rose only marginally from 2010 to 2013, there was a significant change in the use of a number of specific drugs. The proportion who had misused pharmaceuticals continued to rise to 4.7% in 2013, while the use of ecstasy and heroin declined. While there was no rise in meth/amphetamine use in 2013, there was a change in the main form of meth/amphetamines used. Among meth/amphetamine users, use of powder fell from 51% in 2010 to 29% in 2013 while the use of ice (also known as crystal) more than doubled, from 22% to 50% over the same period.

From the 2013 NDSHS the AIHW reports that Australians aged 20–29 were most likely (27% of that age bracket) to have used an illicit drug in the previous year. While Australians aged 50 and over generally have the lowest rates of illicit drug use, in recent years they have shown the largest rise in illicit use of drugs largely due to cannabis use. Amongst those aged 14–24, the age of initiation into illicit drug use rose from 16.0% in 2010 to 16.3% in 2013.

From the 2013 NDSHS the AIHW also finds that cannabis and meth/amphetamine users were more likely to use these drugs at least every few months (64% and 52% respectively), while ecstasy and cocaine use was more likely to be infrequent, with many users only using the drug once or twice a year (54% and 71% respectively). More frequent use of the drug was reported among meth/amphetamine users in 2013 with an increase in daily or weekly use (from 9.3% in 2010 to 15.5%). Among ice users there was a doubling from 12.4% in 2010 to 25% in 2013.

1.4 Illicit Drug Use in Tasmania

The 2013 National Drug Strategy Household Survey collected information from almost 24,000 people across Australia on their tobacco, alcohol and illicit drug use, attitudes and opinions.

Table 2 below, reports recent use of alcohol and illicit drugs by State and Territory from Table 12A.67 from the AIHW (2014)'s National Drug Strategy Household Survey results for 2013. The table shows that the use of illicit drugs is higher in Tasmania is approximately 10% higher than Australia as a whole and one of the highest usage rates in the nation, comparable to Western Australia. In particular, Table 2 shows that Tasmanians recent use of cannabis and ecstasy is about 20% higher than for Australia and the highest in the nation other than the Northern Territory. While standard errors are high, Table 2 also suggests that Tasmanians use of amphetamine is almost 50% higher than the Australian average and use of ketamine and inhalants is twice as high. The use of cocaine is much lower in Tasmania being 40% below the average and the use of heroin is also much lower than the national average.

Table 2 Illicit Drug Use in the Previous Year by State/Territory and Australia 2013

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Cannabis	9.5	9.1	11.1	11.3	11.0	11.8	10.1	17.1	10.2
Ecstasy	2.4	2.4	2.4	2.6	2.8	*2.9	2.9	3.7	2.5
Meth/amphetamines	1.4	1.9	2.3	3.8	2.2	*3.0	2.2	*2.8	2.1
Cocaine	2.7	2.0	2.0	1.6	*1.2	**1.2	2.8	*2.4	2.1
Hallucinogens	1.0	1.3	1.2	1.9	*1.6	*1.1	*1.7	*1.8	1.3
Inhalants	0.8	0.9	0.8	*0.5	*0.4	*1.7	*1.1	*0.8	0.8
Heroin	*<0.1	*0.1	**<0.1	*0.3	**<0.1	–	**0.3	**<0.1	0.1
Ketamine	*0.3	*0.3	**0.2	–	**0.3	*0.8	**0.2	**0.4	0.3
GHB	*<0.1	**<0.1	**<0.1	**0.1	–	**0.7	–	**<0.1	*<0.1
Synthetic Cannabinoids	1.0	1.0	1.5	*2.5	*0.9	*0.9	*0.8	2.8	1.2
New and Emerging Psychoactive Substances	*0.2	*0.5	*0.5	*0.5	*0.4	**1.1	**0.5	*0.6	0.4
Injected drugs	*0.3	*0.2	*0.3	*0.6	*0.3	*0.9	**0.2	*0.3	0.3
Any illicit Drug	11.4	11.0	12.6	13.7	12.5	13.3	12.4	19.0	12.0
<i>Misuse of Pharmaceuticals</i>	4.4	4.8	4.8	5.6	4.7	4.3	4.2	5.2	4.7
Any Illicit drug use or Pharmaceuticals Misuse	14.2	14.3	15.5	17.0	15.7	15.1	15.3	22.0	15.0

Notes Estimates that have relative standard errors greater than 50 per cent are marked with ** and those with RSEs of between 25 per cent and 50 per cent are marked with * and should be considered with caution

Source: AIHW (2014) National Drug Strategy Household Survey detailed report 2013, Drug statistics series no. 28, Cat. No. PHE 183, Canberra, Table 12A.67.

2 METHODOLOGY

This chapter provides the data sources and explains the methodology and assumptions used to construct the estimate of the cost of illicit drug use in Tasmania under the current law in 2015-16 and after decriminalisation. In particular, section 2.1 outlines the approach of neoclassical economics to cost-benefit analysis and the approach used in this limited study. Section 2.2 discusses methods used in the past and in this study to value the loss of life. In section 2.4 the data sources for each of the four cost categories considered in this study: Crime, Death and Disease, Health and Road Accidents are given. The effects of decriminalisation upon the incidence of the various cost components are discussed in section 2.5 and the assumptions made listed.

2.1 Neoclassical Economics, Market failures and Cost Benefit Analysis

In the standard neoclassical economic model, rational choice reveals preference. If an individual purchases a product, s/he must judge the benefits of that action as exceeding its costs as highlighted by Crampton, Burgess and Taylor (2011). They could find themselves to have erred after the purchase, but their choice was rational prior to the purchase and consumption. The First Theorem of Welfare Economics states that in perfect markets the interaction of optimising individuals in markets is Pareto Efficient. That is, no individual can be made better off without negatively affecting another. Of course markets are not perfect in that they do not meet all the assumptions neoclassical economic model. The neoclassical economic model requires rationality of consumers, no externalities, perfect information, no excessive market power and perfect mobility of capital and labour. Economists define “market failures” as violations of these assumptions and see the role of public policy as being to correct these “market failures”.

2.1.1 Private versus Social Benefits and Costs

Private or internal costs are those costs that principal agents bear themselves of any action. Private or internal benefits are those benefits that accrue to the economic agent of any action. Private individuals or firms take action when the private benefits exceed the costs.

Social or external costs are those costs that are borne by agents external to the principal agent(s) in the action. They are commonly called “externalities”. Social or external benefits are those benefits that accrue to external to the principal agent(s) in the action. They are sometimes called “positive externalities”.

2.1.2 Private and Social Cost Benefit Analysis

Private Cost Benefit Analysis is an evaluation of the benefits and costs accruing to the private agent considering the action. Typically, since the stream of benefits and costs may be in the future, their sums are discounted to the present value using a discount rate. The discount rate is the private agent's next best alternate rate of return or opportunity cost.

A Social Cost Benefit Analysis, in addition to the above, considers the social benefits and costs resulting from the action. In the case of policy reform, governments and public organisations wishing to maximise social welfare should consider the change in social costs and benefits and also the change in benefits and costs to all members in society.

2.1.3 Cost and Benefits Excluded in this Study

Due to the scope of this report and for the sake of simplicity this report ignores the private benefits and cost to members in society of their own drug use. Since individuals will only take actions if the benefits to them outweigh the costs, the net benefit of their own drug use must be positive (to them). Thus, prior to any policy change it is easy to assume that there are no net private costs of drug use. After any policy change individuals may adjust their drug use behaviour but again the net benefit of their own drug use must be positive (to them) or else they would not do it. Of course the size and distribution of the net benefits may change and would normally be considered if not beyond the scope of this study. Given that decriminalisation is likely to increase drug use, the net benefit to drug users and suppliers is likely to rise.

In addition, this study assumes that there are no social benefits of illicit drug use, nor any change after decriminalisation. To some extent this study ignores the benefits of the potential increase in information and decrease in risk drug users are exposed about drug purity and safety. It also ignores the benefit in a potentially improved relationship between police and the public, particularly youth. Essentially this project estimates only the social costs of illicit drug use.

2.1.4 Tangible Costs and Intangible Costs

Tangible benefits and costs are those that are exchanged in markets. Intangible benefits and costs are those not usually exchanged in markets, such as fear, pain, suffering, and lost quality of life. Suppose a consumer purchases an apple for \$2. The \$2 they pay is a tangible cost. The consumer surplus of \$2+ derived from the utility of consuming the apple is the intangible benefit. If the apple gives the consumer a stomach ache this is an intangible cost. If the consumer paid for treatment of the pain then some of this intangible cost would become tangible.

2.2 Loss of Life

The use of illicit drugs can cause premature loss of life directly through overdoses, or indirectly via drug related diseases, suicides, homicides and road accidents. Premature deaths impose an intangible cost on the person who died (the lost value of their remaining life) and their friends and relatives (the lost value of their relationship and mental suffering). It also imposes tangible costs in the form of the lost output to the economy of their remaining life and also medical/coronial costs. These tangible costs for illicit drug related deaths are all external or social costs, since they are not implicitly or explicitly paid for by the drug user. Whether the intangible costs of premature deaths for illicit drug related deaths are social or private depends upon whether the person dying (and their friends and relatives) had a choice over their exposure to the risk of death.

People killed by homicide (and their friends and relatives) have little control over their risk of death in most cases and it can safely be assumed that all the intangible cost of a loss of life in this case is a social cost and should be included in cost benefit analysis (CBA). People who suicide have a large amount of control over their risk of death in many cases. It can safely be assumed that none of the intangible cost of a loss of life for the person is a social cost and should not be included in CBA. While friends and relatives may have some capacity to influence the chance of suicide, many may not know of the extent of the problem. For this reason this study assumes 25% of the loss of life from suicides for friends and relatives is a social cost to be included in CBA.

People who overdose choose to expose themselves to the risk of overdose, given that the dangers of drug use are well known. It can safely be assumed that none of the intangible cost of a loss of life for the person is a social cost and should not be included in CBA. While friends and relatives may have some capacity to influence the chance of suicide, many may not know of the extent of the problem. For this reason this study assumes 50% of the loss of life from drug overdoses for friends and relatives is a social cost to be included in CBA.

People killed by road accidents (and their friends and relatives) by drug affected drivers have little control over their risk of death in most cases and it can safely be assumed that all the intangible cost of a loss of life in this case is a social cost and should be included in CBA. Drug affected drivers who are killed in road accidents choose to expose themselves to the risk of driving under the influence of drugs which are well known. It can safely be assumed that none of the intangible cost of a loss of life for a drug affected driver death is a social cost and should not be included in CBA. Similar to drug overdoses, family and friends may have had some

capacity to influence drug driving behaviour so this study assumes 25% of the loss of life from drug affected driver death for friends and relatives is a social cost to be included in CBA.

This study uses \$500,000 as the value of the pain and suffering to friends and relatives of a premature death in 2015-16. This value is based on the recoverability of “common law damages”, in respect of fault-based motor accident injuries from the Motor Accidents Compensation Act 1999 (NSW) of a ceiling on the maximum damages for non-economic loss currently fixed at \$432,000.

This study uses \$500,000 as the value of the lost value of their remaining life of a premature death. This value is derived from BITRE’s (2010) cost estimate of \$454,600 per car accident death for 2006. Their estimate is based on the statutory value placed on total disability for a non-fatal road crash casualty of \$387,900 per fatality, adjusted for the age of casualties. BITRE (2010) attribute only \$57,421 to be the mental to cost friends and relatives cost, resulting in in an estimate of just under \$400,000 for the value to an individual of their remaining life.

BITRE (2010) also estimate the loss of life (including lost production) and using the WTP method at \$6.19 million, and the HC method at \$2.4 million with a 3% discount rate. They use a hybrid estimate of \$3.5 million based on the Office of Best Practice Regulation (2008) suggestion that a credible estimate of the value of a life based on international and Australian research. Using this figure of \$3.5 million and inflating it to 2015-16 using a 1.5% growth rate in real GDP and income results in approximately \$4.0 million for social cost of premature deaths, subtracting the estimate for the loss to friends and family of \$500,000 and the personal cost of death of \$500,000 results in an estimate of \$3.0 million in lost output per death.

Table 3 Social Proportion of Loss of Life Costs by Disease

	Coroner’s Cost Per Death	Loss of Life to Individual	Loss of Life to Others	Lost Production
Drug use disorders (excluding alcohol)	100%	0%	50%	100%
Chronic liver disease	100%	50%	75%	100%
Liver cancer	100%	50%	75%	100%
Suicide and self-inflicted injuries	100%	0%	50%	100%
HIV/AIDS	100%	50%	75%	100%
Hepatitis B (acute)	100%	50%	75%	100%
Hepatitis C (acute)	100%	50%	75%	100%
Homicides	100%	100%	100%	100%
Road Accidents	100%	100%	100%	100%

2.3 Inflating Estimates for 2015-16

Many of the estimates of the costs of illicit drug use in this study are derived from figures from earlier years. The prices of the crime, health and justice services have been rising at almost 5% per year, well above CPI inflation. Any earlier cost figures are inflated by 5% compounding per annum per year that they are prior to 2015-16.

Table 4 Growth in Broad Expenditure CPI Components Hobart 2011 to 2015-16

Broad Expenditure Group	Annual Growth	2011 to 2015-16 Growth
All Groups	1.8%	9.3%
Health	4.9%	27.0%
Transport	0.8%	4.1%
Housing	2.1%	11.0%

Source: ABS 6401.0 Consumer Price Index, Australia, June 2016.

2.4 Cost Components of Illicit Drug Use

Estimates of the social costs of illicit drug in this study can be broken up into four categories.

1. Crime (C)
2. Deaths and Disease (D)
3. Health (H)
4. Road Accidents (R)

2.4.1 (C) Crime

The costs of crime are the most obvious external or social cost of illicit drug use. Since criminals even when caught often do not suffer the full cost of their crime they have imposed on others. Even a fraction of the full cost of courts, policing and to victims are rarely paid for by the perpetrator. Criminals bear some of the costs of imprisonment though the depravity of liberty and normal living conditions, but many do not internalise these into their decisions to commit crimes. This is particularly so for those crimes committed under the influence of drugs or to support drug habits. For these reasons this study assumes all crime and justice costs are social costs. Typically, the largest intangible component of the crime costs of illicit drug use, are the costs to victims. While the largest tangible components are police, court and prison costs.

Payne and Gaffney (2012) report data collected by the AIC's DUMA program which surveys the self-reported alcohol and drug attributions of 1,884 police detainees across Australia. It is possible that detainees over reported that alcohol and/or illicit drugs had contributed to their

crime, to absolve themselves of the moral guilt of the crime. Table 5 contains the self-reported attributable charges from Payne and Gaffney (2012)

Table 5 Self-reported Substance Attributable Charges from DUMA 2009

	Alcohol	Illegal drugs	Combined
Violent	33.6	12.4	41.7
Property	21.3	36.7	52.1
Drug	11.9	50.4	58.4
Drink driving	73.6	6.4	76
Traffic	31.7	13.1	41.8
Disorder	41.8	24.3	59.8
Breaches	29.4	17.1	43
Other	31.5	15.9	45.1
Total	29.3	22.8	48
Adjusted total	29	27.1	52.4

Source: Payne and Gaffney (2012) , Table 3: Number and proportion of substance-attributable charges, Q3/4 2009 (all sites)

Table 6 contains the proportion of each crime-by-crime type due to illicit drug use applied in this study to the number of crimes when calculating the victim and police costs of drug related crime.

Table 6 Proportion of Crime due to Illicit Drug Use

Crime	Proportion of Crime due to Illicit Drug Use %
Homicide	15
Physical assault	15
Threatened assault	15
Sexual assault	15
Dangerous Or Negligent Acts Endangering Persons	15
Kidnapping/abduction	15
Armed robbery	15
Involving the taking of property	40
Attempted break-in	40
Other theft	25
Motor vehicle theft	40
Theft from motor vehicle	40
Fraud, Deception And Related Offences	5
Illicit Drug Offences	100
Prohibited And Regulated Weapons And Explosives Offences	25
Property Damage And Environmental Pollution	25
Public Order Offences	25
Traffic And Vehicle Regulatory Offences	5
Offences Against Justice Procedures, Government Security And Government Operations	25
Miscellaneous Offences	15
Breaches of bail, suspended sentences, community service orders, probation	15

Table 7 below provides a breakdown of Crime and Justice related cost components of illicit drug use.

Table 7 Crime Cost Components of Illicit Drug Use

C1	Victim
C2	Police
C3	Court
C4	Prison
C5	Community Corrections

C1 Victim

The number of victims of crimes for Tasmania in 2015 by the type of crime was obtained from ABS (2016) 4510.0 Recorded Crime - Victims, Australia, 2016, Table 6. These were inflated by multipliers by crime type for the under reporting of crime, from Smith et al. (2014) Table 2 and the ABS (2017b) Crime Victimization, Australia, 2015-16, Table 2. See Table 8 below for more details.

The cost to victims of each type of crime was obtained from Smith et al. (2014) Australian Institute of Criminology's "Counting the costs of crime in Australia: A 2011 estimate". The costs per crime for 2011 were inflated to 2015-16 using the growth in the most appropriate broad expenditure good Hobart CPI component over that period. The exception being the intangible loss of life costs for homicide which the figures in section 2.2 are used. See Table 8 below for more details.

Table 8 Victim Costs of Crime 2015-16 and Under-Reporting Multipliers

Crime Type	Tangible Cost Per Incident 2015-16	Intangible Cost Per Incident 2015-16	Total Cost Per Incident 2015-16	Multipliers for under reporting
Homicide	\$13,140	\$3,500,000	\$3,513,140	1
Physical assault	\$2,365	\$1,042	\$3,407	2
Threatened assault	\$0	\$572	\$572	3
Sexual assault	\$2,992	\$3,252	\$6,245	5
Dangerous Or Negligent Acts Endangering Persons	\$2,365	\$1,042	\$3,407	3
Kidnapping/abduction	\$5,059	\$1,599	\$6,658	1
Armed robbery	\$5,059	\$1,599	\$6,658	1.2
Unarmed robbery	\$2,365	\$1,042	\$3,407	6
Blackmail/extortion	\$0	\$572	\$572	3
Involving the taking of property	\$2,327	\$1,156	\$3,483	3
Attempted break-in	\$343	\$771	\$1,115	3
Other theft	\$573	\$255	\$827	3
Motor vehicle theft	\$4,315	\$2,385	\$6,700	1.2
Theft from motor vehicle	\$1,132	\$837	\$1,969	2.3
Property Damage And Environmental Pollution	\$683	\$1,394	\$2,077	3

Source: AIC (2014) Counting the Cost of Crime various Tables, ABS 6401.0 and derived by the author.

C2 Police

The number of crimes by the type of crime was obtained from ABS (2016) 4519.0 - Recorded Crime - Offenders, 2015-16, Table 6. The Police cost per crime were derived by dividing the total recurrent expenditure for Tasmanian from ROGS Ch6, Table 6A.6 of \$222.9m by the total number of crimes committed, to give a police cost per crime in Tasmanian in 2015-16 of \$20,503.04.

C3 Court

The number of court lodgements by type of crime was obtained from the annual reports of the Tasmanian Supreme Court and the Tasmanian Magistrates Court. The average of Supreme Court criminal lodgements by crime in 2014-15 and 2015-16 was used for this report since the figures vary from year to year. In total, this gave 472 Supreme Court and 21,811 Tasmanian Magistrates lodgements. The court cost per criminal lodgement in the Tasmanian Supreme Court and the Tasmanian Magistrates Court was obtained from ROGS Ch7, Table 7A.31 as \$16,648.93 and \$490.98.

C4 Prison

The number of prisoners by crime was obtained from ABS (2016) 4517.0 - Prisoners in Australia, 2016, Table 15. In total, there were 569 prisoners in Tasmania in 2015-16. The number of persons in community correction by crime was obtained from ABS (2017a) 4512.0 Corrective Services, Australia, 2016, Table 1. In total, there were 1842 persons in community correction in Tasmania in 2015-16. Prisoner and Community Correction costs were obtained from ROGS Ch8, Table 8A1, 8A.4 and 8A.8 for Tasmania in 2015-16 of \$138,045 per prisoner and \$4,831 per person in community correction.

2.4.2 (D) Death and Disease

Stafford and Breen (2015) and Roxburgh and Burns (2015). report from the Illicit Drug Reporting System (IDRS) that there were 7 accidental deaths due to opiate use in Tasmania in 2011. For Australia it reports 101 accidental deaths due to methamphetamines and 12 due to cocaine. Apportioning these using Tasmania's share of population provides an estimate of 2 deaths due to methamphetamine use in Tasmania in 2011 and a total of 9 for illicit drug use.

There were 9 Tasmanian coronial data records that explicitly mention drug overdose as the cause of death over 2015-17 and an additional 34 as drug and alcohol related. Assuming a quarter of the latter are due to illicit drug use, this gives a figure of 15 death over the two year period or 7.5 per year.

ABS 3303.0 Causes of Death, Tasmania, 2015, Table 7.2 reports that 18 *Accidental poisoning by and exposure to noxious substances* (X40-X49) with 12 being specifically related to illicit drug use (X41 and X42). It also reports 11 deaths due to *Mental and behavioural disorders due to psychoactive substance use* (F10-F19) with 9 being due to alcohol. This study assumes that there 12 accidental deaths due to drug overdoses in Tasmania in 2015-16.

AIHW (2012) Australian Burden of Disease Study 2011 Table S13.1 reports 542,554 DALY due to *Mental & substance use disorders* of which 31,951 were due to *Drug use disorders (excluding alcohol)* and 15,620 *Other mental and substance use disorders*. The sum of these suggests that 8.77% or 865 DALYS of the 9,867 DALYs reported to be from 'Mental & substance use disorders' in Table S10.3 for Tasmania in 2011 were due to illicit drug use. The DALY for Tasmania in 2011 for the other diseases associated with illicit drug use were apportioned using the Australian Illicit Drug DALY Australia 2011 by Disease. The proportion of the disease that the total DALY that illicit drugs is responsible for, is used to determine the proportion of deaths from the ABS that are related to illicit drugs.

Table 9 Deaths and DALYS due to Illicit Drug Use in Australia 2011.

	Population				Illicit Drug Users			
	Deaths	YLL	YLD	DALY	Deaths	YLL	YLD	DALY
Drug use disorders (excluding alcohol)	1,198	3,577	28,375	31,951	140	3,577	28,374	31,951
Chronic liver disease	15,351	45,832	1,772	47,604	922	23,612	913	24,525
Liver cancer	9,736	29,067	309	29,376	598	15,305	163	15,468
Suicide and self-inflicted injuries	37,486	111,920	1,550	113,470	254	6,504	90	6,594
HIV/AIDS	1,125	3,358	1,715	5,073	7	168	86	254
Hepatitis B (acute)	79	236	4	240	4	101	2	103
Hepatitis C (acute)	17	52	7	59	2	43	6	49
Total	64,992	194,041	33,732	227,773	1,926	49,311	29,633	78,944

Source: AIHW (2016) Australian Burden of Disease Study 2011 Tables S6.2, S10.3, S13.1, S13.8 and S13.11 and derived by the author.
Notes: YLL = Years of Life Lost, YLD = Years Living with Disease, DALY = YLL + YLD

Table 10 Deaths and DALYS due to Illicit Drug Use in Tasmania 2011

	Population	Illicit Drug Users			
	Deaths	Deaths	DALY	YLL	YLD
Drug use disorders (excluding alcohol)	12	12	581	65	516
Chronic liver disease	38	20	446	429	17
Liver cancer	42	22	281	278	3
Suicide and self-inflicted injuries	85	5	120	118	2
HIV/AIDS	2	0	5	3	2
Hepatitis B (acute)	2	1	2	2	0
Hepatitis C (acute)	0	-	1	1	0
Total	181	60	1,436	897	539

Source: AIHW (2016) Australian Burden of Disease Study 2011 Tables S6.2, S10.3, S13.1, S13.8 and S13.11 and derived by the author.
Notes: YLL = Years of Life Lost, YLD = Years Living with Disease, DALY = YLL + YLD

The AIHW (2012) Australian Burden of Disease Study found that illicit drug use was responsible for 1.8% of the total burden of disease and injury in 2011. There has been an increase in the burden attributable to drug use, with drug use moving from being the 10th top ranking risk factor for disease and injury in Australia in 2003 to the 9th in 2011. It was responsible for the entire disease burden due to drug use disorders, 83% of the Hepatitis C burden 53% of the liver cancer burden and 52% of the chronic liver disease burden.

2.4.3 (H) Health

Many of the health costs of illicit drug use are also external or social cost of illicit drug use. Illicit drug users typically do not explicitly or implicitly pay for an ambulance call out, emergency admission, hospitalisation or treatment. They pay to some extent, if they pay taxes, but many illicit drug users pay below average amounts of tax, due to lower incomes and non-GST black market purchases. While some may pay implicitly for the mental health consequences of drug use, through mental suffering, many do not consider this in their drug taking behaviour or heavily discount the costs being incurred by them in the future. In addition, it is unclear if this mental suffering from drug use is more or less than the cost to the government and taxpayers of providing. Indeed, it is difficult to estimate the amount of mental suffering drug use causes.

Typically, health cost studies of alcohol and other drugs find the largest component to be from the loss of life. When a life is lost due to illicit drug use society bears two main potential costs. These costs are the tangible loss of productive capacity and the intangible psychological costs

borne by the drug abuse victim and others. How much these costs are borne by society or individuals is the subject of considerable debate in the economic literature. Only the proportion of these costs not internalised or paid for by the drug user are social costs. Table 11 below provides a breakdown of the health related cost components of illicit drug use.

Table 11 Health Cost Components of Illicit Drug Use

H1	Ambulances
H2	Emergencies
H3	Hospitalisations
H4	Treatment
H5	Mental Health

H1 Ambulances

The number and cost of ambulance trips was sourced from ROGS 2017, Ch. 11 Table 11A.3, Table 11A.3 and Table 11A.16. Lloyd et al. (2015) on the Victorian Ambulances services in 2013-14 found that there were 11,618 ambulance calls due to illicit drugs. This represents 1.38% of the 844,227 ambulance calls in Victoria in 2013-14. Given illicit drug use in Tasmania is 20.9% higher than for Victoria the 1.38% proportion was inflated by 20.9% to give the proportion of emergencies due to illicit drug use of 1.66% for Tasmania. ROGS 2017, Ch. 11 Table 11A.3 reports that there were 90,177 ambulance responses in Tasmania in 2015-16 applying 1.66% gives 1,505 illicit drug related ambulance responses. ROGS 2017, Ch. 11 Table 11A.16 reports that total expenditure on ambulance responses in Tasmania in 2015-16 was \$69.25m applying 1.66% gives a cost of \$1.15m. Combined, this results in a cost of \$767.89 per ambulance response in 2015-16.

H2 Emergencies

The proportion of emergency presentations attributable to illicit drug use for Australia in 2013-14 was derived as 0.64% from ROGS 2016, Chapter 11A.66 and 11A.67 Emergency department presentations by Urgency Related Groupings (URG) codes - presentations and average cost per presentation. Given illicit drug use in Tasmania is 10.1% higher than for Australia the 0.64% proportion was inflated by 10.1% to give the proportion of emergencies due to illicit drug use of 0.71% for Tasmania. This figure was applied to the number of emergency presentations for Tasmania, 153,541 was obtained from Australian Institute Health and Welfare hospital statistics, Emergency Department Care 2015-16.

The weighted cost of emergencies due to illicit drug use for Australia in 2013-14 was derived from ROGS 2016, Chapter 11.A66 as \$818.13 40.1% higher compared to the average cost of emergency presentations of \$583.00. Given the average cost of all emergency presentations from Tasmania from Table 11A.66 was \$582.39 this figure was inflated by 40.1% to give the cost of illicit drug related emergency presentations in 2013-14 of \$814.40. Inflated for two years at 5.13% the growth in Hobart Health CPI gives an average cost drug related emergency presentation in Tasmania in 2015-16 of \$900.10.

H3 Hospitalisations

The number of hospitalisations from 'Injuries, poisoning and toxic effects of drugs' and 45% of 'Alcohol/drug use and alcohol/drug induced organic mental disorders' were obtained from Australian Institute Health and Welfare hospital statistics, Admitted patient care 2014-15. In particular Table 5.7: Same-day acute separations and Table 5.10: Overnight acute separations by Major Diagnostic Category AR-DRG version 7.0, public hospitals, States and Territories.

The cost per overnight acute separations was constructed as \$5,929.61 in 2014-15 from the sum of recurrent and capital cost per weighted separation from separations. ROGS Ch12, Table 12A.56, 12A.57. The cost per same-day separations of \$1,259.23 in 2014-15 was sourced from 'Average cost per admitted acute emergency department presentation' ROGS Ch12, Table 12A.58. These figures were inflated by 5.83%, the increase in the Hobart Health CPI over this period to give \$6,254.56 per overnight acute and \$1,328.23 per same-day separation in 2015-16 for Tasmania.

H4 Treatment

The number of treatment episodes for illicit drugs by treatment type in Tasmania in 2014-15 was obtained from the Australian Institute Health and Welfare's Alcohol and other drug treatment service data 2014-15. The proportion of each treatment type that was residential and non-residential was also obtained from that source to derive the number of residential 203 and non-residential treatments 3241 in 2014-15.

The average cost per residential treatment is assumed to be \$20,000 and the average cost per non-residential treatment is assumed to be \$2,500. These figures were based on the Australian National Council on Drugs, ANCD (2012) treatment cost per episode of \$16,110 and the community-based patient costs of \$2,089 per episode in 2011-12.

H5 Mental Health

The proportion of mental health admissions to public hospitals due to other psychoactive substances use for Australia in 2014-15 is reported as 5.48% in ROGS 2017 Chapter 12 Table 12A.22. AIHW (2015) Mental Health Services Table 12A.20 reports 12.7% of total GP mental health encounters that are illicit drug related. This report assumes 5% of the Tasmanian mental health hospital services of 10,573 and 10% of 40,761 Tasmanian MBS Services are due to illicit drug use. This gives 529 mental health hospital services and 4,076 mental health MBS Services due to illicit drug use in Tasmania. The total expenditure on mental health for Tasmania in 2014-15 from ROGS 2017, Chapter 13, Table 13A.3 was \$116m, inflated by 5.48% the growth in the Hobart Health CPI to give an estimate of Tasmanian mental health expenditure of \$122.39m in 2015-16.

2.4.4 (R) Road Accidents

The number of road accidents for Tasmania in 2015-16 was obtained from the Tasmanian Department of State Growth's Tasmanian Crash Statistics. They report 33 road deaths in Tasmania in 2015 and 41 in 2016 and 276.7 serious injuries in 2015 and 280 in 2016. These figures are averaged to provide a figure of 37 road deaths and 278 serious injuries for Tasmania in 2015-16. The Department of State Growth manages the Tasmanian Vehicle Crash database on all vehicle crashes on Tasmanian roads reported by Tasmanian police, or in the case of property damage only, crashes reported by the public. It reports there were 1,576 minor crashes and 4,342 other crashes in 2013. Given that fatal and serious crashes grew 8.1% from 2013 to 2015-16 these figures are inflated to 1,705 minor and 4,697 other crashes in Tasmania in 2015-16.

Table 12 Total Crashes and those caused by Illicit Drugs by Severity Tasmania 2015-16

Severity	Total Crashes	% Drug Attributed	Drug Crashes
Fatal	37	3.3%	1
Serious	278	1.7%	5
Minor	1,705	1.1%	19
Uninjured	4,697	0.4%	18
Total	6,717	0.6%	43

Source: Tasmania Department of State Growth, New South Wales Centre for Road Safety (2017) and derived by the author.

The New South Wales Drug Driving Strategy (1994) attributes psychoactive drugs as a potential factor in around 5% of driver fatalities (compared to 30% for alcohol). A study of driver fatalities in NSW, Victoria and Western Australia by Drummer (1994) found that 36% had used alcohol, 11% had used cannabis (often in combination with alcohol), 3.7% stimulants, 3.1%

benzodiazepines and 2.7% opiates. Drugs-only drivers had a slightly increased risk of being responsible for a crash, compared to the drug-free group but this was not statistically significant.

The New South Wales Centre for Road Safety (2016), Road Traffic Casualty Crashes in New South Wales, December 2015, reports in Table 20a the number of crashes due to alcohol involvement by degree of crash. It reports 13% of fatal crashes, 7% of serious crashes, 4% of minor crashes and 2% of other crashes were due to alcohol. While recent evidence suggests that there are an equal number of fatalities with illicit drugs in their blood as alcohol NIDA (2016). However, many illicit drugs remain in the blood system after the initial effect of the drug have worn off and so the proportion of crashes due to illicit drugs is likely to be much lower than for alcohol which dissipates from the body at a faster rate. This study assumes that crashes due to illicit drug use are 25% the size of those attributable to alcohol and applies the rates for NSW to Tasmania. This results in 0.9% of all crashes being attributable to illicit drug use similar to the rate used by BERL (2009) in their report into the social cost of harmful drug use in New Zealand of 2.3%. Table 12 above shows the total crashes, proportion and the number due to illicit drug use by crash severity that are used in this study for Tasmania in 2015-16. The costs of fatal, serious crashes, minor and other crashes for Tasmania in 2016 were taken from BITRE (2016) Table T7.4.

2.5 Effects of Illicit Drug Decriminalisation on Use and Costs

Decriminalisation is the imposition of an *administrative* penalty rather than a *criminal* sanction for drug use and possession. Decriminalisation models for personal drug use have been introduced in a number of countries including Portugal. In Australia, decriminalisation is in place for minor cannabis use, possession and cultivation offences in South Australia, Western Australia, the Northern Territory and the Australian Capital Territory. The effects of wholesale illicit drug reform are largely unknown in Australia and indeed the world. However, the decriminalisation of illicit drugs in Portugal in 2001, provides some evidence which is used to inform the assumptions about the impact of decriminalisation in Tasmania.

2.5.1 Illicit Drugs Use under Decriminalisation

Pacula (2010) in survey of the literature on the legalisation of marijuana consumption concludes that "... is clear that total consumption will rise in response to legalization due to increases in the number of new users, increases in the number of regular and heavy users, and probable increases in the duration in which marijuana is consumed for average users". Pacula (2010) largely bases this conclusion on an increase in supply, resulting in a drop in price and increase in demand. Pacula (2010) summarises the literature to provide an estimate that the elasticity of

take up by new users with respect to price is -0.30 and that the price elasticity for consumption is -0.225 for existing users.

Hughes and Stevens (2010) present drug use data for Portugal prior to and after it decriminalised the use and possession of all illicit drugs on 1 July 2001. The use of illicit drugs over a lifetime and over the last 12 months from their paper is presented in Table 13. The results suggest that there was a 50% increase in people trying illicit drugs, but that the usage rate in the last 12 months rose by less than 10%.

Table 13 Drug Use in Portugal aged 15–64, by Drug Type, 2001 and 2007

Drug Type	Prevalence of lifetime illicit drug use in			Prevalence of illicit drug use in Portugal in the last 12 months		
	2001	2007	% Change	2001	2007	% Change
Any illicit substance	7.6	12	58%	3.4	3.7	9%
Hashish	7.6	11.7	54%	3.3	3.6	9%
Cocaine	0.9	1.9	111%	0.3	0.6	100%
Ecstasy	0.7	1.3	86%	0.4	0.4	0%
Amphetamines	0.5	0.9	80%	0.1	0.2	100%
Heroin	0.7	1.1	57%	0.2	0.3	50%

Sources: Balsa et al. (2004; 2007) via Hughes and Stevens (2010) Table 1 and 2.

In Portugal from 2001 to 2007 the four-year moving average of the price of Ecstasy fell by 50% and Cocaine and Hashish by 10%. While in neighbouring Spain, the price of these drugs was relatively stable over the period, with the exception being hashish whose price rose by 10% with demand. While no data is available for Portugal on the price of amphetamines the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) Price and Purity information stated that most European countries reported that the real price of amphetamines decreased in most of the countries; for example Spain recorded a 20% fall from €21 a gram in 2002 to €17 a gram in 2005.

It should also be noted that while the use of cocaine and amphetamines doubled (100% growth) these are from very small bases with the usage rate still being below 1%. In addition while the rates of illicit drug use rose for Portugal over this period, their prices fell. In addition Portuguese drug use also grew at similar rates to countries such as Italy and Spain. Given that these countries have experienced growth in the use of illicit drugs over this period, with prices stable, this suggests that other non-market related factors have contributed to the increase in use.

Furthermore Hughes and Stevens (2010) argue that Portugal too, may have been subject to these forces that have increased demand.

Assumption of Decriminalisation:

The proportion of the population using illicit drugs in the previous year will rise by 10%

2.5.2 (C) Drug Related Crime under Decriminalisation

Following the decriminalisation of personal drug use in Portugal, Hughes and Stevens (2010) report there was a substantial reduction in the number of alleged drug offenders being arrested and sent to the criminal courts. The number of people arrested for criminal offences related to drug offences reduced from over 14,000 offenders in 2000 to an average of 5,000–5,500 offenders from 2006 to 2011. The number of crimes strongly linked to drugs—that is theft, robberies, public assaults and certain types of fraud—increased by 9 per cent between 1995-99 and 2000-04 according to Hughes and Stevens (2010). The most notable increases were street robberies, theft from motor vehicles and theft of motor vehicles, which increased by 66, 30 and 15 per cent, respectively. Other forms of theft such as assaults/robberies from post offices and thefts from homes and businesses (which were deemed strongly linked to drugs) declined by 60, 8 and 10 per cent, respectively. The report by the central police agencies concluded that there had been an increase in more opportunistic crimes but a reduction in crimes that were more complex, pre-mediated and likely to involve threats or use of violence, Hughes and Stevens (2010). Hughes and Stevens (2010) report the proportion of drug-related offenders in the Portuguese prison population, that is offences committed under the influence of drugs and/or to fund drug consumption, has dropped from 44 per cent in 1999 to 21 per cent in 2008.

Table 14, on the next page, contains the number of crimes per 100,000 drug users, used in this study to obtain the estimates of illicit drug costs in 2015-16, and the % change upon decriminalisation and resulting crime rates if illicit drugs were decriminalised in Tasmania in 2015-16. These crime rates for drug users are used to derive the victim costs. In addition, the middle column ‘the % change upon decriminalisation’ is used to alter the number of illicit drug related crimes reported to police, Supreme and Magistrate Court lodgements and prisoners and those in community corrections.

Assumption of Decriminalisation:

(C) Drug related Crime per drug user with estimated change % according to Table 14

Table 14 Victims of Crime per 100,000 Drug Users Prior to and After Decriminalisation

Crime Type	Current Law	Change	Decriminalisation
Homicide	1.6	-20%	1.3
Physical assault	473.1	-20%	378.4
Sexual assault	25.9	-20%	20.7
Dangerous or Negligent Acts Endangering Persons	0.8	-20%	0.6
Kidnapping/abduction	4.2	-20%	3.3
Armed robbery	12.8	-20%	10.3
Attempted break-in	177.1	+0%	177.1
Motor vehicle theft	580.2	+0%	580.2
Fraud, Deception and Related Offences	21.1	+0%	21.1
Illicit Drug Offences	2,391.8	-50%	1,195.9
Prohibited and Regulated Weapons And Explosives Offences	151.7	+0%	151.7
Property Damage and Environmental Pollution	199.2	+0%	199.2
Public Order Offences	1,428.2	+0%	1,428.2
Offences Against Justice Procedures, Government Security and Government Operations	311.2	+0%	311.2
Miscellaneous Offences	357.5	+0%	357.5

2.5.3 (D) Drug Related Deaths and Disease under Decriminalisation

Hughes and Stevens (2010) reported that there were 400 drug-related deaths in Portugal in the year preceding the reforms, but from 2001-2006 the annual average had decreased to 290 drug-related deaths. This study assumes the drug related deaths from disease and burden of disease per drug user will fall by 25% under decriminalisation.

Assumption of Decriminalisation:

(D) Drug related Death and Disease per drug user will be reduced by 25%

2.5.4 (H) Drug Related Health Costs under Decriminalisation

The number of illicit drug related ambulance, emergency and hospitalised incidents per drug user are likely to change in a similar way to death and disease. This study assumes the drug

related ambulance, emergencies and hospitalised incidents per drug user will fall by 25% under decriminalisation.

Assumptions of Decriminalisation:

(H1) Ambulance drug related incidents per drug user will be reduced by 25%

(H2) Emergency drug related incidents per drug user will be reduced by 25%

(H3) Hospitalised drug related incidents per drug user will be reduced by 25%

Hughes and Stevens (2010) point out that the positive effects of decriminalisation experienced in Portugal were due in large part due to increases in treatment rates for illicit drug users. For this reason the proportion of illicit drug users receiving mental health services and other treatment is assumed to rise by 25%.

Assumptions of Decriminalisation:

(H4) Mental Health drug related incidents per drug user will increase by 25%

(H5) Treatment drug related incidents per drug user will increase by 25%

2.5.5 (R) Drug Related Road Accidents under Decriminalisation

The number of road accidents due to illicit drug use is strongly related to the number of users. This report assumes that the number of car accidents per drug user remains constant, with the total number of drug related crashes rising at the same rate that drug use does.

Assumption of Decriminalisation:

(R) Road Accidents per drug user will remain constant

3 RESULTS

This chapter contains the estimates of the cost of illicit drug use in Tasmania under the current law in 2015-16 and how those estimates would change upon decriminalisation. In particular it presents these estimates for each of the cost components as outlined in section 2.4: Crime in section 3.1, Death and Disease in section 3.2, Health in section 3.3, Road Accidents in section 3.4 and summarised in Section 3.5.

3.1 (C) Crime Costs of Illicit Drugs in Tasmania 2015-16

Table 15 Crime Costs of Illicit Drugs in Tasmania - Current and Decriminalisation

Crime Component	Cost (\$/n)	Current Law		Decriminalisation		Difference
		n	Cost	n	Cost	
Victim Cost	\$2,115	15,659	\$33.12m	16133.9	\$34.12m	\$1.00m
Police Cost	\$20,503	3,520	\$72.17m	3051.8	\$62.57m	-\$9.60m
Supreme Court Cost	\$16,649	143	\$2.38m	111.7	\$1.86m	-\$0.52m
Magistrates Court Cost	\$491	3,842	\$1.89m	3583.2	\$1.76m	-\$0.13m
Prison Cost	\$138,045	133	\$18.40m	117.3	\$16.20m	-\$2.21m
Community Correction Cost	\$4,831	452	\$2.18m	413.5	\$2.00m	-\$0.18m
TOTAL CRIME	\$5,480	23,749	\$130.13m	23,411	\$118.50m	-\$11.63m

3.2 (D) Death and Disease Costs of Illicit Drugs in Tasmania 2015-16

Table 16 Death/Disease Costs of Illicit Drugs in Tasmania - Current and Decriminalisation

Disease/Death	Cost (\$/n)	Current Law		Decriminalisation		
		n	Cost	n	Cost	Difference
Drug use disorders	\$82,500	65	\$5.37m	54	\$4.43m	-\$0.94m
Chronic liver disease	\$93,750	429	\$40.25m	354	\$33.21m	-\$7.04m
Liver cancer	\$93,750	278	\$26.09m	230	\$21.53m	-\$4.57m
Suicide and self-inflicted injuries	\$82,500	118	\$9.76m	98	\$8.05m	-\$1.71m
HIV/AIDS	\$93,750	3	\$0.29m	3	\$0.24m	-\$0.05m
Hepatitis C (acute)	\$93,750	1	\$0.07m	1	\$0.06m	-\$0.01m
Hepatitis B (acute)	\$93,750	2	\$0.17m	2	\$0.14m	-\$0.03m
Total Cost of Disease	\$91,450	897	\$82.00m	740	\$67.65m	-\$14.35m
Drug use disorders	\$82,500	516	\$42.57m	426	\$35.12m	-\$7.45m
Chronic liver disease	\$93,750	17	\$1.56m	14	\$1.28m	-\$0.27m
Liver cancer	\$93,750	3	\$0.28m	2	\$0.23m	-\$0.05m
Suicide and self-inflicted injuries	\$82,500	2	\$0.14m	1	\$0.11m	-\$0.02m
HIV/AIDS	\$93,750	2	\$0.15m	1	\$0.12m	-\$0.03m
Hepatitis C (acute)	\$93,750	0	\$0.01m	0	\$0.01m	\$0.00m
Hepatitis B (acute)	\$93,750	0	\$0.00m	0	\$0.00m	\$0.00m
Total Cost of Death	\$82,944	539	\$44.69m	445	\$36.87m	-\$7.82m
Drug use disorders	\$13,140	12	\$0.16m	10	\$0.13m	-\$0.03m
Chronic liver disease	\$13,140	20	\$0.26m	16	\$0.21m	-\$0.05m
Liver cancer	\$13,140	22	\$0.29m	18	\$0.24m	-\$0.05m
Suicide and self-inflicted injuries	\$13,140	5	\$0.06m	4	\$0.05m	-\$0.01m
HIV/AIDS	\$13,140	0	\$0.00m	0	\$0.00m	\$0.00m
Hepatitis C (acute)	\$13,140	-	\$0.00m	0	\$0.00m	\$0.00m
Hepatitis B (acute)	\$13,140	1	\$0.01m	1	\$0.01m	\$0.00m
Total Coroners Costs	\$13,140	60	\$0.78m	49	\$0.65m	-\$0.14m
TOTAL DEATH AND DISEASE			\$127.48m		\$105.17m	-\$22.31m

Notes: n for Disease costs are YLD (Years Living with Disease), n for Death costs are YLL (Years of Life Lost), n for Coroner's costs are Deaths

3.3 (H) Health Costs of Illicit Drugs in Tasmania 2015-16

Table 17 Health Costs of Illicit Drugs in Tasmania - Current and Decriminalisation

Health Component	Cost (\$/n)	Current Law		Decriminalisation		
		n	Cost	n	Cost	Difference
Total Emergency Cost	\$900	1,093	\$0.98m	901	\$0.81m	-\$0.17m
Overnight acute Hospitalisations	\$6,255	2,136	\$13.36m	1,762	\$11.02m	-\$2.34m
Same-day acute Hospitalisations	\$1,328	1,192	\$1.58m	983	\$1.31m	-\$0.28m
Total Hospitalisations	\$4,490	3,328	\$14.94m	2,746	\$12.33m	-\$2.62m
Ambulance Responses	\$768	1,505	\$1.16m	1,241	\$0.95m	-\$0.20m
MBS Treatment Services	\$2,260	4,076	\$9.21m	5,605	\$9.21m	\$0.00m
Hospital Treatment Services	\$2,260	529	\$1.19m	727	\$1.19m	\$0.00m
Total Treatment Services	\$2,260	4,605	\$10.41m	6,332	\$10.41m	\$3.90m
Residential Care	\$20,000	203	\$4.06m	279	\$5.59m	\$1.52m
Other Treatment	\$2,500	3,038	\$7.59m	4,177	\$10.44m	\$2.85m
Total Treatment	\$3,597	3,241	\$11.66m	4,456	\$16.03m	\$4.37m
TOTAL HEALTH COSTS			\$39.14m		\$44.43m	\$5.28m

3.4 (R) Road Accidents Costs of Illicit Drugs in Tasmania 2015-16

Table 18 Road Costs of Illicit Drugs in Tasmania - Current and Decriminalisation

Crash Severity	Cost (\$/n)	Current Law		Decriminalisation		
		n	Cost	n	Cost	Difference
Fatal	\$2,663,817	1.2	\$3.25m	1.3	\$3.58m	\$0.33m
Serious	\$266,000	4.8	\$1.28m	5.3	\$1.40m	\$0.13m
Minor	\$14,747	18.8	\$0.28m	20.7	\$0.31m	\$0.03m
Uninjured	\$9,831	18.3	\$0.18m	20.1	\$0.20m	\$0.02m
TOTAL CRASHES	\$115,624	43	\$4.98m	47	\$5.48m	\$0.50m

3.5 Total Costs of Illicit Drugs in Tasmania 2015-16

Table 19 Total Costs of Illicit Drugs in Tasmania - Current and Decriminalisation

	Current Law	Decriminalisation	
	Cost	Cost	Difference
TOTAL CRIME	\$130.13m	\$118.50m	-\$11.63m
TOTAL DEATH AND DISEASE	\$127.48m	\$105.17m	-\$22.31m
TOTAL HEALTH	\$39.14m	\$44.43m	\$5.28m
TOTAL CRASHES	\$4.98m	\$5.48m	\$0.50m
TOTAL COST	\$301.74m	\$273.58m	-\$28.02m

4 CONCLUSION

This report has provided estimates of the costs of illicit drug use in Tasmania in 2015-16 and what that cost would be if the use of illicit drugs was decriminalised. The principle costs associated with illicit drug use of crime, death/disease, health and car accidents were estimated based on previous studies and figures from government reports, similar to past cost studies of drug use. The cost of illicit drug use in Tasmania in 2015-16 is estimated to be \$302m. The two largest components of this cost are the crime costs (\$130 million) and death and disease cost (\$127m), followed by health costs (\$39m). The crime costs consist largely of policing costs at \$72m and victim costs of \$33m and \$18m in prison costs. The death and disease cost is comprised of \$48m directly attributed to illicit drug use, \$42m from liver disease, \$26m from liver cancer and \$10m from suicide.

This study has ignored any potential benefits of illicit drug use, such as the benefit or consumer surplus that users derive as they do when consuming any good. Similarly the investigation has also ignored the profit or producer surplus, drug sellers make and potentially spend in the legitimate economy. Any potential social benefits that illicit drug use may provide, have also been disregarded. It has also largely ignored the private costs of illicit drug use. That is the cost of the illicit drug use that the user has knowledge of and bears themselves. For example illicit drug users lost wages through inferior labour market outcomes or early death or disease.

Due to the limited scope of this study only the costs incurred in a single year are estimated, rather than the present value (PV) of the stream of future costs and benefits as is custom in cost-benefit studies. The cost estimate in this study can be used to construct an approximate estimate of the PV of the stream of future costs by simply dividing by the assumed social discount rate. This assumes a constant population, drug usage rate and incident rates such that the \$302m cost occurs each and every year into the future. For example a social discount rate of 5% results in PV of the stream of future costs of \$6,040m for Tasmanian illicit drug use. Furthermore an approximation of the PV of the stream of future costs with a growing population and usage rates can be calculated by subtracting the population and usage rates from the social discount rate. For example, a 5% social discount rate, 2% population annual growth rate and 1% annual growth rate in usage, results in an estimate of \$30,200m for the PV of the stream of cost of illicit drug use for Tasmania into the future.

The author believes the current cost estimates derived for Tasmania in 2015-16 are relatively accurate when compared to other similar cost studies of illicit drug use. Due to the limited scope of this study no sensitivity analysis has been performed. There is little evidence to suggest the information sourced is incorrect and no indication of any margin of error, so little guidance for

performing sensitivity analysis. The single item which cost per incidence that influences the figures is the value of a productivity loss of life at 2.5 million generally applied as \$75,000 per year of life lost (YLL). Reducing it and related loss of life costs by 20% reduces the cost estimate for 2015-16 by 5.9% and the cost after decriminalisation by 5.1%.

The estimates of the costs after decriminalisation of illicit drugs are largely based on the author's interpretation of the changes that occurred in Portugal and neighbouring countries after it decriminalised in 1991. For this reason the author is not as confident in the estimates of the costs of illicit drug use after decriminalisation relative to the estimates of the current cost of illicit drugs in 2015-16. Future studies could obtain more accurate estimates by explicitly modelling the demand and supply of illicit drugs, although data is limited.

The estimate of costs due to illicit drug use in Tasmania after decriminalisation is \$274m, or approximately 10% reduction from the 2015-16 cost. This is despite an assumed 10% increase in the use of illicit drugs under decriminalisation. The reduction is largely due to 20% decrease in the illicit drug death and disease costs and a 10% reduction in the crime costs, while health and car crash costs rise. The reduction in crime costs result from reduced policing and prison costs, while the death and disease cost result from increased early treatment.

Yours sincerely,



Dr Paul Blacklow
Chief Investigator

5 REFERENCES

- Australian Bureau of Statistics (2016a). *Australian Demographic Statistics, June 2016*, ABS 3101.0, Canberra: Australian Bureau of Statistics (ABS)
- Australian Bureau of Statistics (2016b). *Causes of Death, Australia, 2015*. ABS 3303.0, Canberra: Australian Bureau of Statistics (ABS).
- Australian Bureau of Statistics (2016c). *Consumer Price Index, June 2016*. ABS 6401.0, Canberra: Australian Bureau of Statistics (ABS).
- Australian Bureau of Statistics (2016d). *Prisoners in Australia 2016* „, ABS 4517.0, Canberra: Australian Bureau of Statistics (ABS).
- Australian Bureau of Statistics (2016e). *Recorded crime - Victims, Australia 2015*. ABS 4510.0. Canberra: Australian Bureau of Statistics (ABS).
- Australian Bureau of Statistics (2016f). *Recorded Crime - Offenders, 2015-16*. ABS 4510.0. Canberra: Australian Bureau of Statistics (ABS).
- Australian Bureau of Statistics (2017a). *Corrective Services, Australia, December Quarter 2016*. ABS 4512.0. Canberra: Australian Bureau of Statistics (ABS).
- Australian Bureau of Statistics (2017b). *Crime Victimisation, Australia, 2015-16*. ABS 4530.0. Canberra: Australian Bureau of Statistics (ABS).
- Australian Bureau of Statistics (2017c). *Criminal Courts, Australia, 2015-16*. ABS 4513.0. Canberra: Australian Bureau of Statistics (ABS).
- Australian Institute of Criminology (2016). *Australian crime: Facts & Figures 2014*. Trends and Issues in Crime and Criminal Justice, No. 319, Canberra: Australian Institute of Criminology (AIC) <http://aic.gov.au/publications/current%20series/facts/1-20/2014.html>
- Australian Institute of Health and Welfare (2016). *Australia's health 2016*. Australia's health series no. 15. cat. no. AUS 199. Canberra: AIHW
- Australian Institute of Health and Welfare (2011). *Drugs in Australia 2010: tobacco, alcohol and other drugs*, Drug statistics series no. 27, PHE 154, Canberra: Australian Institute of Health and Welfare.
- Australian Institute of Health and Welfare (2014). *National Drug Strategy Household Survey detailed report: 2013*. Drug statistics series no. 28, PHE 183, Canberra: Australian Institute of Health and Welfare (AIHW).
- Australian Institute of Health and Welfare (2013a). *Australian hospital statistics 2011–12*. Health services series no. 50. cat. no. HSE 134. Canberra: Australian Institute of Health and Welfare (AIHW).
- Australian Institute of Health and Welfare (2012a). *Alcohol and other drug treatment services in Australia, 2010-11*. Drug Treatment Series no. 18. cat. no. HSE 128. Canberra: Australian Institute of Health and Welfare (AIHW).
- Australian Institute of Health and Welfare (2012b). *Australia's hospitals 2010–11, at a glance*. Health services series no. 44. cat. no. HSE 118. Canberra: Australian Institute of Health and Welfare (AIHW).
- Australian Institute of Health and Welfare (2012c). *Australian hospital statistics 2010–11: Supplementary tables*. Health services series no.40. cat. no. HSE 107. Canberra: Australian Institute of Health and Welfare (AIHW).

- Australian National Council on Drugs (2012). *An economic analysis for Aboriginal and Torres Strait Islander offenders: Prison vs. residential treatment*. Canberra: National Indigenous Drug and Alcohol Committee, Australian National Council on Drugs (ANCD)
- Baker, J. and D. Goh (2004), *The Cannabis Cautioning Scheme three years on: An implementation and outcome evaluation*, NSW Bureau of Crime Statistics and Research, Sydney.
- Bureau of Infrastructure, Transport and Regional Economics (2000), *Road crash costs in Australia*. Report 102. Canberra: Bureau of Infrastructure, Transport and Regional Economics (BITRE) http://www.bitre.gov.au/publications/2000/report_102.aspx
- Bureau of Infrastructure, Transport and Regional Economics (2010), *Road crash costs in Australia 2006*. Report 118. Canberra: Bureau of Infrastructure, Transport and Regional Economics (BITRE).
http://www.bitre.gov.au/publications/2010/report_118.aspx
- Bureau of Infrastructure, Transport and Regional Economics (2012), *Road deaths Australia 2011 statistical summary*. Canberra: Bureau of Infrastructure, Transport and Regional Economics (BITRE).
<http://statistics.infrastructure.gov.au/atsb/login.do?guest=guest&tableId=user/atsb/guest/Road%20Deaths%20by%20State%20and%20Territory.tx>
- Crampton E., M. Burgess and B. Taylor (2011). *The cost of cost studies*. Working Paper No 29/2011. Christchurch: Department of Economics and Finance, University of Canterbury
- Collins D. and H. Lapsley (2008). *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05*. Monograph series no 66. Canberra: Department of Health and Ageing.
- De Graaff, B. and R. Bruno (2012). *Tasmanian Drug Trends - Findings from the Illicit Drug Reporting System*, School of Psychology, University of Tasmania, Australian Drug Trends Series No. 95
- Drummer, O.H., Gerostamoulos J., Batziris H., Chu M., Caplehorn J., Robertson M.D., Swann P. (2004). "The involvement of drugs in drivers of motor vehicles killed in Australian road traffic crashes", *Accident Analysis and Prevention*, 36(2), pp 239-48. Oxford: Elsevier
- Hughes, C. and A. Stevens (2010), "What can we learn from the Portuguese decriminalization of illicit drugs?" *British Journal of Criminology*, 50 (6). pp. 999-1022.
- Lloyd B., Matthews S., Gao C. X., Heilbronn C., Beck, D. (2015). Trends in alcohol and drug related ambulance attendances in Victoria: 2013/14. Fitzroy, Victoria: Turning Point.
- Mayhew P. (2003a). *Counting the costs of crime in Australia. Trends & Issues in Crime and Criminal Justice No. 247*. Australian Institute of Criminology, Canberra.
<http://aic.gov.au/publications/current%20series/tandi/241-260/tandi247.html>
- Mayhew, P. (2003b). *Counting the costs of crime in Australia: Technical report. Technical and Background Paper Series no. 4*. Canberra: Australian Institute of Criminology.
<http://aic.gov.au/publications/current%20series/tbp/1-20/tbp004.html>
- Mouzos, J., L. Smith and N. Hind (2006). "Drug use monitoring in Australia: 2005 annual report on drug use among police detainees", Research and public policy series no. 70, Canberra: Australian Institute of Criminology.

- Nicholas, R., Lee, N., & Roche, A. (2011). *Pharmaceutical Drug Misuse in Australia: Complex Problems, Balanced Responses*. National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide.
- The New South Wales Centre for Road Safety (2016), Road Traffic Casualty Crashes in New South Wales, December 2015, Sydney: Transport for NSW.
- NSW Roads and Traffic Authority's Drug-Driving Task Force, (1994). The NSW Drug Driving Strategy, Sydney: Transport for NSW
- NIDA (2016). Drugged Driving. Retrieved March 30, 2017 from <https://www.drugabuse.gov/publications/drugfacts/drugged-driving>.
- Pacula, R. (2010). Examining the Impact of Marijuana Legalization on Marijuana Consumption: Insights from the Economics Literature, RAND working RC.-770-paper WR
- Payne, J. and A. Gaffney (2012). *How much crime is drug or alcohol related? Self-reported attributions of police detainees*, Trends & issues in crime and criminal justice, No. 439, Canberra: Australian Institute of Criminology.
- Productivity Commission (2016), Report on government services 2016, Canberra: Productivity Commission, viewed 28 June 2016.
- Rollings, K. (2008). *Counting the costs of crime in Australia: A 2005 update*. Research and Public Policy Series no. 91. Canberra: Australian Institute of Criminology. <http://www.aic.gov.au/publications/current%20series/rpp/81-99/rpp91.html>
- Roxburgh, A. and L. Burns (2015). *Accidental drug-induced deaths due to opioids in Australia 2011*, National Drug and Alcohol Research Centre, Sydney.
- Roxburgh, A. and L. Burns (2013), *Accidental drug-induced deaths due to opioids in Australia 2009*, National Drug and Alcohol Research Centre, Sydney.
- Smith, R.G., P. Jorna, J. Sweeney and G. Fuller (2014). *Counting the costs of crime in Australia: A 2011 estimate*, Australian Institute of Criminology, AIC Reports, Research and Public Policy Series 129.
- Stafford, J. and C. Breen (2015), *AUSTRALIAN DRUG TRENDS Findings from the Illicit Drug Reporting*, (System (IDRSAustralian Drug Trends Series No. 145.
- Tasmania Department of State Growth (2014), Tasmanian Vehicle Crash Database, <http://data.gov.au/dataset/tasmanian/resource/fbdb3f0c-fce0-4acc-8cb7-d455855f9d9a>