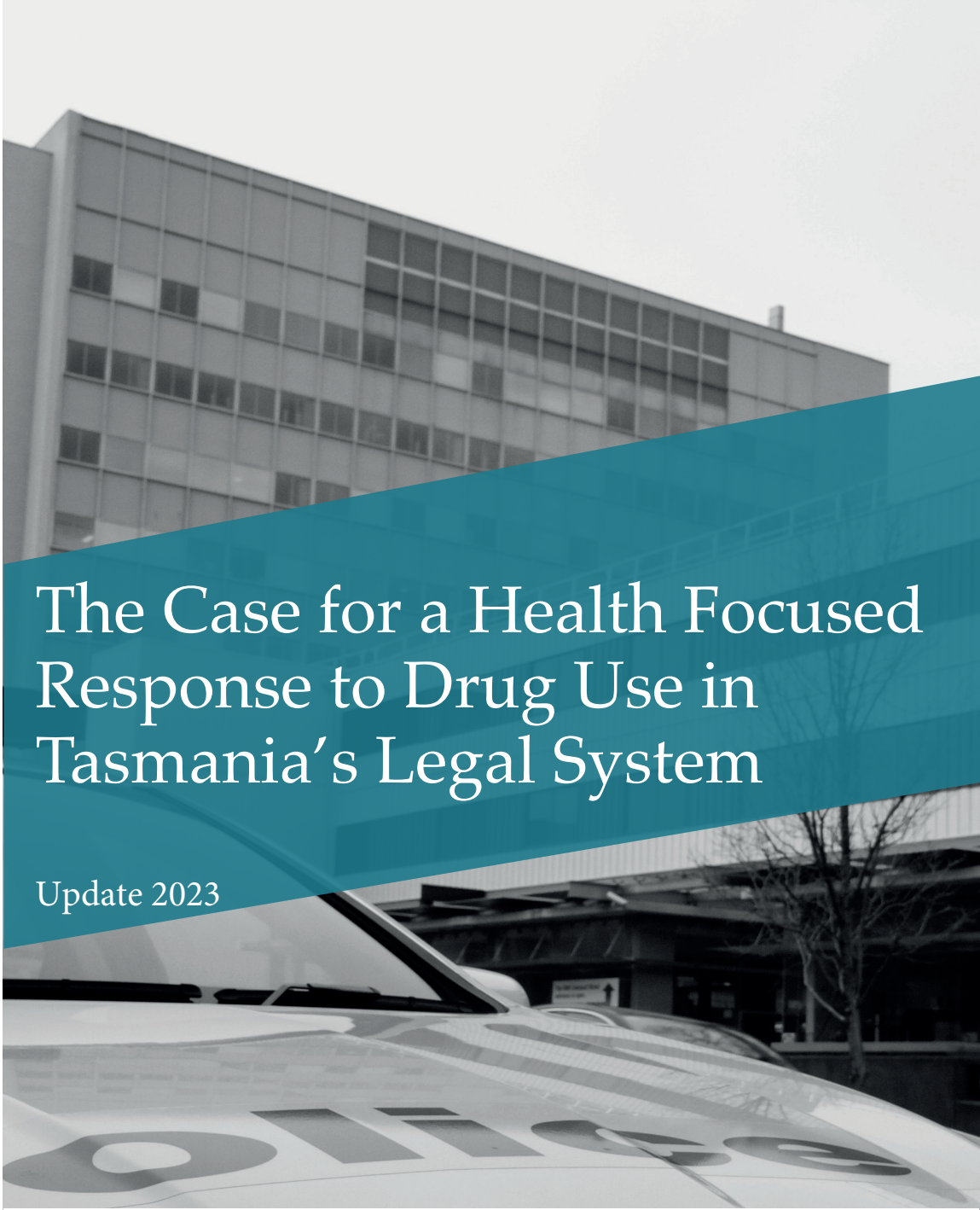

The Case for a Health Focused Response to Drug Use in Tasmania's Legal System

Update 2023

COMMUNITY
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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.

The Case for a Health Focused Response to Drug Use in Tasmania's Legal System was launched in July 2017 by Michael Hill, the former Chief Magistrate and Dr Alex Wodak AM, the President of Australians for Drug Law Reform. This update is based on data released five years after the original report was released and seeks to provide more contemporaneous data and analysis.

Both the original report and this update was prepared by Benedict Bartl, a policy officer and lawyer with Community Legal Centres Tasmania.

Contents

Executive Summary

- More than 9 million Australians (43 per cent) aged 14 years or over have consumed illicit drugs in their lifetime and 3.4 million (16 per cent) have done so in the last 12 months.
- Cannabis is the most frequently used illicit drug in Australia with an estimated 36 per cent of Australians (or 7.6 million persons aged 14 or over) having used cannabis in their lifetime and 11.6 per cent (2.4 million) having used cannabis in the last twelve months. Other commonly used drugs include ecstasy, cocaine and methamphetamine.
- Whilst the last decade has since a 14 per cent increase in the Australian population, the number of illicit drug seizures increase by 74 per cent; the weight of illicit drugs seized increase by 314 per cent; and the number of national illicit drug arrests increase by 96 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 165,000 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.
- Just over half of all offenders sentenced to a minor drug-related offence in Tasmania receive a fine. Nevertheless, over the last five years around 85 offenders each year were sentenced to imprisonment for drug offences of which 68 per cent received either a partially or fully suspended sentence.
- 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 2021-22 at $591.9 million (see attached).
- Blacklow's analysis finds that the total cost of illicit drug use in Tasmania under decriminalisation would be $530.1 million, a financial saving of $61.8 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 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, according to the Australian Criminal Intelligence Commission over the last decade the number of seizures, the weight of drugs confiscated and the number of arrests being made have all reached historic levels.

In Australia, around four in ten adults will use an illegal drug in their lifetime and around 3.4 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.

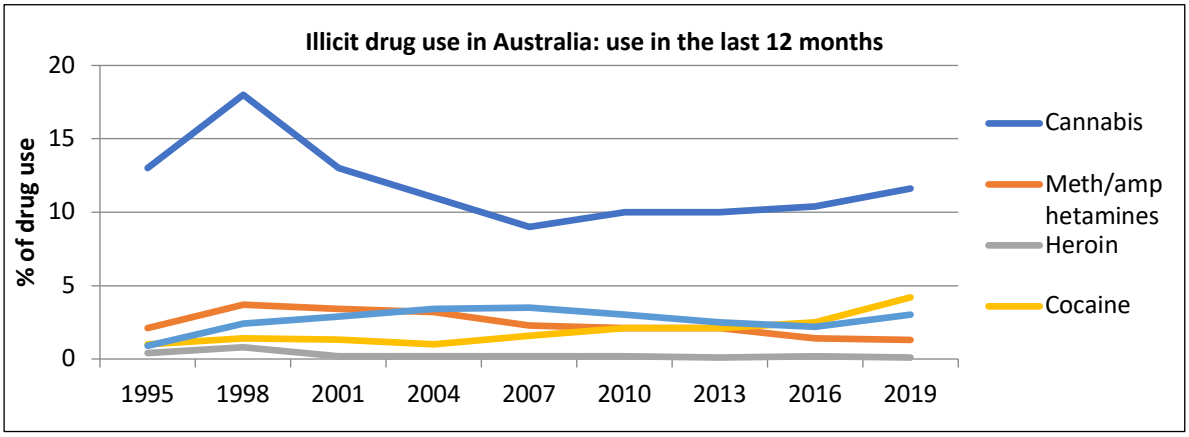
2 Illicit Drugs in Australia

According to the most recent data from the Australian Criminal Intelligence Commission (ACIC), Australia is awash with illicit drugs. The ACIC reports that during 2019–20 law enforcement agencies reported 121,274 illicit drug seizures with a combined weight of 38.5 tonnes and 166,321 arrests.[1] As the Chief Executive Officer of the ACIC summarised in his annual report to the Australian Government, "over the last decade, during which time the Australian population increased around 14 per cent: the number of national illicit drug seizures increased 74 per cent; the weight of illicit drugs seized nationally increased 314 per cent; [and] the number of national illicit drug arrests increased 96 per cent".[2] In the ACIC's own words this equates to 1 illicit drug seizure every 4.5 minutes, 1 kilogram of illicit drugs seized every 14 minutes and 1 illicit drug arrest every 3.5 minutes.[3]

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 2019, 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 9 million Australians (43 per cent) aged 14 years or over had ever illicitly used drugs, including pharmaceuticals used for non-medical purposes. The Survey also found that 3.4 million (16.4 per cent) had done so in the last 12 months.[4]

2.1 Use

Cannabis is the most frequently used illicit drug in Australia with an estimated 36 per cent of Australians (or 7.6 million persons aged 14 or over) having used cannabis in their lifetime and 11.6 per cent (2.4 million) having used cannabis during the previous year,[5] as the following graph highlights:



[1] Australian Criminal Intelligence Commission, *2019-20 Illicit Drug Data Report* at 1-2. As found at https://www.acic.gov.au/sites/default/files/2021-10/IDDR%202019-20_271021_Full_0.pdf (Accessed 3 August 2022).

[2] Ibid 2.

[3] Ibid 4.

[4] Australian Institute of Health and Welfare (AIHW), *National Drug Strategy Household Survey* 2019 (2020), Drug statistics series no. 32. Cat. no. PHE 183. Canberra: AIHW at 28. As found at https://www.aihw.gov.au/getmedia/77dbea6e-f071-495c-b71e-3a632237269d/aihw-phe-270.pdf.aspx?inline=true (Accessed 3 August 2022).

[5] Ibid 34. 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 12.5 per cent of Australians (or 2.6 million) ever having used ecstasy and 3.0 per cent (600,000) of the population having used it during the previous year.[6]

The Survey further found that 11.2 per cent of Australians (2.3 million) had used cocaine in their lifetime with about 4.2 per cent (900,000) of the population having used it during the previous year. While the use of methamphetamines has declined since 2004, the proportion of people using cocaine has been increasing since 2004.[7]

Finally, the Survey found that 5.8 per cent of Australians (1.2 million) had used methamphetamines in their lifetime and 1.3 per cent (300,000) of the population had used them during the previous year.[8] Methamphetamine comes in a number of forms including powder/pills (colloquially known as "speed"), a sticky paste ("base") or crystal methamphetamine ("ice").[9] Whilst the media is quick to portray methamphetamine use as a "scourge" or "pandemic",[10] use has *declined* since its peak at 3.7 per cent in 1998, remained stable at 2.1 per cent between 2010 and 2013 and there was no statistically significant change by age or sex between 2016 and 2019. Nevertheless, it is clear that there has been a change in use with consumers preferring the more intense 'high' experienced from ice and base.[11]

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.[12]

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 specific reference to Australia,

[6] Ibid 38.

[7] Ibid 36.

[8] Ibid 39.

[9] Methamphetamine is an abbreviation of methylamphetamine. Throughout this paper both terms are used interchangeably.

[10] 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.

[11] AIHW, Op cit 4 at 41. For example, the Survey observes that the reported use of powder/speed decreased from 51 per cent in 2010 to 29 per cent in 2013 and to 20 per cent in 2019 while the reported use of ice increased from 22 per cent in 2010 to 50 per cent in 2013 and 2019.

[12] 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.

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".[13]

In 2019-20, the ACIC 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 2019: Key Findings from the Illicit Drug Reporting System (IDRS) Interviews* 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.[14]

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.[15] 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.[16] 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.[17]

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.[18] Section 3(3) of the *Poisons Act 1971* sets out that a person will be deemed to be in "possession" of a controlled substance[19] if it is found on them or at their premises unless they can prove that they had no knowledge of the substance.[20] 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.[21] As well, unlike the criminal law more generally, the onus of proof has been

[13] 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.

[14] A Peacock, J Uporova, A Karlsson, D Gibbs, R Swanton, G Kelly, O Price, R Bruno, P Dietze, S Lenton, C Salom, L Degenhardt, & M Farrell, *Australian Drug Trends 2019: Key Findings from the National Illicit Drug Reporting System (IDRS) Interviews* (2021) National Drug and Alcohol Research Centre, University of New South Wales, Australia at 22-44. As found at https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/National%20IDRS%20Interview%20Report%202019.pdf (accessed 10 January 2023).

[15] AIHW, Op cit Table 7.9 of the 'Supplementary Tables' under 'State and Territory tables'.

[16] Ibid, Table 7.12 of the 'Supplementary Tables' under 'State and Territory tables'.

[17] 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.

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

[19] A 'controlled substance' is defined as a controlled drug, controlled plant or controlled precursor: section 3 of the *Misuse of Drugs Act 2001* (Tas).

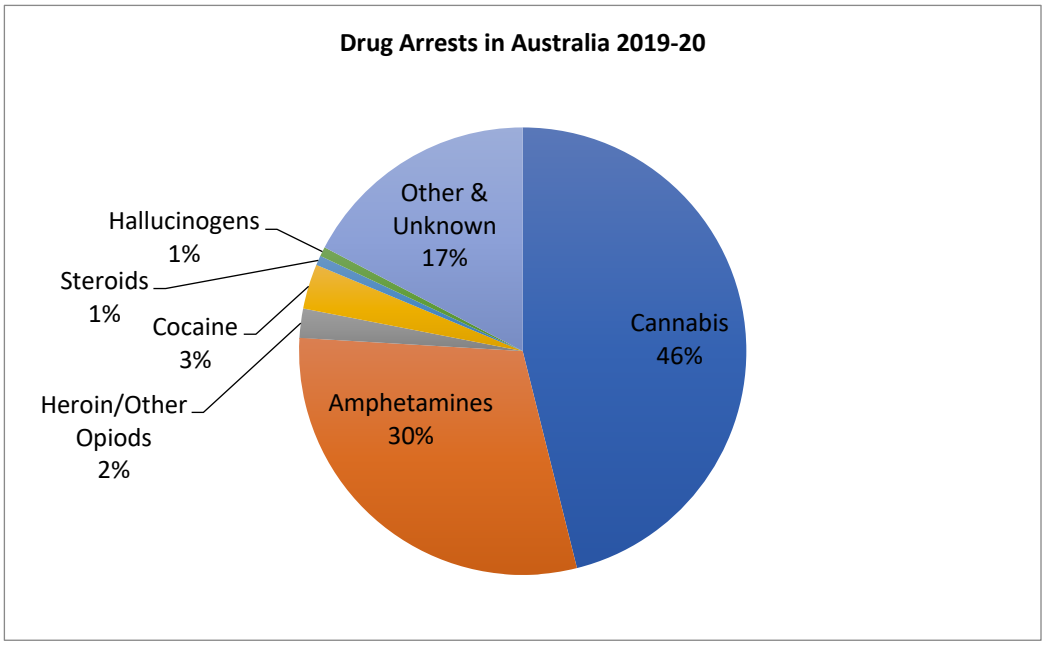
[20] See also ss 3 and 3(3) of the *Misuse of Drugs Act 2001* (Tas) for the same definitions of both "controlled substance" and "possession". See also the cases of *Arnold v Stringer* [2004] TASSC 13; *Alison v Lowe* [1988] Tas R 21; *Lowe v Goodluck* [1985] TASSC 9.

[21] 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).

reversed meaning that the accused bears the onus of proof in establishing that possession of a certain threshold quantity was not intended to be sold.[22] 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 ACIC. This data demonstrates that almost half of all drug-related arrests[23] in Australia are for cannabis. For example, in 2019–20 there were 166,321 arrests for drug-related offences of which 76,669 were for cannabis and 49,638 for amphetamines:[24]



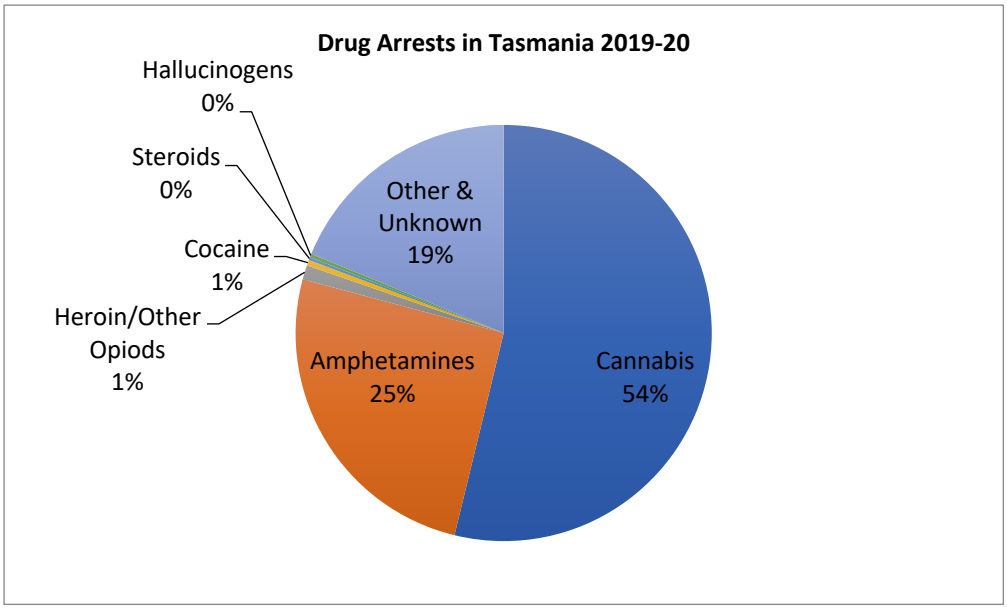
In comparison with the Australia-wide data, Tasmania differs in a number of respects including the higher percentage of cannabis and "other and unknown" drug-related arrests, the lower percentage of amphetamine arrests and the small number of cocaine, steroid and hallucinogen arrests:[25]

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

[23] In its explanatory note the Australian Criminal Intelligence 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 and charge, 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 Criminal Intelligence Commission, Op cit at 165.

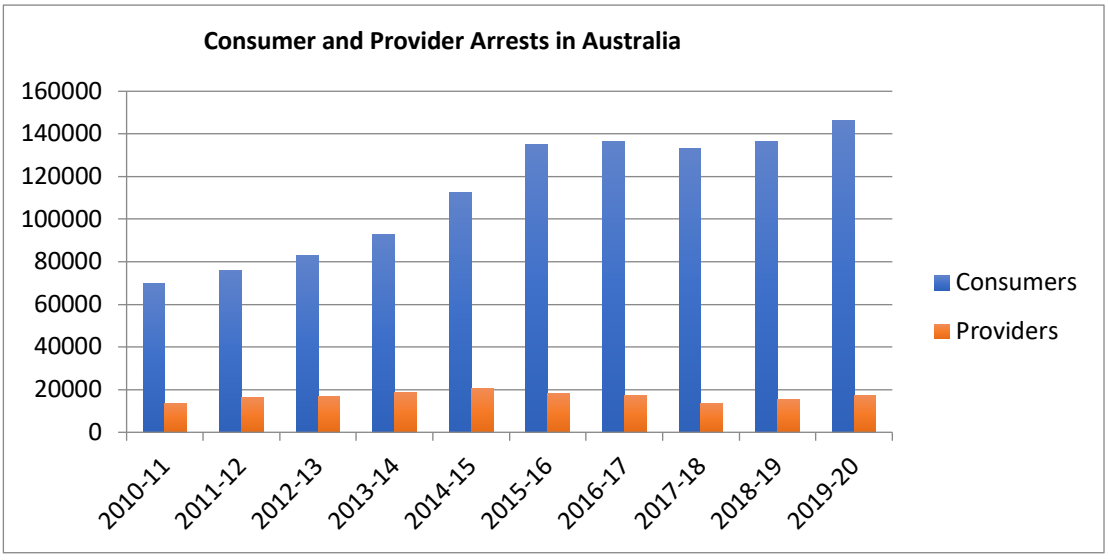
[24] Ibid, Tables 25-32.

[25] Ibid, Tables 25-32.



In their analysis of illicit-drug arrests, the ACIC 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.[26]

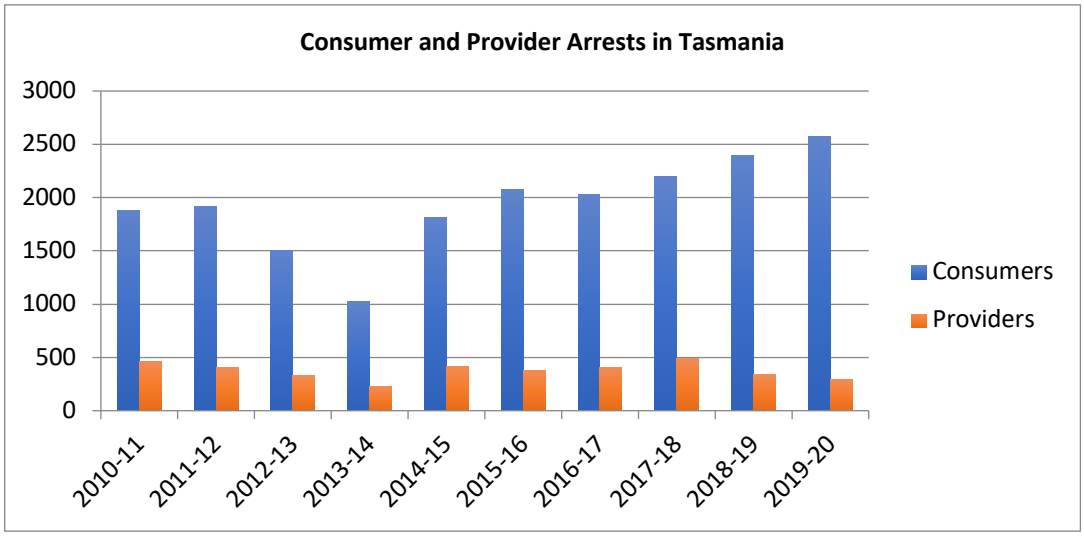
According to the most recent ACIC data, whilst "the Australian population has increased around 14 per cent over the last decade the number of national illicit drug arrests increased 96 per cent over the last decade, from 84,738 in 2010–11 to a record 166,321 in 2019–20".[27] At the same time, as the graph below illustrates, the increase has been primarily against consumers with a 110 per cent increase in consumer arrests from 69,731 in 2010-11 to 146,476 in 2019-20.[28]



Similarly, the Tasmanian specific ACIC data demonstrates that there has been a 22 per cent increase in the number of illicit drug arrests in Tasmania over the last decade, from 2439 in 2010-

[26] Ibid, 159.
[27] Ibid 2.
[28] Ibid, Table 25.

11 to 2970 in 2019-20.[29] Whilst consumer drug arrests as a percentage of all drug arrests have fluctuated over the last decade, the trend has been upwards, rising from 77 per cent of all drug arrests in 2010-11 to 87 per cent in 2019-20. Expressed in another way, more than eight out of ten drug arrests in Tasmania are made against consumers who have been charged with use, possession or administering a drug for their own use.



2.6 The Magistrates Court

Research published by the Magistrates Court of Tasmania demonstrates that over the last decade, around 1100 Tasmanian adults and around 47 youth have been charged on average with drug-related offences per annum. There was a peak of 1442 in 2010–11, a gradual decline over the following three years before once again rising in 2014–15:[30]

Magistrates Court of Tasmania		
Year	No. of Illicit Drug Cases (adults)	No. of Illicit Drug Cases (Youth Justice)
2010–11	1442	86
2011–12	1283	66
2012–13	965	31
2013–14	886	28
2014–15	1036	31
2015-16	1005	43
2016-17	1182	51
2017-18	1265	54
2018-19	1173	37
2019-20	1162	46

[29] Ibid.

[30] The data was found in Annual Reports published by the Magistrates Court in 2014-15 and 2019-20. The Annual Reports can be accessed at http://www.magistratescourt.tas.gov.au/about_us/publications (Accessed 5 January 2023). 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 not guilty 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) website[31] 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 Criminal Intelligence Commission observes that "in 2019-20 cannabis continues to account for the greatest proportion of national illicit drug arrests (46 per cent)"[32] and cannabis accounted for 61 per cent of all seizures in Tasmania in 2019-20.[33]

Whilst the data demonstrates that just over half of all offenders sentenced for a drug-related offence receive a fine,[34] it is concerning that between 2016-2020, 428 offenders were sentenced to imprisonment for drug offences of which 68 per cent received either a partially or fully suspended sentence.[35]

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.[36] 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.

[31] See Sentencing Advisory Council Statistics <http://www.sentencingcouncil.tas.gov.au/statistics> (Accessed 10 January 2017).

[32] Australian Criminal Intelligence Commission, Op cit at 14.

[33] Ibid, Table 35. Of the 3801 seizures conducted by either Tasmania Police or the Australian Federal Police 2331 were cannabis seizures.

[34] In raw numbers, 1088 of the 2010 offenders who were sentenced between 2016–20 for a drug offence under the *Misuse of Drugs Act 2001* (Tas) received a fine. The data requested was for cases not charges meaning that multiple charges for the same offence were not aggregated. The *Misuse of Drugs Act 2001* (Tas) offences reviewed were c cultivating a controlled plant (section 22), possess or use controlled plant or its products (section 25), sell or supply controlled plant (section 27), selling/supplying controlled drug (minor offence) (section 26), possess a controlled drug (section 24(a)), use a controlled drug (section 24(b)), unlawful importation of a controlled drug (minor offence) (section 27A), forge prescription (section 28(2)(a)), manufacturing controlled drug (minor offence) (section 21) and, unlawfully alter a prescription (section 28(3).

[35] In raw numbers of the 428 offenders sentenced to imprisonment between 2016–20 for a drug offence under the *Misuse of Drugs Act 2001* (Tas), 232 were sentenced to a fully suspended sentence, 59 sentenced to a partially suspended sentence and 137 sentenced to imprisonment. It should however be acknowledged that the data includes global sentences which could include multiple instances of a crime or the crime combined with other crimes.

[36] The sentencing comments are available at https://catalogue.lawlibrary.tas.gov.au/#judgments (Accessed 6 January 2023).

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

While more recent data is no longer available for 'drug-related offences', the *Supreme Court Annual Reports* outline the number of offenders charged with 'trafficking in a controlled substance'.[37]

Supreme Court of Tasmania	
Year	No. of offenders charged with trafficking in a controlled substance
2017/18	63
2018/19	73
2019/20	56
2020/21	61

However, the data from both the *Sentencing Database* and the *Supreme Court Annual Reports* 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.[38] An analysis of the sentencing comments between 2008-2016 highlighted 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, around 120 sentences were handed down each year between 2008-2016 in the Supreme Court for offenders with problematic drug use.

[37] Supreme Court of Tasmania, Annual Report 2020/21; Annual Report 2019/20 and Annual Report 2018/19. As found at https://www.supremecourt.tas.gov.au/publications/annual-reports/ (Accessed 6 January 2023).

[38] An electronic database of the sentencing comments is available at https://catalogue.lawlibrary.tas.gov.au/#judgments (Accessed 6 January 2023).

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

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.[39]

[39] 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 January 2023). 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 10 January 2023).

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*;[40]
- 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 use[41] 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".[42] 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.[43]

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'.[44]

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].[45]

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

[40] The *Single Convention* was amended by the 1972 Protocol.

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

[42] *Single Convention on Narcotic Drugs 1961* art 4.

[43] Ibid art 36.

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

[45] Ibid, 113,[23].

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".[46]

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".[47]

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[46] D Bewley-Taylor, Op cit 172.

[47] 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 https://www.unodc.org/documents/treaties/organized_crime/Drug%20Convention/Commentary_on_the_united_nations_convention_1988_E.pdf (Accessed 10 January 2023). Also see article 4 and 36 of the 1961 Convention and articles 5 and 22 of the 1971 Convention.

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.[48]

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.[49]

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

[49] 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,[50] 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).[51] 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".[52]

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".[53] These pillars are defined in the *National Drug Strategy 2010-2015* as:[54]

- **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.

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

[50] 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).

[51] 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.

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

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

[54] 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.

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.[55] 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 Australia[56] and whilst some other jurisdictions have followed,[57] 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).[58]

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.[59]

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 or treatment programs and the majority of participants who were referred to diversion not re-offending in the 12–18 months after being cautioned.[60]

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

[55] 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.

[56] 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.

[57] 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.

[58] Ibid 4.

[59] Ibid 4.

[60] 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.

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.[61] 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.[62]

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.[63]

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.[64]

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.[65]

According to data published by the National Drug and Alcohol Research Centre in 2015, there were on average more than 1000 cautions and diversions in each of the years between 2003–04

[61] 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.
[62] Ibid at 37.
[63] 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).
[64] Jason Payne, Max Kwiatkowski & Joy Wundersitz, Op cit 7.
[65] Ibid 7.

and 2010–11 after which persons under the age of 18 were no longer included for reporting purposes:[66]

Year	No. cautions	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
2015-16	445	222
2016-17	394	209
2017-18	417	207
2018-19	345	196
2019-20	299	148

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.[67] 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.[68] 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".[69]

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 of training provided to police officers,[70] the anecdotal evidence of those employed in the alcohol and other drug sector has in the past been that despite these deficiencies the system appears to be working.[71] It is however of concern that the number of cautions issued has been falling, particularly over the last decade. There may be a number of reasons which explain this decline

[66] 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.

[67] 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.

[68] 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.

[69] C Hughes & A Ritter, Op cit 17.

[70] 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.

[71] 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.

including a lack of police training, but regardless of the reason it is clear that the program needs to be refreshed.

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".[72] 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".[73]

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".[74] 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.[75]

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).[76] 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 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.[77]

Despite its proven ability to rehabilitate, the CMD program was initially restricted to summary or indictable crimes that were able to be determined by the Magistrates Court and was capped at 80

[72] 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'.
[73] Sections 7, 27G and 27H of the *Sentencing Act 1997* (Tas).
[74] Department of Justice, Op cit 68.
[75] Ibid 107, 115–116.
[76] 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.
[77] Ibid 11.

participants.[78] In 2017, CMD was broadened to allow persons charged with indictable offences in the Supreme Court to also be referred[79] and access to the program was increased from 80 to 120 participants.[80]

[78] 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.
[79] 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*.
[80] Guy Barnett, 'Increased cap for Court Mandated Diversion program', *Media Release* 7 June 2017.

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.[81] 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).[82]

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.[83]

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

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[81] A Ritter, K Lancaster, Katrina Grech & Peter Reuter, Op cit 9–10.

[82] 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.

[83] 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.

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,[84] 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.[85]

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.[86]

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.[87]

The report was supported by Government and ultimately became the National Strategy for the Fight Against Drugs, which was adopted in 1999.[88] 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.[89] 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 issue[90] and where the emphasis is on education, early intervention and treatment.

[84] 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).

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

[86] 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.

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

[88] Ibid 15.

[89] Ibid 15–16.

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

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.[91]

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".[92] 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.[93]

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.[94] 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.[95] 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.[96] 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.[97]

Penalties that may be imposed include fines as well as non-pecuniary penalties and warnings.[98] 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

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

[92] 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).

[93] Drug trafficking remains a criminal offence subject to imprisonment.

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

[95] 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.

[96] Article 15(4) of the Decree-Law 30/2000.

[97] Article 3 of the Decree-Law 30/2000.

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

community service order and a prohibition on travel abroad.[99] 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.[100] 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".[101] The Commission may also impose sanctions but then suspend the sanctions on the condition that the person undertakes treatment.[102] 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".[103]

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.[104]

A major review of Portugal's decriminalisation reforms was published in 2010 in the *British Journal of Criminology*.[105] 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:

- 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;

[99] Article 17 of the Decree-Law 30/2000.
[100] Article 11(1) of the Decree-Law 30/2000.
[101] Article 11(2) and (3) of the Decree-Law 30/2000.
[102] Article 14 of the Decree-Law 30/2000.
[103] Artur Domosławski, Op cit 30.
[104] 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.
[105] C Hughes and Alex Stevens, 'What can we learn from the Portuguese decriminalization of illicit drugs?' (2010) 50 *British Journal of Criminology*, 999–1022.

- reductions in the retail prices of drugs.[106]

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.[107]

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".[108] 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".[109] 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"[110] and concluded that "[t]he available evidence thus gives grounds for arguing that 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".[111]

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.[112] Whilst the pro-decriminalisation report reported a decrease to 290 drug-related deaths between 2001–06, the prohibitionist report observed that in

[106] Ibid 1017.
[107] Ibid 1018.
[108] 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.
[109] Ibid 105.
[110] Ibid.
[111] Ibid.
[112] Ibid 106.

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).[113] Whilst Hughes and Stevens ultimately determined that drug-related deaths had decreased since 2001,[114] 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".[115] 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".[116]

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.[117]

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:[118]

> 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.

[113] Ibid 107.
[114] Ibid 108.
[115] Ibid.
[116] Ibid 109.
[117] Ibid.
[118] Ibid 111.

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 $160.2 million in 2021-22. 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 $367 million. Finally, the report analyses the health and road accident costs estimating the cost at $54.8 million and $10 million respectively. In summary, Blacklow's report finds that the total cost of illicit drug use in Tasmania in in 2021-22 at $591.9 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 $530.1 million, a financial saving of $61.8 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.

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 2021-22

Dr Paul Blacklow

TASMANIAN SCHOOL OF BUSINESS & ECONOMICS

UNIVERSITY of TASMANIA

Illicit Drug Reform in Tasmania
A Cost Benefit Analysis 2021-22

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NO CONFLICT OF INTEREST

I declare that I know of no conflict of interest that exists that would affect or influence my methodology or assumptions in this project.

DISCLAIMER

The estimates of the current costs of illicit drug use in Tasmania in 2021-22 in this report are based on data from several Australian and Tasmanian government agencies, previous studies and in some places the author's reasoned assumptions.

The estimates of the costs of illicit drug use under decriminalisation in Tasmania in 2021-22 in this report are based upon the current 2021-22 cost estimates above, and previous reports on the effects of decriminalisation moderated by the author's reasoned assumptions.

All sources and assumptions are given in this report, derivable or available from the author upon request. The author recommends that readers read the methodology section and note the assumptions and exercise their own skill and care when interpreting and using the estimates

This 2022 report is a very-low-budget update of the low-budget Blacklow (2017) report *Illicit Drug Reform in Tasmania - A Cost Benefit Analysis*. For this reason, no investigation or update has been conducted into the rate that crimes are attributable to illicit drugs from the 2017 report. In addition, no investigation or update into the effects that decriminalisation will have has been conducted. This report uses the same decriminalisation effects as in Blacklow (2017). This 2022 report does update all total numbers and dollar figures with the latest available data, inflated to 2021-22 using Tasmania's population and Hobart's CPI data.

While all due care has been taken in compiling the estimates, their accuracy and completeness are dependent upon the original data sources, previous studies and assumptions made. In that respect, the author and the University of Tasmania do not represent, warrant, undertake or guarantee that the information in the report is correct, accurate, complete, or non-misleading; or that the use of this report will lead to any particular outcome or result. Furthermore, the author and the University of Tasmania are not responsible or liable for any losses arising from the use of or reliance on this information.

EXECUTIVE SUMMARY

⇒ This report estimates that

- The total Cost of Illicit Drug Use in **Tasmania in 2021-22** under the **current law** is **$591.9 million.**
  - The two largest components of 2021-22 estimate under the current law are crime costs ($160 million) and death and disease cost ($367m), followed by health costs ($55m).
  - 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.

- The total Cost of Illicit Drug Use in **Tasmania in 2021-22** under **decriminalisation is $530.1 million**

- Decriminalisation of Illicit Drug Use in Tasmania in 2021-22 would save **61.8 million or 10.4%** of the 2021-22 cost.
  - The reduction is largely due to a 17.5% decrease in illicit drug death and disease costs and a 2.5% reduction in crime costs, while health and car crash costs, both rise by 10%. The reduction in crime costs results from reduced prison costs, while the death and disease cost result from increased early treatment.

CONTENTS

TABLES

THE PROPOSAL

The investigator will update Blacklow's (2017) *Illicit Drug Reform in Tasmania - A Cost Benefit Analysis* to provide estimates of the

A. cost of illicit drug use Tasmania in 2021-22;

B. the cost of illicit drug use in Tasmania in 2021-22 under decriminalisation.

Deliverables

A brief updated report outlining the methodology and estimates of the costs of illicit drug use in Tasmania in 2021-22, the effects of decriminalisation and the cost of illicit drug use in Tasmania in 2021-22 under decriminalisation.

1 INTRODUCTION

This project will estimate the costs of illicit drug use in Tasmania in 2021-22, the effects of decriminalisation and what that cost would be if the use of illicit drugs were decriminalised. The following section 1.1, briefly outlines what is considered illicit drugs 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 2021-22. In particular, 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 Crashes are given. The effects of decriminalisation on the incidence of the various cost components are discussed in section 2.5 and the assumptions made are listed. The estimates of the cost of illicit drug use in Tasmania under the current law in 2021-22 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 Crashes in section 3.4 and summarised in Section 3.5. Section 4 concludes the report.

From Blacklow (2017) *Illicit Drug Use in Tasmania – A Cost Benefit Analysis 2015-16*

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, the US and Scotland appears to be the highest among OECD countries[1]. 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 relating 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).

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

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 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 a result of its reduced supply over the period.

While the proportion of Australians 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, the 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 the 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 in Australia as a whole and has 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 the 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**
Misuse of Pharmaceuticals	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 2021-22 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 Crashes are given. The effects of decriminalisation on the incidence of the various cost components are discussed in section 2.5 and the assumptions made are listed.

From Blacklow (2016) *Illicit Drug Use in Tasmania – A Cost Benefit Analysis 2015-16*

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 of the 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 for 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 of 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 costs to members of society of their own drug use. Since individuals will only take actions if the benefits to them out ways 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 to drug purity and safety. It also ignores the benefit of 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 crashes. 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 whom 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 costs 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 costs 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 crashes (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 crashes 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 costs 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 premature death in 2021-22. 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 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 (2009) attribute only $57,421 to be the mental cost to friends and relatives cost, resulting in an estimate of just under $400,000 for the value to an individual of their remaining life.

Using the human capital approach BITRE (2009) estimated the loss of life at $2.4m in 2006 (including lost production). They also estimate the cost using the willingness to pay (WTP) method at $6.2 million. 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 is based on international and Australian research. Using this 2006 estimate of $3.5 million and subtracting the 2006 estimate for the loss to friends and family of $500,000 and the personal cost of the death of $500,000 results in an estimate of $2.5 million in lost output per death in 2006. Coroner's costs are inflated to 2021-22 dollars using Hobart's Health CPI, while the other costs of death are inflated by Hobart's All Groups CPI. This provides a 2021-22 estimate of the cost of a loss of life of $5.0m, comprised of a $717,593 loss to self, a $717,593 loss to others and a $3,587,963 loss of production.

A social discount rate of 3%, as per BITRE (2009), is used to divide the 2021-22 lifetime cost of the loss to the individual, others and production to provide an annual cost of the loss of life of $21,528, $21528, and $107,639 respectively. The proportion that each of these costs by

disease/death type is born by society and not internalised by the individual is provided in Table 3, below provides an annual social cost of death, which are applied to the Years of Life Lost (YLL) and Years of Living with Disease (YLD) for each death/disease- type.

Table 3 Social Proportion and Loss of Life Costs per year lost 2021-22

	Social Proportion of Costs			Loss of Life Costs per year lost 2021-22			
death/disease-type	Loss to Individual	Loss to Others	Lost Production	Loss to Individual	Loss to Others	Lost Production	Total
Liver cancer	50%	75%	100%	$10,764	$16,146	$107,639	$134,549
Chronic liver disease	50%	75%	100%	$10,764	$16,146	$107,639	$134,549
Hepatitis B (acute)	50%	75%	100%	$10,764	$16,146	$107,639	$134,549
Hepatitis C (acute)	50%	75%	100%	$10,764	$16,146	$107,639	$134,549
HIV/AIDS	50%	75%	100%	$10,764	$16,146	$107,639	$134,549
Poisoning	50%	50%	100%	$10,764	$10,764	$107,639	$129,167
Suicide and self-inflicted injuries	50%	50%	100%	$10,764	$10,764	$107,639	$129,167
Anxiety disorders	50%	50%	100%	$10,764	$10,764	$107,639	$129,167
Depressive disorders	50%	50%	100%	$10,764	$10,764	$107,639	$129,167
Drug use disorders (excl. alcohol)	50%	50%	100%	$10,764	$10,764	$107,639	$129,167
Schizophrenia	50%	50%	100%	$10,764	$10,764	$107,639	$129,167

2.3 Inflating Estimates to 2021-22

Table 4 Tasmanian Population and the Hobart CPI

	Tasmanian Population		Health CPI - Hobart		All Groups CPI - Hobart	
Year	Number	Growth to 2021-22	Index	Growth to 2021-22	Index	Growth to 2021-22
2000	473,165	20.4%	58.7	161.3%	473,165	20.4%
2006	490,078	16.2%	79.8	92.2%	490,078	16.2%
2011	511,588	11.3%	98.4	55.9%	511,588	11.3%
2013-14	513,207	11.0%	112.0	37.0%	513,207	11.0%
2014-15	514,467	10.7%	117.4	30.7%	514,467	10.7%
2015-16	516,442	10.3%	123.8	23.9%	516,442	10.3%
2016	519,296	9.7%	126.7	21.1%	519,296	9.7%
2018	541,852	5.1%	137.8	11.3%	541,852	5.1%
2018-19	548,059	3.9%	139.9	9.6%	548,059	3.9%
2019	553,992	2.8%	142.8	7.4%	553,992	2.8%
2019-20	559,776	1.7%	144.6	6.1%	559,776	1.7%
2020	563,830	1.0%	145.7	5.3%	563,830	1.0%
2020-21	566,250	0.6%	148.4	3.4%	566,250	0.6%
2021	568,134	0.3%	151.2	1.5%	568,134	0.3%
2021-22	569,568	0.0%	153.4	0.0%	569,568	0.0%

Source: ABS (2022) National, state and territory population March 2022, Table 4; ABS (2022) Consumer Price Index, Australia, Table 5.

Many of the data sources for the number of crimes, death and disease, health and crash incidents and services and their costs are obtained from reports or publications from several years ago and do not pertain to 2021-22. In this report, all earlier estimates of numbers or services are inflated

to 2021-22 by dividing the Tasmanian population for the earlier period and then multiplying by the 2021-22 Tasmanian population. In this report, all earlier estimates of costs are inflated to 2021-22 by dividing Hobart CPI for the earlier period and then multiplying by the 2021-22 Hobart CPI. For medical and health-related costs Hobart's Health CPI is used for all other costs Hobart's All Groups CPI is used. Table 4 Tasmanian Population and the Hobart CPITable 4 provides the four-quarter average of the Hobart All Groups and Health CPI and the Tasmanian population for various years used to inflate numbers and $ figures for 2021-22.

2.4 Cost Components of Illicit Drug Use

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

1. Crime (C)
2. Death and Disease (D)
3. Health (H)
4. Road Crashes (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 to victims, of courts, policing and imprisonment is rarely paid for by the perpetrator. Criminals bear some of the costs of imprisonment through the depravity of liberty and normal living conditions, but many do not internalise these in 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

Crime type	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).

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
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
Fraud, Deception And Related Offences	5
Illicit Drug Offences	100
Weapons And Explosives Offences	25
Property And Environmental Damage	25
Public Order Offences	25
Traffic And Vehicle Regulatory Offences	5
Offences Against Justice	25
Miscellaneous Offences	15
Breaches	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 and Correction Orders

C1 Victim

The number of victims for Tasmania in 2021 by the type of crime was obtained from ABS (2022) *Recorded Crime - Victims, Australia, 2021*, Table 9. These were inflated by multipliers by crime type for the underreporting of crime, from Smith et al. (2014) Table 2 to obtain estimates of the number of crime incidents in Tasmania by the type of crime in 2021.

Table 8 Criminal Incidents 2021-22 Tasmania

Crime Type	Total	Drug Related
Homicide	9	1
Physical assault	7136	1,070
Threatened assault	17840	2,676
Sexual assault	2355	353
Acts Endangering Persons	6	1
Kidnapping/abduction/harassment	3	0
Armed robbery	58	9
Break In	213	85
Blackmail/extortion	3	1
Involving the taking of property	5718	2,287
Attempted break-in	1794	718
Other theft	19848	7,939
Motor vehicle theft	1452	581
Fraud, Deception and Related Offences	569	28
Illicit Drug Offences	1147	1,147
Weapons And Explosives Offences	518	130
Property Damage and Environmental Pollution	1401	350
Public Order Offences	1640	246
Offences Against Justice	677	0
Miscellaneous Offences	829	124
TOTAL	63,216	17,746

Sources: ABS (2022) Recorded Crime - Victims, Australia 2021, Table 9; Smith et al. (2014) Counting the costs of crime in Australia: A 2011 estimate Table 2; ABS(2022) Consumer Price Index, Australia, Table 5; ABS (2022) National, state and territory population March 2022, Table 4; and Table 6 from this report.

These estimates were inflated to 2021-22 by using the Tasmanian population growth. These estimates were multiplied by the proportions attributable to illicit drug use as provided in Table 6 and explained above to obtain estimates of the number of incidents of illicit drug-related crime.

The cost to victims of each type of crime was obtained from Smith et al. (2014) *Counting the costs of crime in Australia: A 2011 estimate*. The costs per crime reported for 2011 were inflated to 2021-22 using the growth in the most appropriate broad expenditure good Hobart CPI component over that period. The exception is the intangible loss of life costs for homicide, for which the total loss of $5.0m is used as explained in section 2.2 are used. See Table 9 below for more details.

Table 9 Victim Costs of Crime 2021-22

	AIC (2014)'s 2011 Estimate*		2021-22 Estimate	
	Tangible Cost	Total Cost	Tangible Cost	Total Cost
Homicide	$10,100	$2,699,000	$15,745	$5,038,893
Physical assault	$1,818	$2,619	$2,834	$4,083
Sexual assault	$500	$4,100	$779	$6,392
Threatened assault	$40	$440	$62	$686
Acts Endangering Persons	$320	$2,620	$499	$4,084
Robbery	$929	$5,118	$1,160	$6,391
Break-in	$2,109	$3,157	$2,634	$3,942
Attempted break-in	$311	$1,010	$389	$1,262
Motor vehicle theft	$4,130	$6,413	$5,157	$8,008
Theft from motor vehicles	$1,026	$1,785	$1,281	$2,229
Property damage	$609	$1,853	$761	$2,314
Other theft	$519	$750	$648	$937
Fraud	$1,305	$1,631	$1,630	$2,037

Sources: Smith et al. (2014) Counting the costs of crime in Australia: A 2011 estimate, various tables; ABS (2022) Consumer Price Index, Australia, Table 5; ABS (2022) National, state and territory population March 2022, Table 4; and Table 6 from this report.

C2 Police

The number of criminal incidents by type of crime, attributable to illicit drug use was estimated using the same data and procedure as for C1 Victims, see Table 8 above.

The Police cost per criminal incident was derived by first inflating the total recurrent expenditure in 2020-21 for Tasmanian from Productivity Commission (2022)'s ROGS, Ch6, Table 6A.1 of $328.4m by the Hobart All Groups CPI to $344.5m for 2021-22. This total expenditure was divided by the total number of criminal incidents, to give a police cost per incident in Tasmanian in 2021-22 of $5,450.

C3 Court

The number of court lodgements by type of crime for 2019-20 and 2020-21 were obtained from the 2020-21 annual reports of the Supreme Court of Tasmanian (2022) and the Magistrates Court of Tasmania (2022). The two financial years were averaged to give a 2020 estimate of the total Supreme Court and Magistrates Court lodgements in Tasmania. These figures were then inflated to 2021-22 using Tasmania's population growth over the period to give estimates of 389 Supreme Court and 20,541 Magistrates Court criminal lodgements in 2021-22. Multiplying the lodgements by crime type by the proportion of crime attributable to illicit drug use in Table 6 gives the estimates of the illicit drug-related court lodgements.

Table 10 Criminal Court Lodgements 2021-22 – Tasmania

	Supreme Court		Magistrates Court	
Crime Type	**Total**	**Drug Related**	**Total**	**Drug Related**
Homicide	0	0	0	0
Physical assault	179	27	2,850	428
Sexual assault	44	7	0	0
Dangerous Or Negligent Acts	33	5	0	0
Armed robbery	31	5	0	0
Break In	43	17	2,324	930
Illicit Drug Offences	59	59	1,116	1,116
Public Order Offences	0	0	1,937	291
Traffic And Vehicle Offences	0	0	5,884	0
Offences Against Justice	0	0	1,442	0
Miscellaneous Offences	0	0	209	31
Breaches	0	0	4,779	717
TOTAL	389	120	20,541	3,513

Sources: Supreme Court of Tasmania (2022) *Annual Report 2020/2021*, Page 25; Magistrates Court of Tasmania (2022) *Annual Report 2020 to 2021,* Tables 9 and 10; and ABS (2022) *National, state and territory population March 2022,* Table 4.

The net recurrent criminal expenditure in 2019-20 for the Tasmanian Supreme Court and the Tasmanian Magistrates Court was obtained from Productivity Commission (2022) ROGS Ch7, Table 7A.11 as $9.8m and $10.7m. These estimates were inflated by the Hobart All groups CPI to $10.5m and $11.4m respectively and then divided by the total lodgements, as given above, to give a 2021-22 cost per criminal lodgement in the Supreme Court of $26,998 and Magistrates Court of $556.

C4 Prison and Correction Orders

The number of prisoners by crime was obtained from ABS (2022) *Prisoners in Australia* 2021, Table 16. The average number of persons in community correction over 2021-22 was derived from the 2021-22 figures from ABS (2022) *Corrective Services, Australia, June 2022,* Table 15. These 2107 community correction orders were attributed to each non-violent crime type, based on the share of incidents each non-violent crime type formed of this total derived from Table 8 in this report. Table 11, below provides the estimates of prisoners and community correction orders in total and attributed to illicit drug use.

Table 11 Prisoners and Community Correction Orders 2021-22 - Tasmania

	Prisoners		Community Corrections	
Crime Type	**Total**	**Drug Related**	**Total**	**Drug Related**
Homicide	67	10	0	0
Physical assault	154	23	0	0
Sexual assault	82	12	0	0
Acts Endangering Persons	25	4	0	0
Kidnapping/abduction/harassment	0	0	0	0
Armed robbery	56	8	0	0
Break In	36	14	36	14
Blackmail/extortion	0	0	0	0
Involving the taking of property	25	10	100	40
Attempted break-in	0	0	31	12
Other theft	0	0	14	6
Motor vehicle theft	0	0	15	6
Fraud, Deception And Related Offences	10	1	41	2
Illicit Drug Offences	48	48	214	214
Weapons And Explosives Offences	28	7	97	24
Property And Environmental Damage	13	3	87	22
Public Order Offences	0	0	306	46
Traffic And Vehicle Regulatory Offences	24	0	0	0
Offences Against Justice	71	0	126	0
Miscellaneous Offences	5	1	155	23
Breaches	0	0	885	133
TOTAL	644	141	2107	542

Sources: ABS (2022) Prisoners in Australia 2021, Table 16; ABS (2022) Corrective Services, Australia, June 2022, Table 15; and Table 8 from this report.

Prisoner and community correction order recurrent expenditure was obtained from the Productivity Commission (2022) ROGS, Ch8, Table 8A.8 for Tasmania in 2019-20 and inflated by Hobart's All Groups CPI to 2021-22 to be $112.0 and $17.4m respectively. Dividing by the total number of prisoners and community correction orders gives 2021-22 Tasmanian cost estimates of $173,857 per prisoner and $8,268 per person in community correction.

2.4.2 (D) Death and Disease

The total number of deaths, YLL and YLD in Tasmania for 2018 by death-disease type was obtained from the Australian Institute of Health and Welfare (2018) *Australian Burden of Disease Study*, supplementary tables, Table 1C. These estimates were inflated to 2021-22 using Tasmania's population. Table S3 also from AIHW (2018) supplementary tables, provides the deaths, YLL and YLD attributable to illicit-drug use for each death-disease type for Australia. The proportion that illicit-drug use of the deaths, YLL and YLD for each death-disease type for Australia, is used to attribute the total Tasmanian deaths, YLL and YLD to illicit drug use.

Table 12 Deaths, YLL, YLD and DALY 2021-22 - Tasmania

	Population			Drug Users		
Disease/Death	**deaths**	**YLL**	**YLD**	**deaths**	**YLL**	**YLD**
Liver cancer	43	749	12	11	200	3
Chronic liver disease	63	1,393	86	17	371	23
Hepatitis B (acute)	0	0	0	0	0	0
Hepatitis C (acute)	0	0	0	0	0	0
HIV/AIDS	0	1	79	0	0	6
Poisoning	36	1,345	17	26	977	12
Suicide and self-inflicted injuries	82	3,046	34	10	376	4
Anxiety disorders	1	3	2,283	0	0	0
Depressive disorders	2	14	2,445	0	0	1
Drug use disorders (excl. alcohol)	0	5	825	0	5	825
Schizophrenia	2	79	764	0	0	5
Total	229	6,635	6,545	64	1,929	879

Source: AIHW (2018) Australian Burden of Disease Study 2018 Tables 1C and S3, and derived by the author.

Notes: YLL = Years of Life Lost, YLD = Years Living with Disease, DALY = YLL + YLD

2.4.3 (H) Health

Many of the health costs of illicit drug use are also external or social costs 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 13 below provides a breakdown of the health-related cost components of illicit drug use.

Table 13 Health Cost Components of Illicit Drug Use

H1	Ambulances
H2	Emergencies
H3	Hospitalisations
H4	Mental Health
H5	Treatment

H1 Ambulances

The number of ambulance incidents in Tasmania in 2019-20 was 83,947 according to the Productivity Commission (2022) ROGS, Ch.11 Table 11A.2. Tasmania's population growth from 2019-20 to 2021-22 was used to provide an estimate of 85,415 ambulance incidents in Tasmania in 2021-22.

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 in 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. Applying 1.66% to the 85,415 ambulance incidents in Tasmania gives an estimate of 1,414 illicit drug-related ambulance incidents in 2021-22 for Tasmania.

Productivity Commission (2022) ROGS, Ch.11 Table 11A.1 reports that total expenditure on ambulance responses in Tasmania was $108.3m in 2019-20. The growth in Hobart's Health CPI from 2019-20 to 2021-22 was applied to provide an estimate of $114.9m total ambulance

expenditure in 2021-22. Dividing by the estimate of the number of ambulance incidents in Tasmania in 2021-22 from above provides an estimate of $1,345 per ambulance incident in 2021-22.

H2 Emergencies

There were 114,044 admitted and 52,470 non-admitted emergency presentations in Tasmania in 2018-19 according to Productivity Commission (2022) ROGS, Chapter 12, Table 12A.60. Tasmania's population growth from 2019-20 to 2021-22 was used to provide an estimate of 118,520 admitted and 54,529 non-admitted emergency presentations in Tasmania in 2021-22.

The proportion of emergency presentations attributable to illicit drug use for Australia in 2013-14 was derived as 0.64% from Productivity Commission (2016) ROGS, Chapter 11.A66 and 11A.67 Emergency department presentations by Urgency Related Groupings (URG) codes - presentations. Given illicit drug use in Tasmania is 10.7% higher than in Australia the 0.64% proportion was inflated by 10.7% to give the proportion of emergencies due to illicit drug use of 0.71% for Tasmania. This figure was applied to the number of admitted and non-admitted emergency presentations derived above to provide an estimate of 842 non-admitted and 387 admitted illicit drug-related presentations in Tasmania in 2021-22.

The expenditure in Tasmania for 2018-19 on non-admitted and admitted emergency presentations was $47.7m and $81.0m and was obtained from Productivity Commission (2022) ROGS, Chapter 12, Table 12A.60. The growth in Hobart's Health CPI from 2019-20 to 2021-22 was applied to provide expenditure estimate of $54.3m and $92.3m for non-admitted and admitted emergency presentations in 2021-22. Dividing by the estimate of the number of emergencies in Tasmania in 2021-22 from above provides cost estimates of $458 per non-admitted and $1,693 per admitted emergency in 2021-22. The cost of illicit drug-related emergencies in Australia in 2015-16 is reported as being $818 in Productivity Commission (2017) ROGS, Ch.11 Table A67, which was 40.3%, higher than the average cost of emergency presentations of $583. For this reason, the cost per emergency given above was increased by 40.3%, to give cost estimates of $643 per non-admitted and $2,376 per illicit drug-related admitted emergency in 2021-22 for Tasmania.

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 2018–19. In particular, Table S5.7: Same-day acute separations and Table S5.7: Overnight acute separations by Major Diagnostic Category AR-DRG version 7.0, public hospitals, states and territories. These figures were increased by Tasmania's population growth from 2018-19 to 2021-22.

The Productivity Commission (2022) ROGS Ch12, Tables 12A.58 and 12A.59 report the average recurrent and capital costs per acute separation in 2018-19 for Tasmania. The sum of these figures was inflated to 2021-22 prices using Hobart's Health CPI, to provide an estimate of $7,084 per acute separation overnight separation. The cost per same-day separations was assumed to be the same as the average cost per admitted acute emergency department presentation from Productivity Commission (2022) ROGS Ch12, Tables 12A.60. This 2018-19 estimate was inflated to 2021-22 prices using Hobart's Health CPI, to provide an estimate of $1,693 for the cost of same-day acute separation ins Tasmania in 2021-22.

H4 Mental Health

The Australian Institute of Health and Welfare (2015) Mental Health Services Table 12A.20 reports 12.7% of total GP mental health encounters that are illicit drug-related. This report assumes 10% of federal and state government expenditure on mental health is due to illicit drug use.

Government mental health expenditure on:

- Specialised psychiatric units or wards in public acute hospitals
- Community mental health care services
- Residential mental health services
- Community Health Treatment Services,
- Grants to non-government organisations and Other indirect expenditure

in 2019-20 for Tasmania, was obtained from the Australian Institute of Health and Welfare (2022a) *Australian government expenditure on mental health-related services*, Table EXP2. The average annual change in each of these items over the previous 5 years (also reported in the same table) was applied to provide 2021-22 estimates. Australian government Medicare

expenditure on mental health-specific services (MBS) and mental health prescriptions (PBS) for Tasmania in 2019-20, was obtained from the Australian Institute of Health and Welfare (2022a), *Australian government expenditure on mental health-related services*, Table EXP18 and EXP30, respectively. The average annual change in each of these items over the previous 5 years (also reported in each of the tables) was applied to provide 2021-22 estimates. The sum of these seven expenditure items, $194.6 million provides an estimate of the total amount spent on mental health in Tasmania by the Australian and Tasmanian governments.

H5 Treatment

The number of treatment episodes for illicit drugs by treatment type in Tasmania in 2020-21 was obtained from the Australian Institute of Health and Welfare (2022b)'s. *Alcohol and other drug treatment services in Australia 2020–21*, Table ST TAS.6, Table ST TAS.14, and Table ST TAS.17 were used to obtain the proportion of residential and non-resident treatment services. These figures were inflated by Tasmania's population growth to provide 2021-22 estimates.

The average cost per residential treatment is assumed to be $26,133 and the average cost per non-residential treatment is assumed to be $3,267 in 2021-22. 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.

Table 14 Health Services 2021-22 Tasmania

Health Component	Total*	Drug Related
H1 Ambulances	85,415	1,175
H2 Emergencies		
Admitted Emergencies	54,529	387
Non-Admitted Emergencies	118,520	842
H3 Hospitalisations		
Overnight acute*	60,466	2,968
Same-day acute*	72,840	1,670
H4 Mental Health Services		
Australian Government Expenditure		10%
Tasmanian Government Expenditure		10%
H5 Care and Other		
Residential Care		131
Other Treatment		1,479

2.4.4 (R) Road Crashes

The number of fatal and serious road crashes in Tasmania in 2020 and 2021 was obtained from the Department of State Growth (2022)'s Transport Services, Tasmanian Crash Statistics. The same data up to October 2022 was obtained from, BITRE (2022), the Australian Road Deaths Database and then multiplied by 12/10 to include the remaining months of 2022. The data on road crashes is more variable than usual due to the impacts of Covid on road use and concentration. For this reason, the numbers obtained for 2020, 2021 and 2022 are averaged to provide an estimate for 2021, which is then inflated by Tasmanian's population growth to 2021-22. The number of minor crashes and those with no injury for Tasmania in 2019 and 2020 were obtained via www.data.gov.au, which contains the Department of State Growth (2022)'s Tasmania Crash Statistics 2010-20. These numbers were averaged to provide an estimate for 2019-20, which is then inflated by Tasmanian's population growth to 2021-22. The estimates obtained are contained in Table 15 below.

Table 15 Road Crashes by Severity 2021-22 - Tasmania

Severity	Total	% Drug Attributed	Drug Related
Fatal	41	3.3%	1.4
Serious	234	1.7%	4
Minor	1,380	1.1%	15
Uninjured	4,579	0.4%	17.5
Total	62,343	0.6%	37.9

Source: Tasmania Department of State Growth (2022), BITRE (2022), 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 the degree of a 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 on the social cost of harmful drug use in New Zealand of 2.3%. Table 15 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.

The costs of fatal, serious crashes, minor and other crashes for Tasmania in 2006 were obtained from BITRE (2009) Table T7.4 and inflated by Health CPI for Hobart to provide an estimate for 2021-22.

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 that is used to inform the assumptions about the impact of decriminalisation in Tasmania.

2.5.1 Illicit Drugs Use under Decriminalisation

Pacula (2010) in a 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 an 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 16. The results suggest that 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 16 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 assumed % change in crime, by crime type, upon decriminalisation. This change is used to alter the number of illicit drug-related incidents for the Victim, Police costs, criminal court lodgements for Court Costs and the number of prisoners and community correction orders for Prison and Correction Order Costs.

Assumption of Decriminalisation:

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

Table 17 Change in Crimes After Decriminalisation

Crime Type	Change
Homicide	-20%
Physical assault	-20%
Sexual assault	-20%
Acts Endangering Persons	-20%
Kidnapping/abduction	-20%
Armed robbery	-20%
Attempted break-in	+0%
Motor vehicle theft	+0%
Fraud, Deception and Related Offences	+0%
Illicit Drug Offences	-50%
Weapons And Explosives Offences	+0%
Property and Environmental Damage	+0%
Public Order Offences	+0%
Offences Against Justice	+0%
Miscellaneous Offences	+0%

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 that drug-related deaths from disease and the 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 that 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 Crashes under Decriminalisation

The number of road crashes 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 Crashes 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 2021-22 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 Crashes in section 3.4 and summarised in Section 3.5.

3.1 (C) Crime Costs of Illicit Drugs in Tasmania 2021-22

Table 18 shows that police costs are the largest component of the Crime related social costs of illicit drug use, which accounted for 60% of the total in 2021-22. The other two largest contributors to the Crime related costs of illicit drug use are Victim and Prison costs, which contributed 18% and 15% respectively. Given the assumptions of decriminalisation in this report of a 10% increase in illicit drug use but a decrease in violent illicit drug-related crime, the total illicit-drug related Crime costs decrease by only 2.5% or $4 million. The majority of this decrease in costs occurs in Prison costs due to the assumed decrease in the rates of illicit-drug-related incarceration.

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

Crime Component	Current Law			Decriminalisation			Difference	
	n	$/n	Cost ($m)	n	$/n	Cost ($m)	($m)	(%)
Victim	17,746	$1,650	$29.3	17,357	$1,720	$29.9	$0.6	1.9%
Police	17,746	$5,450	$96.7	17,988	$5,450	$98.0	$1.3	1.4%
Court - Supreme	120	$26,998	$3.2	89	$26,998	$2.4	-$0.8	-25.8%
Court - Magistrates	3,513	$556	$2.0	3,157	$556	$1.8	-$0.2	-10.1%
Prison	141	$173,857	$24.5	116	$173,857	$20.2	-$4.3	-17.7%
Community Corrections	542	$8,268	$4.5	478	$8,268	$4.0	-$0.5	-11.8%
TOTAL CRIME			**$160.2**			**$156.2**	**-$4.0**	**-2.5%**

3.2 (D) Death and Disease Costs of Illicit Drugs in Tasmania 2021-22

Table 19 Death/Disease Costs of Illicit Drugs in Tasmania - Current and Decriminalisation

Health Component	Cost ($/n)	Current Law		Decriminalisation		Difference	
		n	Cost ($m)	n	Cost ($m)	($m)	(%)
Coroner's Cost							
Liver cancer	$15,745	11	$0.2	9	$0.1	-$0.03	-18.2%
Chronic liver disease	$15,745	17	$0.3	14	$0.2	-$0.05	-17.6%
Hepatitis B (acute)	$15,745						
Hepatitis C (acute)	$15,745						
HIV/AIDS	$15,745						
Poisoning	$15,745	26	$0.4	21	$0.3	-$0.08	-19.2%
Suicide and self-inflicted injuries	$15,745	10	$0.2	8	$0.1	-$0.03	-20.0%
Anxiety disorders	$15,745						
Depressive disorders	$15,745						
Drug use disorders (excluding alcohol)	$15,745						
Schizophrenia	$15,745						
TOTAL Coroner's Costs		64	$1.0	52	$0.8	-$0.19	-18.8%
Years of Living Lost (YLL)							
Liver cancer	$134,549	200	$26.9	165	$22.2	-$4.7	-17.5%
Chronic liver disease	$134,549	371	$49.9	306	$41.2	-$8.7	-17.5%
Hepatitis B (acute)	$134,549						
Hepatitis C (acute)	$134,549						
HIV/AIDS	$134,549						
Poisoning	$129,167	977	$126.2	806	$104.1	-$22.1	-17.5%
Suicide and self-inflicted injuries	$129,167	376	$48.6	310	$40.0	-$8.5	-17.6%
Anxiety disorders	$129,167						
Depressive disorders	$129,167						
Drug use disorders (excluding alcohol)	$129,167	5	$0.6	4	$0.5	-$0.1	-20.0%
Schizophrenia	$129,167						
TOTAL YLL		1,929	$252.2	0	$208.0	-$44.2	-17.5%
Years of Living with Disease (YLD)							
Liver cancer	$134,549	3	$0.4	2	$0.3	-$0.1	-33.3%
Chronic liver disease	$134,549	23	$3.1	19	$2.6	-$0.5	-17.4%
Hepatitis B (acute)	$134,549						
Hepatitis C (acute)	$134,549						
HIV/AIDS	$134,549	6	$0.8	5	$0.7	-$0.1	-16.7%
Poisoning	$129,167	12	$1.6	10	$1.3	-$0.3	-16.7%
Suicide and self-inflicted injuries	$129,167	4	$0.5	3	$0.4	-$0.1	-25.0%
Anxiety disorders	$129,167						
Depressive disorders	$129,167	1	$0.1	1	$0.1	$0.0	+0.0%
Drug use disorders (excluding alcohol)	$129,167	825	$106.6	681	$88.0	-$18.6	-17.5%
Schizophrenia	$129,167	5	$0.6	4	$0.5	-$0.1	-20.0%
TOTAL YLD		879	$113.7	0	$93.8	-$19.9	-17.5%
TOTAL DEATH AND DISEASE			**$367.0**		**$302.6**	**-$64.3**	**-17.5%**

The assumptions of a 10% increase in illicit-drug use combined with a 25% decrease in the amount of illicit-drug-related death and disease results in a net decrease of 17.5% in the reduction of the total Death and Disease cost of illicit drug use. Given the total cost of Death and Disease cost related to illicit-drug in 2021-22 is estimated to be $367 million, this is a saving of $64 million as shown in Table 19. The largest contributors to the total Death and Disease costs of illicit drug use in 2021-22 are YLL from suicide, poisoning and liver disease and YLD for drug use disorders. These are also the areas where the greatest savings are estimated to be made upon decriminalisation.

3.3 (H) Health Costs of Illicit Drugs in Tasmania 2021-22

Table 20 Health Costs of Illicit Drugs in Tasmania - Current and Decriminalisation

Health Component	Cost ($/n)	Current Law		Decriminalisation		Difference	
		n	Cost ($m)	n	Cost ($m)	($m)	(%)
Ambulances	$1,345	1,414	$1.9	1,167	$1.6	-$0.3	-17.5%
Emergencies	$1,189	1,229	$1.5	1,014	$1.2	-$0.3	-17.5%
Admitted	$2,376	387	$0.9	319	$0.8	-$0.2	-17.6%
Non-Admitted	$643	842	$0.5	695	$0.4	-$0.1	-17.5%
Total Hospitalisations	$5,143	4,638	$23.9	3,826	$19.7	-$4.2	-17.5%
Overnight acute	$7,084	2,968	$21.0	2,448	$17.3	-$3.7	-17.5%
Same-day acute	$1,693	1,670	$2.8	1,378	$2.3	-$0.5	-17.5%
Mental Health			$19.3		$26.5	$7.2	+37.5%
Australian Government			$4.5		$6.1	$1.7	+37.5%
Tasmanian Government			$14.8		$20.4	$5.6	+37.5%
Treatment	$5,127	1,610	$8.3	2,214	$11.4	$3.1	+37.5%
TOTAL HEALTH			**$54.8**		**$60.3**	$5.6	+10.2%

Table 20 shows the 2021-22 estimate of the total Health costs related to illicit drug use in Tasmania was $55 million, with hospitalisations ($24 million), Mental Health Services ($19 million) and Treatment ($8 million) the biggest contributors. The assumptions made about decimalisation are reflected in the far-right column of Table 20 in the change in the cost of each component of total Health costs related to illicit drug use. The 37.5% assumed increase in Treatment and Mental Health Services related, but a 17.5% decline in other Health costs, results in an overall increase in Health costs related to illicit drug use in Tasmania of $5.6 million.

3.4 (R) Road Crashes Costs of Illicit Drugs in Tasmania 2021-22

Table 21 Road Costs of Illicit Drugs in Tasmania - Current and Decriminalisation

Severity	Cost ($/n)	Current Law		Decriminalisation		Difference	
		n	Cost ($m)	n	Cost ($m)	($m)	(%)
Fatal	$5,120,671	1	$7.2	2	$7.9	$0.72	+10.0%
Serious	$511,333	4	$2.0	4	$2.2	$0.20	+10.0%
Minor	$28,348	15	$0.4	17	$0.5	$0.04	+10.0%
Uninjured	$18,898	18	$0.3	19	$0.4	$0.03	+10.0%
TOTAL ROAD CRASHES			**$10.0**		**$11.0**	**$1.00**	**+10.0%**

The assumption of a 10% increase in illicit-drug use results in a 10% increase in the number and cost of Road Crashes in Tasmania related to illicit drug use, resulting in a $1 million increase in costs under decriminalisation.

3.5 Total Costs of Illicit Drugs in Tasmania 2021-22

Table 22 provides a summary of the estimates of the social costs related to illicit drug use in Tasmania in 2021-22 under the current law and under decriminalisation. While Health and Road Crash costs are estimated to increase by 10% under decriminalisation, resulting in a combined $6.6 million increase in costs, this is more than offset by the 17.5% decline in Death and Disease Costs, which results in a $64.3 million saving. The 2.5% reduction in overall Crime costs related to illicit drug use under decriminalisation also results in a $4.0 million saving.

Table 22 Total Costs of Illicit Drugs in Tasmania 2021-22 - Current and Decriminalisation

	Current Law Cost ($m)	Decriminalisation Cost ($m)	Difference ($m)	(%)
TOTAL CRIME	$160.2	$156.2	-$4.0	-2.5%
TOTAL DEATH AND DISEASE	$367.0	$302.6	-$64.3	-17.5%
TOTAL HEALTH	$54.8	$60.3	$5.6	10.2%
TOTAL ROAD CRASHES	$10.0	$11.0	$1.0	10.0%
TOTAL COST	**$591.9**	**$530.1**	**-$61.8**	**-10.4%**

Note: All figures are in 2021-22 prices

4 CONCLUSION

This report has provided estimates of the costs of illicit drug use in Tasmania in 2021-22 and what that cost would be if the use of illicit drugs was decriminalised. The principal 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 2021-22 is estimated to be $592m.

The two largest components of this cost are the crime costs ($160 million) and death and disease cost ($367m), followed by health costs ($55m). 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.

Based on the assumptions made in section 2.5 this report estimates that the costs of illicit drug use in Tasmania in 2021-22 if their use was decriminalised would fall by 10.4% and be reduced by $62 million.

The estimate of costs due to illicit drug use in Tasmania after decriminalisation is $530m, or approximately a 10% reduction from the 2021-22 cost. This is despite an assumed 10% increase in the use of illicit drugs under decriminalisation. The reduction is largely due to a 17.5% decrease in illicit drug death and disease costs and a 2.5% reduction in crime costs, while health and car crash costs, both rise by 10%. The reduction in crime costs results from reduced prison costs, while the death and disease cost result from increased early treatment.

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 $592m cost occurs each and every year into the future.

The author believes the current cost estimates derived for Tasmania in 2021-22 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 influences the estimates the most is the value of a productivity loss of life at 3.5 million generally applied as $107,639 per year of life lost (YLL).

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 was 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 2021-22. Future studies could obtain more accurate estimates by explicitly modelling the demand and supply of illicit drugs, although data is limited.

Yours sincerely,

Dr Paul Blacklow
Chief Investigator
12 January 2023

5 REFERENCES

Australian Bureau of Statistics (2016b). *Causes of Death, Australia, 2015*. ABS 3303.0, Canberra: Australian Bureau of Statistics (ABS).

Australian Bureau of Statistics (2022c). *Consumer Price Index, Australia, September 2022*. ABS 6401.0, TABLE 5. CPI: Groups, Index Numbers by Capital City, Canberra: Australian Bureau of Statistics (ABS). https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/consumer-price-index-australia/latest-release.

Australian Bureau of Statistics (2022d). *Prisoners in Australia* 2021, Table 16 PRISONERS, Indigenous status and most serious offence/charge by state/territory, ABS 4517.0, Canberra: Australian Bureau of Statistics (ABS), https://www.abs.gov.au/statistics/people/crime-and-justice/prisoners-australia/latest-release .

Australian Bureau of Statistics (2022e). *Recorded crime - Victims, Australia 2021*. TABLE 9 Victims, Selected offences by states and territories, 1993–2021, Canberra: Australian Bureau of Statistics (ABS). https://www.abs.gov.au/statistics/people/crime-and-justice/recorded-crime-victims/latest-release

Australian Bureau of Statistics (2016f). *Recorded Crime - Offenders, 2021-22.* ABS 4510.0. Canberra: Australian Bureau of Statistics (ABS).

Australian Bureau of Statistics (2022a). *Corrective Services, Australia, June 2022,* TABLE 15 Persons in Community-Based Corrections By sex, ABS 4512.0. Canberra: Australian Bureau of Statistics (ABS). https://www.abs.gov.au/statistics/people/crime-and-justice/corrective-services-australia/latest-release

Australian Bureau of Statistics (2017b). *Crime Victimisation, Australia, 2021-22.* ABS 4530.0. Canberra: Australian Bureau of Statistics (ABS).

Australian Bureau of Statistics (2017c). *Criminal Courts, Australia, 2021-22.* ABS 4513.0. Canberra: Australian Bureau of Statistics (ABS).

Australian Bureau of Statistics (2022c). *National, state and territory population, March 2022,* TABLE 4 Estimated Resident Population, States and Territories, ABS 3101.0. Canberra: Australian Bureau of Statistics (ABS). https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release.

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 (2022a) *Australian government expenditure on mental health-related services.* https://www.aihw.gov.au/mental-health/topic-areas/expenditure

Australian Institute of Health and Welfare (2022b) *Alcohol and other drug treatment services in Australia 2020–21*, https://www.aihw.gov.au/reports-data/health-welfare-services/alcohol-other-drug-treatment-services/data

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)

Blackow, P. (2017), *Illicit Drug Reform in Tasmania - A Cost Benefit Analysis,* Hobart: University of Tasmania and Tasmanian Community Legal Centres Tasmania.

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 (2022), *Australian Road Deaths Database*. https://www.bitre.gov.au/statistics/safety/fatal_road_crash_database, accessed on 12.12.2022.

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 (2009), *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/atsbguest/Road%20Deaths%20by%20State%20and%20Territory.txd

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

Department of State Growth (2022). *Transport Services, Tasmanian Crash Statistics*, https://www.transport.tas.gov.au/road_safety_and_rules/crash_statistics, and https://data.gov.au, accessed on 12.12.2022.

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.

Magistrates Court of Tasmania (2022), *Magistrates Court of Tasmania Annual Report 2020 to 2021*, Hobart: Magistrates Court of Tasmania.

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 paper WR-770-RC.

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 (2022), *Report on Government Services*, 7 June 2022, Canberra: Productivity Commission, https://www.pc.gov.au/ongoing/report-on-government-services viewed and downloaded on December 2022.

Productivity Commission (2016), *Report on government services 2016*, Canberra: Productivity Commission, https://www.pc.gov.au/ongoing/report-on-government-services viewed and downloaded 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. https://www.aic.gov.au/publications/rpp/rpp129

Stafford, J. and C. Breen (2015), *AUSTRALIAN DRUG TRENDS Findings from the Illicit Drug Reporting* ,System (IDRS)Australian Drug Trends Series No. 145.

Supreme Court of Tasmania (2022), *Annual Report 2020/2021*, Hobart: Supreme Court of Tasmania.

Tasmania Department of State Growth (2014), Tasmanian Vehicle Crash Database, http://data.gov.au/dataset/tasmanian/resource/fbdb3f0c-fce0-4acc-8cb7-d455855f9d9a