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NSW Parliamentary Research Service

Illegal drug use and possession: Current policy and debates

Briefing Paper No 4/2016

By Tom Gotsis, Chris Angus and Lenny Roth

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ISSN 1325-5142

ISBN 978-0-7313-1945-9

August 2016

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SUMMARY

Government policy to address illegal drug use and possession is an ongoing topic of debate both in Australia and internationally. One part of this debate concerns the effectiveness of the criminalisation of drug use as a means of minimising drug-related harms. Illegal drug use and related deaths at music festivals is a topic of current concern in NSW. The NSW Government is reviewing the regulation of these events but has rejected options put forward by some stakeholders, including allowing pill testing and amnesty bins. Another topic on the agenda is the suggestion by drug law reform proponents that ice users be allowed to attend a medically supervised smoke inhalation room. An upcoming forum for discussing these issues is the Parliamentary Cross-Party Harm Minimisation Roundtable, to be held on 11 August at the NSW Parliament. **[1]**

Drug use in NSW and Australia

The distinction between legal and illegal drugs is socially determined and has evolved over time. For instance, heroin was available on prescription until 1953 and was used so widely as a painkiller and in cough mixtures that Australians were amongst the world's largest consumers of opium. It was not until the 1960s, however, that recreational drug use became more visible, counter-cultural and widespread. **[2.1]–[2.2]**

The Australian Institute of Health and Welfare's (AIHW) *National Drug Strategy Survey (2013)* found the following drug use patterns for the NSW population aged 14 years and over:

- "illicit use of drugs" (which includes the use of illegal drugs and the misuse of pharmaceuticals) fell from 19.8% in 1998 to 14.2% in 2013;
- 9.5% used cannabis in the preceding 12 months;
- less than 0.1% used heroin in the preceding 12 months;
- 2.7% used cocaine in the preceding 12 months;
- 1.4% used meth/amphetamines in the preceding 12 months; and
- 2.4% used ecstasy in the preceding 12 months.

Significantly, the percentage of meth/amphetamine users in NSW aged 14 years and older who used ice (the crystalline form of methamphetamine) increased from 14.7% in 2010 to 41.9% in 2013. **[2.3]**

Personal and community harms from illicit drug use

Individual harms associated with illicit drug use include the risk of drug dependence, as well as adverse mental and physical outcomes that range from the insignificant to the fatal. Community costs can include: crime used to fund personal drug use; drug-related violent crimes; treatment and other health costs; criminal justice costs; and social dysfunction. While there remains considerable concern over harms arising from illicit drugs, substantial harms also arise from the use of legal drugs, notably alcohol and tobacco, both of which are more frequently used by Australians than illicit drugs. **[3.1]-[3.3]**

Possible responses to recreational drug use

There exist a number of possible social and institutional responses to drug use, each reflecting a particular social perspective on the issue. For example, drug use may be viewed as a health issue, as occurs with alcohol and tobacco, that warrants public education and treatment services; or it may be viewed as a criminal justice issue that warrants deterrence and punishment. A more nuanced perspective can also be adopted, one that incorporates education, health and criminal justice concerns. **[4.1]**

National policy: Since 1985, Australia has had a national drug policy. The current *National Drug Strategy (2010-2015)* accepts that the eradication of illegal drug use is not achievable. As a necessary alternative, it adopts the goal of harm minimisation, which it seeks to achieve by means of the three pillars of: demand reduction, supply reduction and harm reduction. Other relevant policies, which reflect the policy framework established by the *National Drug Strategy*, include: the *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014–2019*; and the *National Ice Action Strategy*. **[4.2]-[4.3]**

NSW policy: NSW has no separate overarching drug policy, operating as it does under the *National Drug Strategy*. State Plans have often referred to individual projects, such as strengthening the NSW Drug Court, and the State Health Plan refers to drug treatment services. **[4.4]**

In 1999, the NSW Drug Summit was held, in part as a response to public concern over heroin overdoses. Proposals for the decriminalisation of cannabis use and possession raised at the Summit were not accepted by the Government. Nevertheless, in line with the national policy of harm minimisation, the Drug Summit led to the expansion of treatment services, the introduction of the Cannabis Cautioning Scheme and the introduction of the Medically Supervised Injecting Centre. **[4.4]**

NSW drug laws

Generally speaking, the use of drugs for medicinal and scientific purposes is regulated under the *Poisons and Therapeutic Goods Act 1996*. The use of drugs for recreational purposes is — with the notable exception of tobacco and alcohol — prohibited under the *Drug Misuse and Trafficking Act 1985*. **[5.2]**

Possession and use offences: Possession and use of prohibited drugs are summary offences under, respectively, ss 10(1) and 12(1) of the *Drug Misuse and Trafficking Act 1985*. Both offences carry a maximum penalty of $2,200 and/or a term of imprisonment of 2 years. In the NSW Local Court between January 2012 and December 2015 there were 34,192 cases where the principal offence was possession of a prohibited drug and 202 cases where the principal offence was use of a prohibited drug. Most of these cases were sentenced by way of a "s 10 bond", which does not involve a conviction being recorded, or by way of a fine. Custodial sentences were rarely imposed. **[5.2]**

Random roadside drug testing: In 2006 random roadside drug testing was introduced in NSW, allowing police to test drivers for the presence of prescribed illicit drugs in oral fluid. The Government has recently confirmed that drivers will be charged if they test positive for any amount of illicit drugs in their system. This has been a matter of recent debate, following media coverage of cases where a person was charged at least several days after last using a drug. **[5.3]**

Diversion programs: NSW's approach to illegal drugs incorporates a range of criminal justice diversion programs. These include:

- warnings, cautions and youth justice conferences under the *Young Offenders Act 1997*;
- the Cannabis Cautioning Scheme;
- the Magistrates Early Referral into Treatment Program; and
- the Drug Court.

Empirical evaluations have supported the effectiveness of these programs. **[5.4]**

The NSW Law Reform Commission has recommended that: the Cannabis Cautioning Scheme be expanded to cover possession of small quantities of other prohibited drugs; and that consideration should be given to expanding the operation of the MERIT program and the Drug Court program. **[5.5]**

Harm reduction programs: Two major harm reduction programs introduced in NSW are the Needle and Syringe program (which commenced in 1986) and the Medically Supervised Injecting Centre (which commenced in 2001). Evaluations have supported the effectiveness of these programs:

- Between 2000 and 2009 an estimated 23,324 HIV cases and 31,953 Hepatitis C cases were averted by the Needle and Syringe Program. The $81 million spent on the program over that period resulted in a net financial saving of $432 million to the NSW health system.
- The Medically Supervised Injecting Centre has been shown to save "at least $658,000 per annum over providing similar health outcomes through other means in the health system". From May 2001 to April 2010, it managed 3,426 overdose events with no deaths onsite. **[5.5]**

Music festivals

Music festivals are a popular feature of youth culture in Australia and around the world. While they have been shown to have a positive impact on the psychological and social well-being of young adults, music festivals are also a social space within which prohibited drug use is common. For instance, in one day 184 people attending the 2016 Field Day festival were charged with drug related offences and 212 people received medical attention. After the festival, Premier Mike Baird and Deputy Premier Troy Grant said organisers of music festivals may have to comply with stricter screening requirements in future or risk being shut down. **[6.1]**

Advocates of drug law reform have argued that drug harm at music festivals could be reduced if pill testing and amnesty bins were introduced. They further argue that the use of drug detection dogs at music festivals should be discontinued because their use by police increases, rather than decreases, drug related harm. The NSW Government opposes the introduction of pill testing and amnesty bins at music festivals, and has indicated that it will continue, or possibly expand, the use of drug detection dogs at music festivals. **[6.2]-[6.4]**

The law reform debate: prohibition or decriminalisation?

Legal models: There are four main legal models that can apply to recreational drug use and possession: (i) prohibition; (ii) depenalisation; (iii) decriminalisation; and (iv) legalisation. Policy debates often refer to these models in their pure form but, in practice, jurisdictions can adopt variations of these models. **[7.1]**

The legal model adopted in NSW for recreational drug use and possession most closely reflects the prohibition model, with exceptions including the Cannabis Cautioning Scheme, and the Medically Supervised Injecting Centre. The Government continues to support this approach but a range of experts and public figures have criticised the prohibition model and called for reform, most commonly decriminalisation. **[7.2]-[7.4]**

Summary of the debate: The key arguments are summarised below.

The case for prohibition and against decriminalisation	
Arguments for prohibition	*Arguments against decriminalisation*
Limits legitimate opportunities for illicit drug use, reducing use and subsequent harms	Insufficient evidence that decriminalisation will not increase drug use
Raises both non-monetary and monetary costs associated with illicit drugs, making it more difficult for drug users to obtain these substances	Will lead to an increase in drug use and dependence, including in low socio-economic or minority communities
Results in less overall harm than any other model	Decriminalisation risks unintended consequences, resulting in more overall harm than prohibition
Prohibition is a frequently used policy response to inhibit other types of socially undesirable activity	Does not address drug supply and other illegal activities, which may result in a “worst of both worlds” approach between prohibition and legalisation
The case against prohibition and for decriminalisation	
Arguments against prohibition	*Arguments for decriminalisation*
Does not deter and reduce drug use and dependence	Decriminalisation has no or small effects on rates of drug use
Marginalises drug users which further exacerbates existing personal, social and community problems	Improved health outcomes, with more people accessing treatment services and lower risk of spreading diseases
Criminalisation often fails to recognise and respond appropriately to health and addiction issues	Improves employment and other social prospects for those detected with drugs
Involves substantial law enforcement costs to the detriment of other services	Savings in law enforcement costs can be diverted to prevention and treatment

Public attitudes to prohibition and decriminalisation: The AIHW *National Drug Strategy Survey* is a useful indicator of public opinion on drug-related issues. The 2013 survey results reveal that, although the vast majority of respondents supported increased penalties for individuals who sold or supplied illicit drugs, the most popular responses to possession of illicit drugs for personal use were: referral to treatment or education programs; a caution or warning; or no action at all. The majority of respondents were unsupportive of reforms that legalise drug use, although that result should be used cautiously as the surveys did not distinguish between decriminalisation and legalisation. **[7.5]**

Decriminalisation in Australia: All Australian jurisdictions have, to some extent, moved away from a strict prohibitionist position by introducing reforms for the possession/use of minor quantities of one or more types of illicit drugs. Three jurisdictions (South Australia, the Australian Capital Territory and the Northern Territory) have introduced decriminalisation, in the form of civil penalty schemes, but only in relation to cannabis. All jurisdictions have introduced depenalisation in the form of police diversion programs; in most jurisdictions these programs apply to a range of illicit drugs, in two (NSW and Queensland), they only apply to cannabis. **[7.6]**

Several Australian studies have examined the correlation between cannabis decriminalisation in three jurisdictions (SA, ACT, and NT) and cannabis use. These studies generally found a positive correlation. Separate evaluations of two South Australian initiatives generally found positive results across a range of indicators. A 2008 study, which examined the impact of Australian police drug diversion initiatives on reoffending, reported that “on the whole, the findings were generally very positive”. **[7.6]**

Decriminalisation in other countries: A 2016 report by the UK charity organisation Release noted that there were around 30 countries that had adopted formal decriminalisation (including depenalisation) policies: mainly in South America, Europe and Australia. There is only limited evidence on the outcomes associated with drug decriminalisation policies in other countries. The research has to account for divergent and evolving social circumstances, and measure a range of distinct indicators. The experience in Portugal, which decriminalised drug use in 2001, is often cited by those who favour decriminalisation; but others contend that the evidence does not support claims that the policy has been successful. **[7.7]**

1. INTRODUCTION

Government policy to address illegal drug use and possession is an ongoing topic of debate both in Australia and internationally. One part of this debate concerns the effectiveness of the criminalisation of drug use as a means of minimising drug-related harms. Illegal drug use and related deaths at music festivals is a topic of current concern in NSW. The NSW Government is reviewing the regulation of these events but has rejected options put forward by some stakeholders, including allowing pill testing and amnesty bins. Another topic on the agenda is the suggestion by drug law reform proponents that ice users be allowed to attend a medically supervised smoke inhalation room.

An upcoming forum for discussing these issues is the Parliamentary Cross-Party Harm Minimisation Roundtable, to be held on 11 August at the NSW Parliament.[1] This follows a similar event earlier this year at the Commonwealth Parliament: the Parliamentary Drug Summit 2016.

This paper aims to inform the current debate and has two main parts. The first part looks at rates of illegal drug use, the harms from illegal drug use and current Government policy in relation to illegal drug use. It outlines how the criminal justice system responds to illegal drug use and possession, as well as key harm reduction initiatives that exist in NSW, some of which arose out of the 1999 NSW Drug Summit. The second part discusses illegal drug use at music festivals, and the broader debate on prohibition versus decriminalisation. The arguments put forward by key stakeholders are outlined as well as the approaches taken in other Australian and overseas jurisdictions.

This paper focuses on illegal recreational drug use and does not discuss in any detail the issues of: legal recreational drug use such as tobacco and alcohol; the trafficking and supply of illegal drugs; or the medical use of cannabis. The paper also focuses on only two elements of drug policy, namely: (1) the criminal laws and their enforcement; and (2) harm reduction measures. It is beyond the scope of this paper to deal with other, equally important, aspects of drug policy such as drug education and the provision of drug treatment services.[2]

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[1] See J Haylen, Cross-party Harm Minimisation Roundtable to Renew Illicit Drugs Policy Debate, *Media Release,* 4 July 2016; and J Robertson and E Duff, "Decades on, old foes unite for new drug approach", 24 July 2016, *Sydney Morning Herald*.

[2] As to drug treatment services, see Legislative Council General Purpose Standing Committee, Drug and alcohol treatment, Report 40, August 2013 (and the Government's response); and A Ritter et al, New Horizons: The review of alcohol and other drug treatment services in Australia, Final Report, July 2014

2. DRUG USE IN NSW AND AUSTRALIA

As the following historical overview illustrates, patterns of drug use have changed in response to social and medical developments. This is also true of the distinction between legal and illegal drugs, and public perceptions of illegal drug use. After tracing relevant historical developments, this chapter presents statistics on the current use of illegal drugs in NSW and Australia.

2.1 Early use of tobacco, spirits and opiates

Before European settlement, the drug most widely used by Indigenous people was a native form of tobacco known as *pitjurri*.[3] Tobacco smoking had also been introduced to northern Indigenous communities by Indonesian fishermen in the early 1700s.[4] Some Indigenous people also made, consumed and traded mild alcoholic beverages from fermented fruit and honey.[5]

European settlement led to more widespread tobacco consumption, as well as the introduction of distilled spirits, cannabis, opium and morphine. All of these drugs were legal up until the late nineteenth century, at which point moves towards the criminalisation of drug use first emerged in Western societies.[6] Prior to that, drug consumption was considered a personal decision – subject to social disapproval, but not illegal.[7]

In the nineteenth century, Australians were among the world's largest consumers of opiates, particularly opium, morphine and Laudanum (a mixture of alcohol and opium), which were used for a wide range of medicinal purposes:

> Morphine and laudanum were sold virtually unregulated, often by door-to-door salesmen in the form of mixtures, powders and lozenges. The use of morphine increased as physicians became more accustomed to prescribing, dispensing and administering the drug, and societal recognition increased due to marketing through newsprint and magazines. …
>
> Australian society seemed largely indifferent to the use of medical opioids for recreational or habitual use, as this practice remained mostly invisible and of little moral consequence.[8]

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[3] W Hall and A Carter, "Historical Perspectives of Drug use and ramifications for the future", in A Ritter, T King and M Hamilton (eds), *Drug Use in Australian Society*, 2013, Oxford University Press, Victoria, p 31.

[4] "A brief history of tobacco smoking in Australia", in *Tobacco in Australia: Facts and Issues*, 2016, The Cancer Council.

[5] W Hall and A Carter, "Historical Perspectives of Drug use and ramifications for the future", in A Ritter, T King and M Hamilton (eds), *Drug Use in Australian Society*, 2013, Oxford University Press, Victoria, p 31.

[6] *History of drug laws*, 2015, State Library of NSW.

[7] *History of drug laws*, 2015, State Library of NSW.

[8] M Grant, J Philip and A Ugalde, "A functional dependence? A social history of the medical use of morphine in Australia", 2014, 200(4) *Medical Journal of Australia* 230 at 230. See also: *History of drug laws*, 2015, State Library of NSW.

Heroin was legally available on prescription up until 1953, largely due to the lack of alternative medicines. Up until that time it was so widely used as a painkiller and in cough mixtures that Australians were the largest per capita users of heroin in the Western world.[9]

2.2 The 1960s and the spread of recreational drug use

By the 1960s, recreational drug use no longer "remained mostly invisible and of little moral consequence".[10] During the Vietnam War, illicit drug use by US soldiers visiting Australia helped create a market for those drugs and increased their allure.[11] But it was the 1960s counter-cultural revolution — epitomised by Timothy Leary's catchcry of "Turn on, tune in, drop out" — that pushed recreational drug use into mainstream consciousness across Western nations and gave it an anti-establishment sentiment. In response, the then President of the United States, Richard Nixon, called Leary "the most dangerous man in America".[12] Public opinion in Australia also began to turn against the recreational use of illegal drugs:

> Until the 1960s, drug dependence was not viewed as a major social problem in Australia. Dependent users whose addiction was therapeutically induced were maintained on heroin, pethidine, morphine and opium. However, in the 1960s and 1970s there was increased and visible use of drugs like cannabis, heroin, and LSD. The use of illicit drugs by the youth of Australia and other Western nations provoked fears of social unrest and moral decay. In addition, there was disquiet about the costs — societal and personal — which stemmed from the impact of criminal laws on drug users.[13]

2.3 1970s to the present: recent trends for selected drugs

2.3.1 Cannabis

Derived from the cannabis plant, cannabis is known colloquially by a variety of names, including marijuana, pot, weed, hash, dope and gunja. The main active chemical in cannabis is THC (delta-9 tetrahydrocannabinol).[14] Cannabis generally acts as a depressant drug, slowing down the central nervous system; in large amounts it can also produce hallucinogenic effects.[15]

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[9] *History of drug laws*, 2015, State Library of NSW; A Campbell; and C Kaya, Y Tugai, J Filar et al, "Heroin Users in Australia: Population Trends" (2004) 23(1) *Drug Alcohol Review* 107 at 107.

[10] M Grant, J Philip and A Ugalde, "A functional dependence? A social history of the medical use of morphine in Australia", 2014, 200(4) *Medical Journal of Australia* 230 at 230.

[11] *History of drug laws*, 2015, State Library of NSW.

[12] L Mansnerus, "Obituary: Timothy Leary, Pied Piper of Psychedelic 60's, Dies at 75", 1 June 1996, *New York Times*; P Joseph, "Myth of the drop out: 'Turn on, Tune in, Drop Out' Never Really Described Berkeley Ethos" 2015, Spring, *California Magazine*.

[13] J Norberry, "Illicit drugs, their use and the law in Australia", 1997, Background Paper 12, Commonwealth Parliamentary Library, p 73.

[14] *Cannabis Factsheet*, 2016, Australian Drug Foundation.

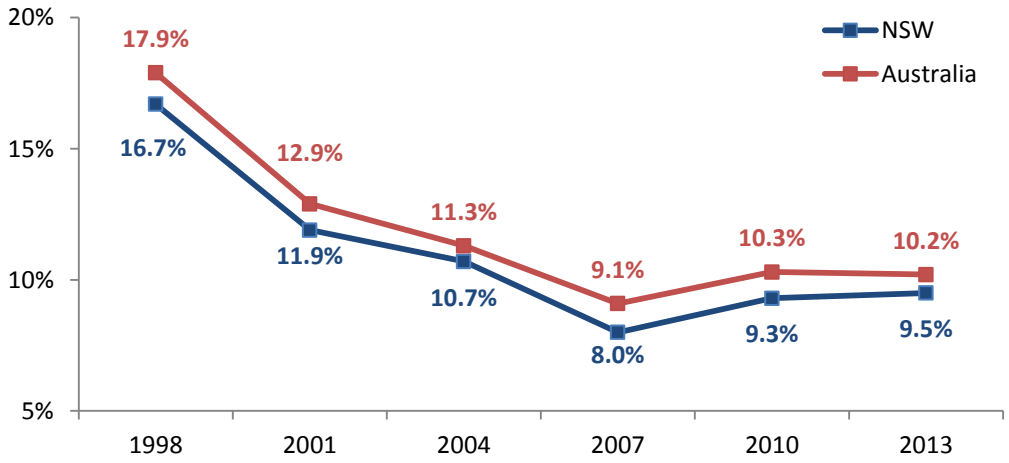
[15] *Cannabis Factsheet*, 2016, Australian Drug Foundation.

Cannabis use increased in the 1970s, having become a symbol of youthful rebellion in the 1960s. Despite increased efforts at law enforcement, its appeal broadened throughout the 1980s and 1990s.[16] Moreover, the rising rate of cannabis use:

> [Was] accompanied by a decline in the age of first use, reflecting a combination of easier access among adolescents and the 'normalisation' of cannabis use among young Australians.[17]

Since 1998, cannabis use by persons aged 14 years and over has generally declined (Figure 1).

Figure 1: Use of cannabis in last 12 months, 2013, persons aged 14 years and over[18]



2.3.2 Heroin

Derived from the opium poppy, heroin is a member of the opioid class of drugs. Known colloquially by a variety names including smack, dope, H, harry and horse, heroin is a depressant drug. In large doses it can be fatal, as it slows down the central nervous system to the point where essential involuntary bodily processes, such as breathing, can no longer be maintained.[19]

In the 1980s, the increase in the number of dependent heroin users and heroin-related property crime, together with concerns about the potential for heroin use to exacerbate the spread of the new public health threat of HIV/AIDS, led to a national Special Premiers' Conference and the establishment of the National

[16] W Hall and A Carter, "Historical perspectives of drug use and ramifications for the future", in A Ritter, T King and M Hamilton (eds), *Drug Use in Australian Society*, 2013, Oxford University Press, Victoria, p 41.

[17] W Hall and A Carter, "Historical perspectives of drug use and ramifications for the future", in A Ritter, T King and M Hamilton (eds), *Drug Use in Australian Society*, 2013, Oxford University Press, Victoria, p 41.

[18] *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare, Table S7.7.

[19] *Heroin factsheet*, 2016, Australian Drug Foundation.

Campaign Against Drug Abuse.[20] Concerns about heroin use continued into the 1990s, especially in Sydney, where heroin dominated the illicit drug market and deaths from opioid overdose increased. This "heroin crisis" was followed by a "heroin shortage" that began in 2000 and lasted for most of the next 10 years.[21]

Data from the Australian Institute of Health and Welfare's (AIHW) *National Drug Strategy Survey 2013* shows that across Australia, heroin use fell from 0.4% of the population aged 14 years and over in 1995 to 0.1% of the population aged 14 years and over in 2013 (preceding 12 months).[22] In NSW, the percentage of people aged 14 years or over using heroin in 2013 in the preceding 12 months was estimated to be less than 0.1%.[23]

2.3.3 Cocaine

Cocaine is derived from the leaves of the coca bush and comes in two powdered forms (cocaine hydrochloride and Freebase) and one crystalline form (crack).[24] Colloquially known by such names as coke, snow, white lady, Charlie and blow, cocaine is a stimulant drug that speeds up the central nervous system.[25] Lower doses can cause positive emotional states in some people; however, high doses and/or frequent use can lead to "cocaine psychosis"[26] (paranoid delusions, hallucinations and aggressive behaviour). High doses can also lead to fatal heart failure, strokes and serious liver and kidney damage.[27]

In the 1980s, there was concern in Australia about a potential cocaine epidemic due to the crack cocaine epidemic that had emerged in the United States. Although the availability of cocaine did increase in Sydney in the 1990s and 2000s, a US-type cocaine epidemic did not eventuate.[28] In NSW, 2.7% of the population aged 14 years and over used cocaine in 2013 (preceding 12 months); across Australia, 2.1% of the population aged 14 years and older used cocaine in the same timeframe.[29]

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[20] W Hall and A Carter, "Historical perspectives of drug use and ramifications for the future", in A Ritter, T King and M Hamilton (eds), *Drug Use in Australian Society*, 2013, Oxford University Press, Victoria, p 41.

[21] W Hall and A Carter, "Historical perspectives of drug use and ramifications for the future", in A Ritter, T King and M Hamilton (eds), *Drug Use in Australian Society*, 2013, Oxford University Press, Victoria, p 43–44.

[22] *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare, Table 5.23.

[23] *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare, Table 7.12.

[24] *Cocaine Factsheet*, 2016, Australian Drug Foundation.

[25] *Cocaine Factsheet*, 2016, Australian Drug Foundation.

[26] *Cocaine Factsheet*, 2016, Australian Drug Foundation.

[27] *Cocaine overdose*, 2016, Cocaine.org.

[28] W Hall and A Carter, "Historical perspectives of drug use and ramifications for the future", in A Ritter, T King and M Hamilton (eds), *Drug Use in Australian Society*, 2013, Oxford University Press, Victoria,, p 45.

[29] *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare, Table S7.13.

2.3.4 Amphetamines and methamphetamines

Amphetamines and methamphetamines (or methylamphetamines) are synthetic (man-made) stimulant drugs.[30] The drugs have the same chemical base, but amphetamines are methylated once and methamphetamines are methylated twice.[31] Methamphetamines (such as ice) are generally regarded as being more potent and more addictive than amphetamines (such as speed and other uppers).[32] Both amphetamines and methamphetamines can lead to fatal overdoses.[33]

Illegal amphetamine use was endemic in Australia in the mid and late 1960s, mainly due to the diversion of prescribed amphetamines, which were liberally prescribed at the time.[34] In the 1980s and 1990s, amphetamines were increasingly manufactured and sold as part of organised criminal operations. While there was an increase in arrests for amphetamine possession and supply, amphetamine use in the general population remained low.[35]

In the early 2000s, illegal methamphetamine use increased, especially of the crystalline form of the drug known as ice, as did rates of meth/amphetamine-related psychosis, requests for treatment and arrests for meth/amphetamine possession.[36] Ice use became such a major public concern that in 2015 a National Ice Taskforce was established and a National Ice Action Strategy was developed.[37]

In NSW, 1.4% of the population aged 14 years and over used meth/amphetamines in the 12 months preceding the 2013 AIHW survey,

[30] *Amphetamines*, 2013, Centre for Substance Abuse Research, University of Merylands.

[31] "What's the difference between amphetamine and methamphetamine?", 2016, *Elements Behavioural Health/drugrehab.us*.

[32] "What's the difference between amphetamine and methamphetamine?", 2016, *Elements Behavioural Health/drugrehab.us*. See also: "Ice, speed and other methamphetamines", 2016, State Library of NSW.

[33] *Amphetamines Factsheet* and *Ice Factsheet*, 2016, Australian Drug Foundation.

[34] W Hall and A Carter, "Historical perspectives of drug use and ramifications for the future", in A Ritter, T King and M Hamilton (eds), *Drug Use in Australian Society*, 2013, Oxford University Press, Victoria, p 46.

[35] W Hall and A Carter, "Historical perspectives of drug use and ramifications for the future", in A Ritter, T King and M Hamilton (eds), *Drug Use in Australian Society*, 2013, Oxford University Press, Victoria, p 46.

[36] W Hall and A Carter, "Historical perspectives of drug use and ramifications for the future", in A Ritter, T King and M Hamilton (eds), *Drug Use in Australian Society*, 2013, Oxford University Press, Victoria, p 46.

[37] For instance, see: *Trends in methylamphetamine availability, use and treatment 2003–4 to 2013–14*, 2015, Australian Institute of Health and Welfare; T Drabsch, *Crystal Methamphetamine Use in New South Wales*, 2006, Briefing Paper 19/06, NSW Parliamentary Research Service; S Dunlev, "Ice addiction triples in five years: UNSW drug study", 28/2/2016, *News.com.* National Ice Taskforce: *Final Report of the National Ice Taskforce*, 2015, Department of the Prime Minister and Cabinet, Canberra; *National Ice Action Strategy*, 2015, Department of the Prime Minister and Cabinet, Canberra.

compared to 2.1% of the equivalent Australian population.[38] As revealed in Table 1, ice has become the most common form of meth/amphetamine used by recent users of meth/amphetamines aged 14 years or older.

Table 1: Form of meth/amphetamine used, 2010 and 2013, recent users aged 14 years or older (%)[39]

	NSW		Australia	
Form of meth/amphetamine	*2010*	*2013*	*2010*	*2013*
Powder	51.9	27.0*	50.6	28.5*
Liquid	0.7	0.0	0.9	0.5
Crystal, ice	14.7	41.9*	21.7	50.4*
Base/Paste/Pure	25.7	14.7	11.8	7.6
Tablet	3.6	6.5	8.2	8.0
Prescription amphetamines	3.3	6.1	6.8	3.0*
Capsules	n/a	3.8	n/a	2.0

*Indicates a statistically significant change between 2010 and 2013.

2.3.5 Ecstasy (MDMA)

Ecstasy (MethyleneDioxyMethAmphetamine or MDMA) is a synthetic stimulant drug that speeds up the central nervous system.[40] However, the formulation of pills marketed as ecstasy can vary considerably, and some pills marketed as ecstasy (or "E") contain little or no MDMA at all.[41] Instead, they may contain a combination of MDMA, speed and/or synthetic hallucinogens.[42] While Ecstasy use often leads to a euphoric state, it may also result in a broad range of adverse health outcomes, including: hallucinations; memory impairment; anxiety; rhabdomyolysis-induced kidney failure;[43] "serotonin syndrome";[44] and heart damage and/or failure in susceptible individuals.[45]

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[38] *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare, Table S7.12.

[39] *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare, Table S7.15.

[40] *Ecstasy Factsheet*, 2016, Australian Drug Foundation;

[41] *Ecstasy Factsheet*, 2016, Australian Drug Foundation;

[42] *Ecstasy or methylenedioxymethamphetamine (MDMA): National Drug Campaign*, Australian Government, Department of Health and Ageing.

[43] M Cunningham, "Ecstasy-induced rhabdomyolysis and its role in the development of acute kidney failure" (1997) 13 *Intensive and Critical Care Nursing* 216–223; and G Campbell and M Rosner, "The Agony of Ecstasy: MDMA (3,4-Methylenedioxymethamphetamine) and the Kidney" (2008) 3 *Clin J Am Soc Nephrol* 1852–1860.

[44] A Ables, "Prevention, Diagnosis, and Management of Serotonin Syndrome" (2010) 81(9) *Am Fam Physician* 1139. Serotonin syndrome refers to a range of symptoms caused by an increase in the amount of the neurotransmitter Serotonin, which can result from the use of various legal and illegal drugs. The symptoms associated with Serotonin Syndrome, which in severe cases can be fatal, include: agitation, confusion, poor muscle control, fevers, seizures, excessive and/or irregular heartbeat and loss of consciousness.

[45] *Ecstasy or methylenedioxymethamphetamine (MDMA): National Drug Campaign*, Australian

Ecstasy was first used recreationally in the late 1970s and early 1980s, when it gained a small following amongst some psychiatrists in the United States as a psychotherapeutic tool—"penicillin for the soul"—despite the fact that the drug had never undergone formal clinical trials nor received approval from the U.S. Food and Drug Administration (FDA) for use by humans.[46] It was during this time that street use emerged in the United States and later spread to other nations.

Recreational ecstasy use in Australia was first raised as a concern in the 1990s, after the arrival of "acid house" dance parties and ecstasy-related deaths at such dance parties.[47] In NSW 2.4% of persons aged 14 years and over used ecstasy in the 12 months preceding the 2013 AIHW survey, compared to 2.5% of the equivalent Australian population.[48] A study of patient data from 59 NSW hospital emergency departments has revealed a recent significant increase in the number of ecstasy-related presentations for people aged 16 to 24; from 413 in 2010 to 814 in 2015.[49]

2.4 Recent rates of recreational drug use: an overview

The following sub-chapters present an overview of recreational drug use in NSW and Australia in 2013, based on the AIHW *National Drug Strategy Survey 2013*. The AIHW survey results are best understood as an underestimate of actual drug use:

> It is widely considered that the household survey probably underestimates illegal drug use, in particular heroin use. Apart from deliberate under-reporting (due to stigmatisation), heroin users tend to be concentrated in geographic areas and may not live in conventional households for inclusion in the survey. [50]

Two distinct measures of recreational drug use are presented. Chapter 2.4.1 presents data on the **use of illicit drugs** in 2013. Chapter 2.4.2 presents data on the **illicit use of drugs** in 2013, which is a broader measure encompassing both the use of illegal drugs and the misuse of pharmaceuticals.[51]

Government, Department of Health and Ageing. *MDMA (Ecstasy) Abuse: What are the effects of MDMA?*, 2006, National Institute of Drug Abuse, Maryland (US).

[46] MDMA (Ecstasy Abuse), March 2006, National Institute on Drug Abuse. In 1985, the U.S. Drug Enforcement Administration (DEA) banned the drug, placing it on its list of Schedule I drugs, corresponding to those substances with no proven therapeutic value.

[47] W Hall and A Carter, "Historical perspectives of drug use and ramifications for the future", in A Ritter, T King and M Hamilton (eds), *Drug Use in Australian Society*, 2013, Oxford University Press, Victoria, p 46.

[48] *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare, Table 7.12.

[49] M Christodoulou, C Meldrum Hanna, J Balendra and E Worthington, "Government urged to consider pill testing as number of ecstasy users appearing at NSW hospitals doubles", 15 February 2016, *ABC News*.

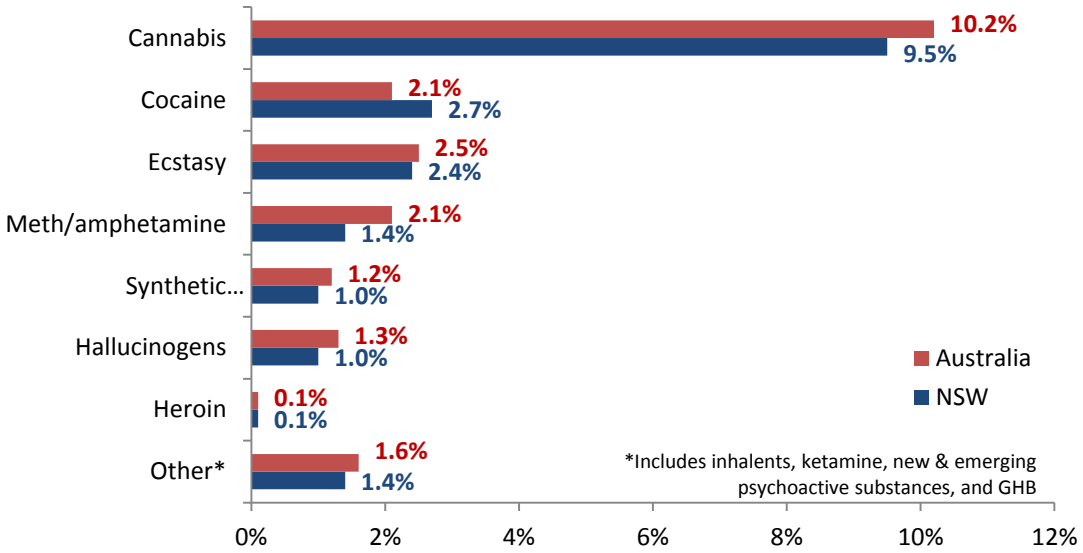
[50] D Brown, D Farrier, L McNamara et al, *Criminal Laws: Materials and Commentary on Criminal Law and Process of New South Wales* (6th Edition), 2015, The Federation Press, Sydney, p 1048.

[51] AIHW, National Drug Strategy Household Survey 2013, *Illicit Use of Drugs*.

2.4.1 Use of illicit drugs

Figure 2 sets out the percentage of the NSW and Australian population aged 14 years and over who in 2013 **used an illicit drug** in the preceding 12 months. Cannabis was the most commonly used illicit drug.

Figure 2: Used illicit drugs in last 12 months, 2013, by type of drug, persons aged 14 years and over[52]



2.4.2 Illicit use of drugs

As set out in Figure 3, in 2013 15% of the Australian population aged 14 years and over engaged in the **illicit use of drugs** in the 12 months preceding the survey; compared to 14.2% of the corresponding NSW population. These figures are substantially lower than those of 1998, which were, respectively, 21.9% and 19.8%.

[52] *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare, Table 7.12. Note that the NSW results for heroin and GHB and the Australian results for GHB were all <0.1 and have a relative standard error of 25% to 50%, so should be used with caution.

Figure 3: "Illicit use of drugs" in last 12 months, 2013, persons aged 14 years and over[53]

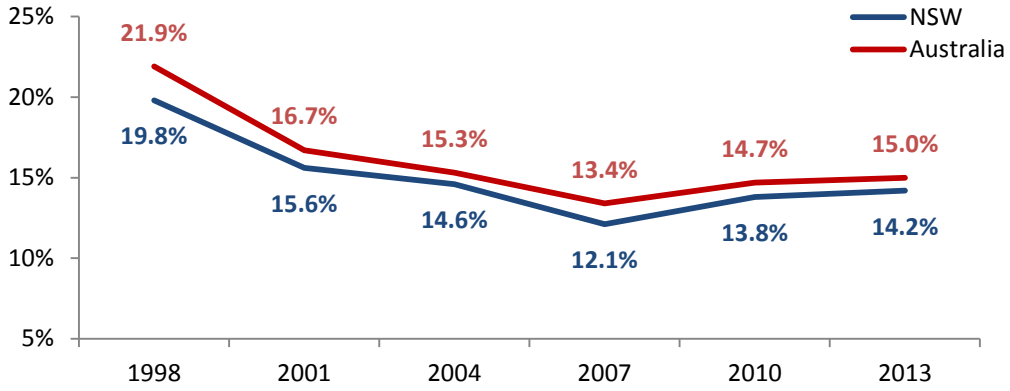
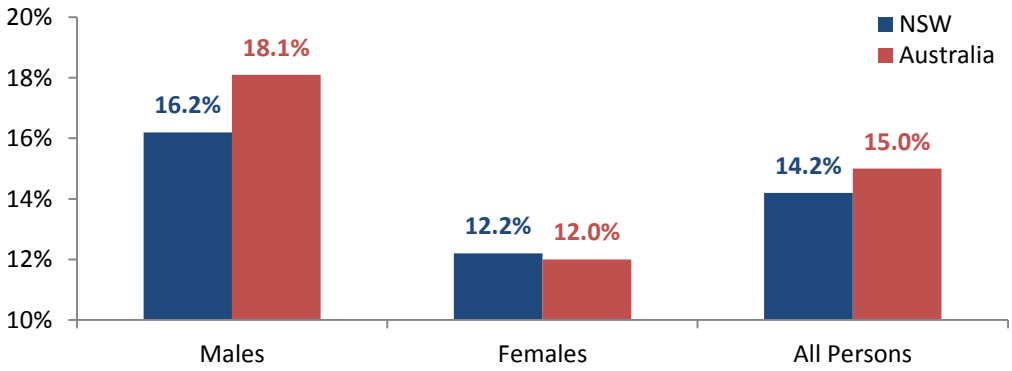


Figure 4 details, by sex, the percentage of the population aged 14 years and over illicitly using drugs in the 12 months before responding to the 2013 survey. It reveals that in NSW and Australia illicit use of drugs was more commonly undertaken by men (4.0% and 6.1% difference, respectively).

Figure 4: Illicit use of drugs in last 12 months, 2013, by sex, persons aged 14 years and over[54]

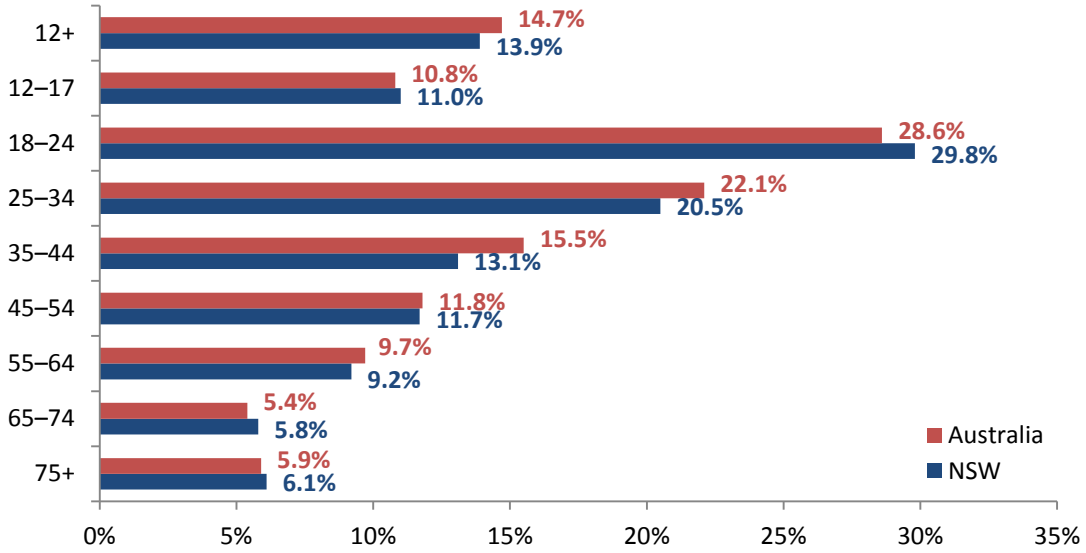


The 2013 AIHW survey results depicted in Figure 5 suggest that illicit use of drugs peaks in the 18-24 age group, and gradually declines thereafter as the population ages.

[53] National Drug Strategy Survey 2013, November 2014, Australian Institute of Health and Welfare, Table 7.9.

[54] National Drug Strategy Survey 2013, November 2014, Australian Institute of Health and Welfare, Table 7.10.

Figure 5: Illicit use of drugs in last 12 months, 1998–2013, by age, persons aged 12 years and over[55]



3. PERSONAL AND COMMUNITY HARMS FROM DRUG USE

Almost all drugs pose some degree of harm to both the individual and the broader community; whether they are legal (e.g. alcohol or tobacco) or illegal (e.g. heroin, cannabis or amphetamines).[56] There is ongoing debate as to whether certain legal drugs are more harmful than some illicit drugs.[57]

3.1 Individual illicit drug harms: dependence and health problems

Individual harms associated with illicit drugs include the potential for individuals to develop dependence on these drugs. A 2007 monograph by the National Drug and Alcohol Research Centre (NDARC) estimated the number of dependent and non-dependent[58] drug users in Australia by drug type (Table 2).

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[55] *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare, Table S7.6.

[56] For further information on individual and community harms that can result from legal and illegal drugs, see D Nutt, L King and L Phillips, "Drug harms in the UK: a multicriteria decision analysis" (2010) 376 *The Lancet* 1558; *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare.

[57] D Nutt, L King and L Phillips, "Drug harms in the UK: a multicriteria decision analysis" (2010) 376 *The Lancet* 1558.

[58] Dependent users are defined in the study as daily, or near-daily, drug users, while non-dependent users are characterised as people who generally use no more than one or two days a week, primarily in social settings. See T Moore, *Working estimates of the social costs per gram and per user for cannabis, cocaine, opiates and amphetamines*, 14 February 2007, Monograph 14, National Drug and Alcohol Research Centre, p 19.

Table 2: Illicit drug prevalence estimates by level of dependence and drug type, Australia, 2007[59]				
	Cannabis	**Cocaine**	**Opiates**	**Amphetamines**
Dependent drug users	247,500	13,892	41,401	73,257
Non-dependent drug users	1,662,575	162,454	107,898	495,500
All illicit drug users	1,910,075	176,346	149,299	568,757

As shown above, a significant minority of drug users are estimated to have become dependent on illicit drugs: 27.7% of opiate users; 12.9% of cannabis users; 12.8% of amphetamine users; and 7.9% of cocaine users.

Illicit drug use can cause immediate and long term health problems for individuals. With regard to **cannabis**, the Australian Government's National Drugs Campaign website lists short and long terms health problems that can arise from its use:

Table 3: Health problems arising from cannabis use[60]	
Short term	**Long term**
• Difficulty concentrating • Impaired motor skills • Slow reflexes • Reduced coordination • Bloodshot or glassy eyes • Dryness of the mouth • Paranoia • Anxiety • Decreased motivation • Hallucinations	• Increased risk of respiratory illnesses (chronic bronchitis and lung, mouth, throat and tongue cancers) • Lowered sex drive • Impact on sperm count for males • Irregular menstrual cycles for females • Low birth weight babies • Memory loss • Learning difficulties • Lower educational attainment

Available evidence indicates that cannabis use may lead to mental health problems, particularly if an individual starts using the drug before turning 18 years old, or uses cannabis on a weekly or more frequent basis.[61] According to a 2016 article by Gates, a range of studies have investigated possible mental health issues that arise from cannabis use. The findings of this research are paraphrased below:

- **Schizophrenia:** The relationship between cannabis use and the risk of developing symptoms of psychosis has been well established in many different review articles. Early and frequent cannabis use is a component

[59] T Moore, *Working estimates of the social costs per gram and per user for cannabis, cocaine, opiates and amphetamines*, 14 February 2007, Monograph 14, National Drug and Alcohol Research Centre, p 19.

[60] National Drugs Campaign, *Problems using marijuana (cannabis)*, March 2014, Government of Australia.

[61] P Gates, "Does cannabis cause mental illness?", 25 February 2016, *The Conversation*.

cause of psychosis, which interacts with other risk factors such as family history of psychosis, history of childhood abuse and expression of the COMT and AKT1 genes.

- **Depression and anxiety:** A number of studies have found a significant association between cannabis use and the onset of depression and anxiety disorders. However, other studies finding this connection have suffered from methodological issues, while the few longitudinal studies that have been conducted have mixed findings.[62]

Even though cannabis use has a range of negative impacts, it does not result in fatal overdoses.[63] In contrast, other illicit drugs are not only more addictive, but are more likely to result in serious or even fatal health consequences as a result of their use.

Cocaine has been linked to a number of health problems, including high blood pressure, cardiac arrest and respiratory failure, as well as mental illness and behavioural problems in the long term. The NSW Bar Association has cited studies indicating that heavy and intravenous cocaine use has been associated with: criminal activity; unemployment; suicide; transmission of blood borne viruses; and death (for example, 23 cocaine-related deaths occurred in Australia during 2009).[64]

Use of **amphetamine-type stimulants** (such as ice) or **ecstasy** can result in convulsions, cardiac arrhythmia, aggressive behaviour or psychosis.[65] Ice in particular has been associated with significant medical, social and criminal problems, leading to increasing concern by both authorities and the wider community. The Victorian Parliament's 2014 inquiry into the supply and use of methamphetamines listed some of the health impacts of ice use:

> In the short term, methamphetamine can cause dehydration, sweating, headaches, sleep disorders, anxiety and paranoia. Used over the longer term, physiological impacts include weight loss, dermatological problems, neurotoxicity, reduced immunity, elevated blood pressure, damage to teeth and gums, cardiovascular problems and kidney failure. Long-term use can lead to psychological, cognitive and neurological impacts including, depression, impaired memory and concentration and aggressive or violent behaviour. It may also impact negatively on people with a predisposition to schizophrenia.[66]

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[62] P Gates, "Does cannabis cause mental illness?", 25 February 2016, *The Conversation*.

[63] L Degenhardt and W Hall (eds), "Extent of illicit drug use and dependence, and their contribution to the global burden of disease" (2012) 379 *The Lancet* 55.

[64] *Drug Law Reform Discussion Paper*, November 2014, NSW Bar Association, p 8.

[65] E Silins, "The acute effects of ecstasy (MDMA) use", in L Degenhardt and W Hall (eds), *The health and psychological effects of "ecstasy" (MDMA) use*, 2010, Monograph 62, National Drug and Alcohol Research Centre p 83; *Inquiry into the supply and use of methamphetamines, particularly ice, in Victoria*, Vol 1, September 2014, Parliament of Victoria, Law Reform, Drugs and Crime Prevention Committee, Ch 6.

[66] *Inquiry into the supply and use of methamphetamines, particularly ice, in Victoria*, Vol 1, September 2014, Law Reform, Drugs and Crime Prevention Committee, Parliament of Victoria, pp x-xi.

According to the NSW Bar Association, opiates are associated with a disproportionately large range of health and social harms:

> [Nationally, the] number of non-fatal overdoses is substantial, estimated to be between 10,500 and 20,500 annually. It is also important to note the substantial contribution that drug injection makes to the high levels of HIV and HCV [Hepatitis C virus] infections. Hospital costs associated with heroin use amounted to $13 million/year in 2004–05. …
>
> In comparison to the rest of the world, the rate of drug-related deaths in Australia is high. In 2009 there were 563 deaths attributable to opioids. It has been estimated that among dependent users there is a 33.3% likelihood of death from its use.[67]

3.2 Community illicit drug harms: crime and other social problems

A significant range of harms affect the wider community. Drug-related crime is a particular problem for authorities; income generating offences account for a significant proportion of this crime (Table 4), while amphetamine-derived drugs are increasingly associated with violent crime.[68]

NDARC's 2007 monograph on the social costs of illicit drugs between 2003 and 2006 estimated the costs of crime in Australia that are attributable to these substances. Over this three year period, drug-attributable crime cost the nation an estimated $7.26 billion. Dependent drug users were responsible for approximately 90.5% of this total; the cost of crimes committed by dependent amphetamine users was estimated at $2.79 billion (38.5% of the total), followed by dependent opiate users, ($1.71 billion or 23.6% of the total) and dependent cannabis users ($1.6 billion, or 22.1% of total estimated costs).

Table 4: Estimated costs of illicit drug-attributable crime, Australia, 2003-06 ($m)[69]

	Cannabis	Cocaine	Opiates	Amphet.	Other	Total
Income generating offences						
Dependent users	1,601	105	1,551	2,203	325	5,785
Non-dependent users	319	26.1	28.4	204	55.6	633
Total ($m)	**1,919**	**131**	**1,579**	**2,407**	**380**	**6,416**
Other offences						
Dependent users	0	30.2	163	592	196	981
Non-dependent users	0	0.63	1.2	39.8	12.7	54

[67] *Drug Law Reform Discussion Paper*, November 2014, NSW Bar Association, p 7.

[68] *Drug Law Reform Discussion Paper*, November 2014, NSW Bar Association, p 9.

[69] T Moore, *Working estimates of the social costs per gram and per user for cannabis, cocaine, opiates and amphetamines*, 14 February 2007, Monograph 14, National Drug and Alcohol Research Centre. Appendix 2 of the study defined "income generating offences" as burglary, fraud, robbery, shop theft, vehicle-related theft (theft from and of vehicles) and other theft; "Other offences" were defined to include arson, assault, sexual assault and criminal damage.

Table 4: Estimated costs of illicit drug-attributable crime, Australia, 2003-06 ($m)[69]						
Total ($m)	**0**	**30.8**	**164**	**632**	**209**	**1,036**
All offences						
Dependent users	1,601	135.2	1,714	2,795	325	6,570
Non-dependent users	319	26.7	29.6	243.8	68.3	687
Total ($m)	***1,919***	***161.9***	***1,743.6***	***3,038.8***	***393.3***	***7,257***

A 2015 report by the Australian Crime Commission on methamphetamine markets concluded that ice "poses the highest risk to the Australian community and is of significant national concern".[70] The impact of ice on the community was discussed in the NSW Parliamentary Research Service's *Key Issues for the 56th Parliament* briefing paper:

> Methamphetamine use is also linked to violent crime. A 2008 study by the National Drug Law Enforcement Research Fund concluded that methamphetamine use significantly increased the risk of violent offending, with approximately 40% of study participants violently offending in the previous 12 months.
>
> Much of the violent behaviour and aggression by methamphetamine users was domestic in nature, raising issues about the safety of children of methamphetamine users; concern has also been expressed for police and emergency personnel who deal with users under adverse circumstances (although evidence indicates that problematic alcohol consumption remains the primary concern of many of these workers).
>
> The impact of methamphetamines extends beyond drug users. A 2014 Victorian inquiry into methamphetamines found that the families of users suffer from financial strain and loss of assets, fear of aggression and violence and family breakdown as a result of these drugs. Furthermore, towns reputed to be "ice hotspots" face economic consequences due to the negative impact on tourism and business.[71]

The damages caused to social cohesion by illicit drug use places a heavy burden on government authorities, while also affecting the productivity of the nation.[72] These social costs appear to be greater in low socioeconomic communities. The AIHW found that people living in remote and very remote areas were more likely than their urban counterparts to have used cannabis and meth/amphetamines in the previous 12 months.[73] There are particular concerns about the impact of illicit drugs in Indigenous Australian communities. In 2013, according to the AIHW:

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[70] *The Australian methylamphetamine market*, 2015, Australian Crime Commission, p 6.

[71] *Key Issues for the 56th Parliament*, Briefing Paper 4/2015, NSW Parliamentary Research Service, pp 110-11.

[72] *Drug Law Reform Discussion Paper*, November 2014, NSW Bar Association, p 4.

[73] *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare, p 89; *Trends in methylamphetamine availability, use and treatment 2003–4 to 2013–14*, 2015, Australian Institute of Health and Welfare, p vi.

> Indigenous Australians were: 1.6 times more likely to use any illicit drug in the last 12 months; 1.9 times more likely to use cannabis; 1.6 times more likely to use meth/amphetamines; and 1.5 times more likely to misuse pharmaceuticals than non-Indigenous people.[74]

Turning to treatment services, the AIHW reported that in 2013-14 the illicit drugs which accounted for the largest majority of treatment services over time in NSW were cannabis (20% of all episodes), amphetamines (17%) and heroin (8%).[75] According to the AIHW, amphetamines replaced heroin as the third most common principal drug of concern in 2011–12 (after alcohol and cannabis) and have continued to grow in use. In 2013-14, across Australia, "amphetamines were a drug of concern (principal or additional) in 30% of closed treatment episodes, and were the third most common principal drug of concern" after alcohol and cannabis.[76]

In NSW, rising amphetamines use has led to increasing numbers of hospitalisations. A 2015 NSW Health background paper gives the following statistics for hospitalisations and emergency department presentations for methamphetamines:

- Between 2009-2010 and 2013-14, there were 7,097 methamphetamine-related hospitalisations for NSW residents aged 16 years and over.
- In 2013-14, methamphetamine-related hospitalisations comprised 0.1% of all NSW hospitalisations.
- In NSW between 2009-10 and 2013-14, the annual rate of methamphetamine-related hospitalisation increased almost 5-fold from 10.0 to 47.2 per 100,000 persons. Over the same period the number of hospitalisations increased from 534 to 2,616. …
- Between 2009 and 2014, the annual total number of overdose, drug and alcohol or mental health presentations to 59 NSW public hospital emergency departments where methamphetamine use was recorded increased more than 7-fold, from 394 to 2,982.[77]

The cost of providing these and other health services to illicit drug users is considerable. For example, in relation to treatment for cannabis use, a 2010 NDARC study estimated that associated health care costs in NSW in 2007 totalled $16.9 million (see Table 5):

---

[74] *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare, p 95.

[75] *Alcohol and other drug treatment services in Australia 2013–14: state and territory summaries*, 2015, Drug Treatment Series 25, Australian Institute of Health and Welfare, pp 14-15.

[76] *Alcohol and other drug treatment services in Australia 2013–14*, 2015, Drug Treatment Series 25, Australian Institute of Health and Welfare, p 23.

[77] *Crystalline Methamphetamine Background Paper – NSW Data*, September 2015, NSW Health, pp 5-6.

Table 5: Estimated cannabis treatment and health care costs in NSW in 2007[78]				
Cannabis treatment	**No episodes/ separations***	**Cost (2007 $)**	**% cost**	**Cost per occasion**
Residential rehabilitation (episodes*)	431	$2,898,684	17.1	$6,725
Hospital (separations**)	902	$1,307,610	7.7	$1,450
Withdrawal management (detoxification) (episodes*)	1,127	$1,083,124	6.4	$961
Counselling (episodes*)	2,451	$1,072,308	6.3	$437
GP (consultations)	3,018	$217,170	1.3	$72
Assessment only (episodes*)	1,727	$163,674	1.0	$95
Information/education only (episodes*)	113	$35,098	0.2	$310
Subtotal cannabis treatment	-	*$6,777,668*	*40.1*	-
Treating health consequences of cannabis use	**No persons/ separations**	**Cost (2007 $)**	**% cost**	**Cost per occasion**
Psychotic disorders/schizophrenia (persons)	916	$6,220,049	36.8	$6,790
Road traffic accident casualties (persons)	443	$2,309,115	13.7	$5,212
Low birth weight (separations**)	90	$1,605,291	9.5	$17,837
Subtotal cannabis treatment	-	*$10,134,454*	*59.9*	-
Grand total	-	***$16,912,123***	***100.0***	-

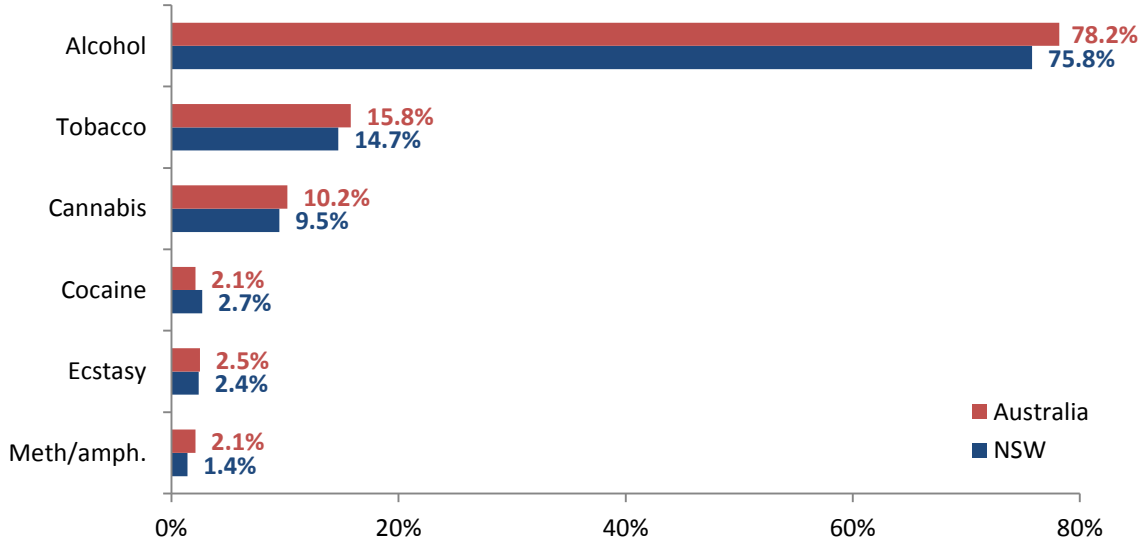
Note: totals may not sum due to rounding. * All episodes, including complete and incomplete. ** Separations are defined as the process by which an episode of care for an admitted patient ceases.

3.3 Harms caused by alcohol and tobacco

While there is concern over harms arising from illicit drugs, substantial harms also arise from legal substances, notably alcohol and tobacco. Legal drugs are more frequently used by Australians than illicit drugs (Figure 6):

[78] R Ngui and M Shanahan, *Cannabis use disorder treatment and associated health care costs in New South Wales, 2007*, December 2010, Monograph No 20, National Drug and Alcohol Research Centre, p 3.

Figure 6: Selected drug use, last 12 months, 2013, people 14 years and over[79]



The AIHW's *National Drug Strategy Survey 2013* summarised the harms associated with tobacco and alcohol:

> Tobacco smoking is a leading risk factor for chronic disease and death, including many types of cancer, respiratory disease and heart disease and is the major cause of cancer, accounting for about 20–30% of cancer cases. In Australia in 2004–05, about 15,000 deaths per year were attributable to smoking.
>
> …
>
> The harmful use of alcohol has both short-term and long-term health effects. In the short term, the effects are mainly related to injury of the drinker or others that the drinker's behaviour affected. With its ability to impair judgment and coordination, excessive drinking contributes to crime, violence, anti-social behaviours and accidents. Over the longer term, harmful drinking may result in alcohol dependence and other chronic conditions, such as high blood pressure, cardiovascular diseases, cirrhosis of the liver, types of dementia, mental health problems and various cancers.[80]

Alcohol and tobacco use are two of the highest risk factors resulting in disease and injury in Australia. According to the AIHW's 2011 *Impact and causes of illness and death in Australia* report, tobacco use was the most burdensome risk factor in 2011, responsible for 9.0% of disability-adjusted life years (DALY),[81]

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[79] *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare, Table 7.12

[80] *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare, pp 17, 30.

[81] According to the AIHW, a DALY combines the estimates of years of life lost due to premature death and years lived in ill health or with disability to count the total years of healthy life lost due to disease and injury: see *Impact and causes of illness and death in Australia: 2011*, 2016, Australian Burden of Disease Study series No 3, Australian Institute of Health and Welfare, p 1.

while alcohol formed the third most burdensome risk factor (5.1%).[82] The AIHW summarised the contribution of these two drugs to diseases and injuries:

> Tobacco use was responsible for 80% of lung cancer DALY. Similarly, it was responsible for 75% of the COPD [chronic obstructive pulmonary disease] DALY. Around half of the total burden of oesophageal cancer (54%) and nearly half of the mouth & pharyngeal cancer (46%) burden was attributed to tobacco.
>
> …
>
> Alcohol use contributed to the burden for a large number of linked diseases and injuries. It was responsible for the entire burden due to alcohol use disorders, 28% of the burden due to road traffic injuries (road traffic injuries—motor vehicle occupants), 24% of the burden due to chronic liver disease and 23% of the burden due to suicide and self-inflicted injuries.[83]

Referring to 2003 data, a 2014 discussion paper by the NSW Bar Association outlined the estimated tangible and intangible social costs of alcohol and tobacco use, and compared these estimates to the estimated costs of illicit drug use:

Table 6: Costs of alcohol, tobacco and illicit drug use, $m, 2003[84]

Estimated costs	Alcohol	Tobacco	Illicit drugs	Alcohol and illicit drugs together	All drugs
Tangible*	10,829.5	12,026.2	6,915.4	1,057.8	30,828.9
Intangible**	4,488.7	19,459.7	1,274.5	-	25,222.9
Total	**15,318.2**	**31,458.9**	**8,189.8**	**1,057.8**	**56,051.8**
Proportion of unadjusted total	*27.3%*	*56.2%*	*14.6%*	*1.9%*	*100%*

* Tangible drug-related costs include crime, lost productivity and road accidents. **Intangible drug-related costs include loss of life, fear, pain and suffering.

4. THE POLICY FRAMEWORK

4.1 Possible responses to drug use

There exist a number of possible social and institutional responses to drug use, each reflecting a distinct social perspective of the issue. As Norman Kerr, a leading addiction physician, said in 1888:[85]

> In drunkenness of all degrees of every variety, the Church sees only the sin; the World the vice; the State the crime. On the other hand the medical profession uncovers a state of disease.

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[82] *Impact and causes of illness and death in Australia: 2011*, 2016, Australian Burden of Disease Study series No 3, Australian Institute of Health and Welfare, p 54.

[83] *Impact and causes of illness and death in Australia: 2011*, 2016, Australian Burden of Disease Study series No 3, Australian Institute of Health and Welfare, pp 171, 173.

[84] *Drug Law Reform Discussion Paper*, November 2014, NSW Bar Association, p 10.

[85] NS Kerr, *Inebriety, or Narcomania,*1888, HK Lewis, London, cited in A Ritter, T King and M Hamilton (eds), *Drug Use in Australian Society*, 2013, Oxford University Press, Victoria, p 54.

Those possible social perspectives and institutional responses are detailed in Table 7. Arrows in the table indicate a general clear linear relationship across the rows, while the long brackets indicate there is no such clear linear relationship:

Table 7: Possible social perspectives and institutional responses to recreational drug use[86]

Substance-related problem	Perspective	Dominant profession	Institutional base	Action models
Injury Illness Death Loss of control Violence Hedonism Slothfulness Intoxication	Physical illness →	Doctors →	Health institutions →	Medicine Behavioural therapy Psychiatric therapy Prison Counselling Skills training Shelter
	Mental illness →	Psychiatrists →	Mental institutions →	
	Crime /law →	Police/ Judges →	Criminal Justice system →	
	Sin/ vice →	Priests →	Religious institutions →	
	Moral issue →	Counsellors →	School/prison /welfare →	
	Disability/ Destitution →	Social workers →	Welfare system →	

The perspective(s) taken influence the policy options that are adopted. Drug policy options can be classified into four broad domains, as shown overleaf: [87]

[86] Based on R Room and W Hall, "Frameworks for understanding drug use and societal responses", in A Ritter, T King and M Hamilton (eds), *Drug Use in Australian Society*, 2013, Oxford University Press, Victoria, p 59, Figure 3.2.

[87] A Ritter and K Lancaster, "Policy Models and Influences on Policy Processes, in A Ritter, T King and M Hamilton (eds), *Drug Use in Australian Society*, 2013, Oxford University Press, Victoria, p108

4.2 Historical note

Up until the 1980s, Australian drug policy had tended to be reactive and sporadic, rather than proactive and unified. This situation was considered in *Drug Problems in Australia – An intoxicated society?*,[88] a 1977 report of the Senate Standing Committee on Social Welfare that has been described as the first comprehensive government report on drugs in Australia and an "ancestral document to today's National Drug Strategy":

> Australian Governments have never committed themselves to any substantive and comprehensive policy on drugs. Drug abuse in Australia is dealt with in a piecemeal fashion. Law enforcement authorities are expected to enforce laws, some of which have neither full community support, nor, as many police believe, full support in the courts. Health authorities struggle to deal with a health problem which is continually growing and changing. Supporting organisations provide a myriad of services, poorly integrated one with another and without any coherent overall community goal.[89]

In 1985, a special Premier's Conference on drugs led to the establishment of the National Campaign Against Drug Abuse, which:

> [A]imed to provide a national framework for minimising the harmful consequences of drug use, actively encouraging liaison across all jurisdictions. A major strength of the campaign was that it provided a basis for consultation and cooperation among health, education and law enforcement agencies. Following two reviews in 1988 and 1991 the Campaign evolved into the National Drug Strategy.[90]

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[88] *Drug Problems in Australia – An intoxicated society?*, 1977, Government of Australia, Senate Standing Committee on Social Welfare, Australian Government Publishing Service, Canberra.

[89] "Drug problems in Australia — an intoxicated society?", n.d., Australian Policy Online; *Drug Problems in Australia – An intoxicated society?*, 1977, Government of Australia, Senate Standing Committee on Social Welfare, Australian Government Publishing Service, Canberra, p 18.

[90] P Dillon (Ed), "Preface", in *The National Drug Strategy: The First Ten Years and Beyond: Proceedings from the Eighth National Drug and Alcohol Research Centre Annual Symposium*, 1995, National Drug and Alcohol Research Centre, p iv.

4.3 National Policy

4.3.1 The National Drug Strategy

The strategy most recently endorsed by the Intergovernmental Committee on Drugs is the *National Drug Strategy 2010–2015*; a draft *National Drug Strategy 2016–2025* has been published but, at the time of writing, not finalised.[91] The *National Drug Strategy* applies to alcohol, tobacco and illegal drugs. Each State and Territory has scope to refine its own policy settings and trial new approaches to further the objectives of the *National Drug Strategy*.

The *National Drug Strategy* is formulated on the realistic basis that eradication of both legal and illegal drug use is not achievable. As a necessary alternative, the strategy has, since its inception in 1985, adopted the overarching goal of harm minimisation,[92] which it seeks to achieve by means of the three pillars of: demand reduction; supply reduction; and harm reduction (Figure 7).[93]

Figure 7: Overview of the National Drug Strategy[94]

[91] *Communique*, 25 February 2011, Ministerial Council on Drug Strategy; *Draft National Drug Strategy 2016–2025*, September 2015, Government of Australia, Intergovernmental Committee on Drugs.

[92] We note that in recent public debate in NSW medically supervised injecting centres, pill testing and amnesty bins have sometimes been referred to as harm minimisation measures, whereas in the framework adopted by the *National Drug Strategy* they are classified as harm reduction measures. While that distinction is largely semantic, for the sake of maintaining consistency with the *National Drug Strategy* pill testing and amnesty bins are in this paper referred to as harm reduction measures.

[93] *National Drug Strategy 2010–2015: A framework for action on alcohol, tobacco and other drugs*, 2011, Government of Australia, Ministerial Council on Drug Strategy, Canberra.

[94] *National Drug Strategy 2010–2015: A Framework for action on alcohol, tobacco and other drugs*, 2011, Government of Australia, Ministerial Council on Drug Strategy, Canberra, p 3; *Draft National Drug Strategy 2016–2025*, September 2015, Government of Australia, Intergovernmental Committee on Drugs, p 8.

Demand reduction: This pillar of the *National Drug Strategy* seeks to:

- prevent uptake of drug use;
- delay onset of drug use;
- reduce use of drugs in the community;
- support people to recover from dependence; and
- foster social connections and resilience for individuals, families and communities.[95]

In order to achieve this aim, the demand reduction pillar can utilise a range of initiatives, including:

- community awareness campaigns;
- education programs;
- community-relations policing;
- high visibility policing;
- counselling and support to individuals and affected families; and
- drug addiction treatment services.[96]

Supply reduction: This pillar of the *National Drug Strategy* seeks to restrict the supply of drugs in the community, so that they are more difficult to access.[97] In order to achieve this aim, the supply reduction pillar utilises:

- covert and high visibility police operations to disrupt supply;
- the criminal justice system to prosecute and sentence illegal drug suppliers; and
- the regulatory system to control and manage the supply of alcohol, tobacco and other legal drugs.[98]

Harm reduction: This pillar of the *National Drug Strategy* aims to reduce the harmful consequences of drug use to: (i) community safety and amenity; (ii) families; and (iii) individuals.[99] In order to achieve this aim, the harm reduction pillar can utilise a range of strategies, including:

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[95] *National Drug Strategy 2010–2015: A Framework for action on alcohol, tobacco and other drugs*, 2011, Government of Australia, Ministerial Council on Drug Strategy, Canberra, p ii.

[96] *National Drug Strategy 2010–2015: A Framework for action on alcohol, tobacco and other drugs*, 2011, Government of Australia, Ministerial Council on Drug Strategy, Canberra, p 9–13.

[97] *National Drug Strategy 2010–2015: A Framework for action on alcohol, tobacco and other drugs*, 2011, Government of Australia, Ministerial Council on Drug Strategy, Canberra, p ii.

[98] *National Drug Strategy 2010–2015: A Framework for action on alcohol, tobacco and other drugs*, 2011, Government of Australia, Ministerial Council on Drug Strategy, Canberra, p 13–16.

[99] *National Drug Strategy 2010–2015: A Framework for action on alcohol, tobacco and other drugs*, 2011, Government of Australia, Ministerial Council on Drug Strategy, Canberra, p ii.

- emergency medical response and ongoing treatment;
- support for affected families and communities;
- special measures for high-risk situations (for example, facilities for the safe access and disposal of syringes, medically supervised injecting facilities and "the provision of chill-out spaces, water, information and peer support and emergency medical services at events where drug use may be occurring"[100]);
- public awareness campaigns about drug-related violence;
- police and criminal justice system responses to drug-related violence;
- alcohol and drug driving programs (in order to ensure public safety on the roads); and
- police and court diversion programs, such as the Cannabis Cautioning Scheme, the Magistrates Early Referral into Treatment Program and the Drug Court. The aim of diversion programs is to minimise the adverse impact of conviction and incarceration on individual drug users, their families and the community, and promote treatment and general rehabilitation.[101]

The *National Drug Strategy* expressly states that each of the three pillars of harm minimisation is equally important to the success of the Strategy. However, the precise emphasis that is given to each pillar, as well as the individual measures that can be applied under each pillar, is left open to be determined by each jurisdiction, taking into account its own particular needs and circumstances.[102]

Commenting on the overall approach to implementing the *National Drug Strategy* across Australia, the NSW Bar Association, drawing on research conducted by the National Drug and Alcohol Research Centre,[103] said:

> There is no indication in the National Drug Strategy as to what the ideal balance among supply reduction, demand reduction and harm reduction should be. However, if you consider levels of government spending, almost two-thirds is devoted to law enforcement.[104]

[100] *National Drug Strategy 2010–2015: A Framework for action on alcohol, tobacco and other drugs*, 2011, Government of Australia, Ministerial Council on Drug Strategy, Canberra, p 16.

[101] *National Drug Strategy 2010–2015: A Framework for action on alcohol, tobacco and other drugs*, 2011, Government of Australia, Ministerial Council on Drug Strategy, Canberra, p 16–19.

[102] *National Drug Strategy 2010–2015: A Framework for action on alcohol, tobacco and other drugs*, 2011, Government of Australia, Ministerial Council on Drug Strategy, Canberra, p 9.

[103] A Ritter, R McLeod and M Shanahan, *Government Drug Policy Expenditure in Australia – 2009*, 2013, National Drug and Alcohol Research Centre, Sydney.

[104] *Drug Law Reform Discussion Paper*, November 2014, NSW Bar Association, p 5

The Intergovernmental Committee on Drugs manages the ongoing work of the *National Drug Strategy*. The committee is a Commonwealth, State and Territory government forum of senior officers who represent health and law enforcement agencies in each Australian jurisdiction and in New Zealand, as well as representatives of the Australian Government Department of Education, Employment and Workplace Relations.

4.3.2 Related national drug strategies

There are a number of other related national drug strategies.[105] One of these is the *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014–2019,* which is a sub-strategy of the *National Drug Strategy.*[106] Four principles underpin the sub-strategy, namely:

1. Aboriginal and Torres Strait Islander ownership of solutions
2. Holistic approaches that are culturally safe, competent and respectful
3. Whole-of-government effort and partnerships
4. Resourcing on the basis of need

The *National Ice Action Strategy* and National Ice Taskforce *Final Report* both reflect the policy framework established by the *National Drug Strategy*.[107] The *National Ice Action Strategy* notes that, despite current law enforcement efforts, the market for ice "remains strong".[108] In light of that resilience, the *National Ice Action Strategy* prioritises the need for:

- support for families and communities;
- targeted prevention;
- investment in treatment services and workforce;
- more effective and targeted law enforcement; and
- better research and data, which can be used to improve the effectiveness of future responses to ice use.[109]

[105] See National Drug Strategy website

[106] *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014 - 2019,*

[107] *National Ice Action Strategy*, 2015, Commonwealth of Australia, Department of the Prime Minister and Cabinet, Canberra, p 14; *Final Report of the National Ice Taskforce*, 2015, Commonwealth of Australia, Department of the Prime Minister and Cabinet, Canberra.

[108] *National Ice Action Strategy*, 2015, Commonwealth of Australia, Department of the Prime Minister and Cabinet, Canberra, p 18–20.

[109] *National Ice Action Strategy*, 2015, Commonwealth of Australia, Department of the Prime Minister and Cabinet, Canberra, pp 22–23.

4.4 NSW Drug Policy

4.4.1 The NSW Drug Summit

In 1999, following public concern relating to heroin overdoses, Premier Bob Carr hosted the NSW Drug Summit. [110] Premier Carr was reported as saying:

> It will be a no-holds barred, non-party examination of the drug problem ...This is a community problem that touches all of us. It should be treated as a challenge above politics. We will push aside all other business. We have to look at fresh ideas.[111]

Proposals for decriminalising cannabis use and possession were raised at the Drug Summit but were not accepted by the Government.[112] The Drug Summit did, however, lead to numerous reforms, including: the expansion of treatment services;[113] the introduction of a cannabis cautioning scheme;[114] and the introduction of a medically supervised injecting centre.[115] The Government also accepted the proposal that, in line with the *National Drug Strategy*, drug legislation and policing should have a harm minimisation objective, rather than a punitive one.[116]

The Drug Summit was both practically and symbolically significant. As a measure of its practical significance, the Government allocated $500 million over four years to implementing summit recommendations.[117] As to its symbolic significance, the Drug Summit: "signalled a distinct policy move away from an exclusive reliance on a prohibitionist approach";[118] and a commitment to

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[110] See: M Swain, *The New South Wales Drug Summit: Issues and Outcomes*, 1999, Briefing Paper 3/99, NSW Parliamentary Research Service; *NSW Drug Summit 1999: Government Plan of Action*, 1999, Government of NSW. Recently there have been calls for a new Drug Summit in NSW: E Duff, "Bob Carr joins calls for drug summit", 30/11/2014, *Sydney Morning Herald*; J Haylen, "We need a drug summit because we're losing the war", 18/2/2016, *The Drum*. See also the Parliamentary Drug Summit 2016, which was convened by the Parliamentary Group on Drug Policy and Law Reform; C Calcino, "NSW Government skips parliamentary drug summit", 4/3/2016, *The Queensland Times;* M Safi, "Parliamentary drug summit to hear case in favour of decriminalising possession", 2/3/206, *The Guardian*.

[111] "Carr calls summit", 7 February 1999, *Sun Herald*, in M Swain, *The New South Wales Drug Summit: Issues and Outcomes*, 1999, Briefing Paper 3/99, NSW Parliamentary Research Service, p 2.

[112] *NSW Drug Summit 1999: Government Plan of Action*, 1999, Government of NSW, 6.9; and related discussion in D Brown, D Farrier, L McNamara et al, *Criminal Laws: Materials and Commentary on Criminal Law and Process of New South Wales* (6th Ed), 2015, The Federation Press, Sydney, p 1062 ff.

[113] *NSW Drug Summit 1999: Government Plan of Action*, 1999, Government of NSW, 3.1.

[114] *NSW Drug Summit 1999: Government Plan of Action*, 1999, Government of NSW, 6.7.

[115] *NSW Drug Summit 1999: Government Plan of Action*, 1999, Government of NSW, 3.15. As to the effectiveness of the medically supervised injecting centre, see: KPMG, *Further evaluation of the Medically Supervised Injecting Centre During its Extended Trial Period (2007–2011)*, 2010, NSW Health, Sydney.

[116] *NSW Drug Summit 1999: Government Plan of Action*, 1999, Government of NSW, 9.5.

[117] D Brown, D Farrier, L McNamara et al, *Criminal Laws: Materials and Commentary on Criminal Law and Process of New South Wales* (6th Ed), 2015, The Federation Press, Sydney, p 1062.

[118] J Shaw and J Smith, "Choosing Life: The Drug Summit and Beyond" (2001) 1(1) *Macquarie*

problem-focused evidence-based reform.[119]

4.4.2 NSW Government policy

NSW has no separate overarching drug policy, operating as it does under the *National Drug Strategy*. State Plans have often referred to individual projects, such as strengthening the NSW Drug Court.[120] Currently a broad drug-related policy objective for NSW Health is set out in the *NSW State Health Plan — Towards 2021*, which states that NSW Health will address "drug misuse" by:

> [C]ontributing to whole of government strategies and programs to address drug related issues, ranging from prevention to treatment and resource planning; continuing to build a comprehensive range of treatment and withdrawal management services that range from brief to intensive interventions according to need; [and] encouraging and supporting local communities to lead local responses to local drug issues.[121]

5. NSW DRUG LAWS

Drug offences do not share the long common law heritage that characterises many other criminal offences, especially the many offences against the person and property found in the *Crimes Act 1900*. Instead, they are a modern statutory creation, one which reflects the social developments set out in chapter 2.[122] The statutory landscape is complex; as Brown, Farrier, McNamara et al explain:

> The importation of drugs into NSW is prohibited under the Commonwealth *Criminal Code*. The use, possession and supply of drugs within NSW are subject to overlapping Commonwealth and NSW laws, both of which prohibit the same forms of behaviour. There is also a bifurcation within the NSW legislative scheme, between the *Drug Misuse and Trafficking Act 1985* and the *Poisons and Therapeutic Goods Act 1986*.[123]

The situation is further complicated when legislation relating to young offenders, drug driving and various diversion, harm reduction and treatment programs is also considered. Additionally, it should be noted that some drug-related programs, such as the Cannabis Cautioning Scheme and Magistrates Early Referral into Treatment Scheme (MERIT), operate without a legislative basis.

Law Journal 145 at 147-148.

[119] J Shaw and J Smith, "Choosing Life: The Drug Summit and Beyond" (2001) 1(1) *Macquarie Law Journal* 145 at 146.

[120] *NSW 2021: A Plan to Make NSW Number One*, 2011, Government of NSW, p 35.

[121] NSW Ministry of Health, *NSW State Health Plan – Towards 2021*, 2014, Government of NSW, North Sydney, p 10.

[122] D Brown, D Farrier, L McNamara et al, *Criminal Laws: Materials and Commentary on Criminal Law and Process of New South Wales* (6th Ed), 2015, The Federation Press, Sydney, p 1050.

[123] D Brown, D Farrier, L McNamara et al, *Criminal Laws: Materials and Commentary on Criminal Law and Process of New South Wales* (6th Ed), 2015, The Federation Press, Sydney, p 1080.

The following NSW Acts relating to illegal drug use and possession are discussed in this chapter:

Table 8: Legislative overview
Drug Misuse and Trafficking Act 1985
• Prohibits the manufacture, supply, possession and use of prohibited drugs. • Provides for the operation of a Medically Supervised Injecting Centre. • Facilitates the Needle and Syringe Program by legalising the possession of hypodermic needles and syringes.
Drug Court Act 1998
• Established the Drug Court of NSW in order to: ○ reduce the drug dependency of eligible persons and eligible convicted offenders; ○ promote the reintegration of such drug dependent persons into the community; and ○ reduce the need for such drug dependent persons to resort to criminal activity to support their drug dependency
Poisons and Therapeutic Goods Act 1996
• Regulates, controls and prohibits the supply and use of poisons, restricted substances, drugs of addiction, certain dangerous drugs and certain therapeutic goods. • Facilitates the Methadone Maintenance Program by enabling methadone to be prescribed by doctors to heroin addicts.
Road Transport Act 2013
• Broad range of provisions relating to road users, road transport and the improvement of road safety. • Provides for random roadside drug testing and related offences
Young Offenders Act 1997
• Establishes procedures for dealing with children (persons over 10 and under 18 years of age) who commit certain offences (including possession and use of small quantities of prohibited drugs) through the use of youth justice conferences, cautions and warnings instead of court proceedings.

5.1 Historical development

One of the earliest attempts to regulate recreational drug use was the *Poisons Act 1902*. The Act adopted a regulatory approach; in that it established a licensing system for pharmacists and provided that drugs such as laudanum and opium could only be obtained from licensed pharmacists. The Act contained offences for non-compliance with its requirements.[124] For instance, s 5(2) of the *Poisons Act 1902* stated:

> Whosoever not being the holder of a certificate granted under this Act sells any poison shall be liable to a penalty not exceeding fifty pounds.

An overtly criminal approach was adopted by the *Police Offences (Amendment) Act 1908*. That Act made it an offence to sell, smoke or possess opium (except for medical purposes). Brown et al have commented:

[124] D Brown, D Farrier, L McNamara et al, *Criminal Laws: Materials and Commentary on Criminal Law and Process of New South Wales* (6th Ed), 2015, The Federation Press, Sydney, p 1080.

> [T]here is a considerable body of evidence to suggest the initial attack on non-medicinal opium was racially motivated, stemming from antagonism towards the Chinese community, where opium was smoked as a recreational drug.[125]

During the 1920s, the prohibitionist movement gathered pace in the United States and the rest of the international community.[126] NSW followed suit with the *Police Offences Amendment (Drugs) Act 1927* which, in addition to introducing new offences relating to opium smoking, prohibited the possession (except on prescription) of morphine, heroin and cocaine; and, from 1930 onwards, Indian Hemp (cannabis) and barbiturates.[127]

Although drug legislation in NSW had begun with two separate strands, one regulating medicinal drugs and the other criminalising recreational drugs, the regulatory and prohibitionist strands merged in the *Poisons Act 1966* (now known as the *Poisons and Therapeutic Goods Act 1966*).[128] This was reversed with the introduction of the *Drug Misuse and Trafficking Act 1985* because recreational drug use had become more widespread and drug-related harm more noticeable. As stated in the Second Reading speech, the *Drug Misuse and Trafficking Act 1985*:

> [C]odifies and extends the range of drug offences and penalties available in the war against drug trafficking. At present, the law relating to illegal drug use, possession and supply is contained in the *Poisons Act 1966*. This Act was originally designed as a public health measure. As the dimensions of the drug problem grew, and were recognized, the *Poisons Act* was periodically amended to incorporate new criminal procedures and offences. The result was a statute which was unnecessarily complicated and an unsatisfactory vehicle for dealing with what are properly regarded as some of the most serious of all criminal offences. In a sense, it never quite lost the character of a chemists and pharmaceuticals regulatory Act. This has now changed. … [T]he *Poisons Act* will return to its original function and a new statute, the *Drug Misuse and Trafficking Act*, will cover the criminal activity involving prohibited drugs.[129]

This historical development — one of a renewed emphasis on criminalisation — has resulted in the situation where, as the Judicial Commission found in 2012, "illicit drug offences"[130] were the most common type of offence sentenced in the

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[125] D Brown, D Farrier, L McNamara et al, *Criminal Laws: Materials and Commentary on Criminal Law and Process of New South Wales* (6th Ed), 2015, The Federation Press, Sydney, p 1080.

[126] S Bolt, *History of Drug Laws*, 2015, State Library of NSW.

[127] D Brown, D Farrier, L McNamara et al, *Criminal Laws: Materials and Commentary on Criminal Law and Process of New South Wales* (6th Ed), 2015, The Federation Press, Sydney, p 1081.

[128] *Poisons Amendment (Therapeutic Goods) Act 1996*, Sch 1[2]. Date of commencement, 1 September 1996, sec 2 and GG No 99 of 30.8.1996, p 4984.

[129] NSWPD, 28 November 1985, pp 11122-11123 (B Unsworth).

[130] This includes all drug-related offences, including: import, export, supply, manufacture, cultivation, possession, use and "other": P Poletti, Z Baghizadeh and P Mizzi, *Common offences in the NSW higher courts: 2010*, 2012, Sentencing Trends and Issues 41, Judicial Commission of New South Wales p 31, Appendix A.

NSW higher courts in 2010 (17.46% of all proven offences).[131] In the Local Court, illicit drug offences were the fifth most common type of offence sentenced in 2010 (6.08% of all proven offences).[132]

5.2 Possession and use offences

5.2.1 Possession of prohibited drugs

Possession of a prohibited drug[133] is a summary offence against s 10(1) of the *Drug Misuse and Trafficking Act 1985*, which states that: "A person who has a prohibited drug in his or her possession is guilty of an offence." Exemptions to the offence are provided for by s 10(2), including that the possession of a prohibited drug is not unlawful if a person:

- is licensed or authorised to have possession of a prohibited drug under the *Poisons and Therapeutic Goods Act 1996*;
- is approved to possess the drug for scientific research, instruction, analysis or study;
- has been lawfully prescribed or supplied the drug; and
- is possessing the drug for the sole purpose of caring for another person to whom the drug has been lawfully prescribed or supplied.

Where the amount of prohibited drugs possessed by a person is greater than the "traffickable quantity" for that particular drug, s 29 deems the possession to be for the purposes of supply. This renders a person liable to the offence of supply under s 25 of the *Drug Misuse and Trafficking Act 1985*.[134] The s 29 "deeming provision" reverses the criminal law burden of proof that — traditionally and as a matter of legal principal — is carried by the prosecution,[135] as it applies unless:

- the accused proves that he or she had the prohibited drugs in his or her possession for reasons other than for supply; or
- (except where the prohibited drug is prepared opium, cannabis leaf,

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[131] P Poletti, Z Baghizadeh and P Mizzi, *Common offences in the NSW higher courts: 2010*, 2012, Sentencing Trends and Issues 41, Judicial Commission of New South Wales, pp 6, 31.

[132] G Brignell, Z Baghizadeh, P Poletti, *Common offences in the NSW Local Courts: 2010*, 2012, Sentencing Trends and Issues 40, Judicial Commission of New South Wales, Appendix A.

[133] "Prohibited drug" is defined in s 3 of the *Drug Misuse and Trafficking Act 1985* to include all substances referred to in Schedule 1 of the Act.

[134] Supply is an indictable offence that carries penalties specified in ss 32, 33 and 33AA. The penalties for supply vary according to the amount and type of drug involved, and whether or not the drugs were supplied to a minor, from a fine of $220,000 and/or 10 years imprisonment to a fine of $462,000 and/or 25 years imprisonment. All penalties for supply greatly exceed the maximum penalties for possession and use, as set out at 5.2.3.

[135] For a discussion of this issue, see: C Hughes, A Ritter, N Cowdery and B Phillips, *Australian threshold quantities for 'drug trafficking': Are they placing drug users at risk of unjustified sanction?*, March 2014, Trends and Issues in Crime and Criminal Justice No 467, Australian Institute of Criminology.

> cannabis oil, cannabis resin, heroin or 6-monoacetylmorphine or any other acetylated derivatives of morphine) the accused proves that the prohibited drug was prescribed to them.

The traffickable quantities that apply to each type of prohibited drug are set out in Schedule 1 of the *Drug Misuse and Trafficking Act 1985*. The quantities for more commonly used prohibited drugs are shown in Table 9:

Table 9: Traffickable quantity where possession is deemed to be supply[136]

Drug	Traffickable quantity (grams)
Amphetamine	3.0
Cannabis leaf	300.0
Cannabis oil	5.0
Cannabis resin	30.0
Cocaine	3.0
Heroin	3.0
Ecstasy	0.75

5.2.2 Use of prohibited drugs

Use of a prohibited drug[137] is a summary offence against s 12(1) of the *Drug Misuse and Trafficking Act 1985*, which states:

> A person who administers or attempts to administer a prohibited drug to himself or herself is guilty of an offence.

As defined in s 5, using or administering a prohibited drug includes: ingesting, injecting, inhaling (both the actual drug and fumes from it), smoking and "any other means of introducing a prohibited drug into any part of the body of a person". As provided for by s 12(2), it is not an offence for a person to administer or attempt to administer to him or herself a prohibited drug that has been lawfully prescribed or supplied to the person.

Although recreational cannabis use remains illegal,[138] the NSW Government has established a Terminal Illness Cannabis Scheme in order to enable NSW residents with a terminal illness who have registered with the scheme to use cannabis to alleviate their symptoms:

> The scheme provides guidelines for NSW police officers to help them determine the appropriate circumstances in which to use their discretion not to charge adults with terminal illness who use cannabis and/or cannabis products to alleviate their symptoms and carers who assist them.[139]

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[136] *Drug Misuse and Trafficking Act 1985*, s 29, Schedule 1 Column 1.

[137] "Prohibited drug" is defined in s 3 of the *Drug Misuse and Trafficking Act 1985* to include all substances referred to in Schedule 1 of the Act.

[138] Cannabis is a prohibited plant/drug under the *Drug Misuse and Trafficking Act 1985*, Sch 1.

[139] "Terminal Illness Cannabis Scheme", 2016, NSW Government. Funding has also been provided for clinical trials into the efficacy of medicinal cannabis, and its possible use in

5.2.3 Applicable maximum penalties

Sections 10(1) and 12(1) are summary offences prosecuted before the Local Court.[140] They carry a maximum penalty of 20 penalty units ($2,200)[141] or a term of imprisonment of 2 years, or both.[142]

5.2.4 Prevalence of possession and use offences

Possession offences are numerous while use offences are not. This is likely to result from it being easier for police to apprehend someone in possession of drugs than someone in the relatively brief act of using drugs.

In the Local Court between January 2012 and December 2015 there were 34,394 cases where the principal offence[143] was possession or use of a prohibited drug against ss 10(1) and 12(1) of the *Drug Misuse and Trafficking Act 1985*: an average of 8,598 cases per year.[144] This figure comprised 34,192 cases where the principal offence was possession of a prohibited drug and 202 cases where the principal offence was use of a prohibited drug.

Table 10: Number of cases in the Local Court, by drug type, where possession or use of a prohibited drug was the principal offence, Jan 2012 to Dec 2015[145]

Drug	Possession*	Use**	Total
Amphetamines	7,224	40	7,264
Cannabis	17,052	75	17,127
Cocaine	1,875	15	1,890
Ecstasy	5,734	11	5,745
Hallucinogens (LSD)	238	1	239
Heroin	1,716	60	1,776

treating a range of medical conditions such as epilepsy: NSW Government, "Funds for medical cannabis research", 15 June 2015. As to potential industrial uses of cannabis, see D Montoya, *Hemp as fibre and food? Regulatory developments and current issues*, 2016, Briefing Paper 3/2016, NSW Parliamentary Research Service.

[140] *Drug Misuse and Trafficking Act 1985*, s 9.

[141] One penalty unit equals $110: see *Crimes (Sentencing Procedure) Act 1999*, s 17.

[142] *Drug Misuse and Trafficking Act 1985*, s 21.

[143] The Judicial Commission defines principal offence in the following terms: "If there is only one proven offence this constitutes the principal offence for the purposes of the statistics. Where two or more charges are proved against a person, the offence with the most severe penalty is selected as the principal offence. If two or more charges attract the same sentence, the offence with the highest maximum penalty is selected as the principal offence. In the higher courts, if two or more offences have the same maximum penalty and the same sentence, the offence with a Form 1 attached…is selected.": Judicial Commission of NSW, Judicial Information Research System, "Explaining the statistics" (as at 4 August 2016).

[144] Judicial Commission, Judicial Information Research System, *Local Court sentencing statistics*, as at June 2016.

[145] Judicial Commission, Judicial Information Research System, *Local Court sentencing statistics*, as at June 2016.

Table 10: Number of cases in the Local Court, by drug type, where possession or use of a prohibited drug was the principal offence, Jan 2012 to Dec 2015[145]

Drug	Possession*	Use**	Total
Other	99	0	99
Sedatives	254	0	254
Total number of cases	***34,192***	***202***	***34,394***

* Contrary to s 10(1) of the *Drug Misuse and Trafficking Act 1985*.

** Contrary to s 12(1) of the *Drug Misuse and Trafficking Act 1985.*

Additionally, in the NSW Children's Court between January 2012 and December 2015, there were: 705 cases where the principal offence was possession of a prohibited drug (of which 596 cases (85%) related to cannabis), an average of 176 cases per year; and 5 cases where the principal offence was use of a prohibited drug.[146]

In the NSW higher courts (District and Supreme Courts), between October 2008 and September 2015 there were 80 cases where the principal offence was possession of a prohibited drug (an average of 13 cases per year), and 1 case where the principal offence was use of a prohibited drug.[147]

5.2.5 Sentencing of possession and use offences in the Local Court

Approximately 98% all cases where the principal offence was the possession or use of a prohibited drug were determined in the Local Court.[148] The types of sentences imposed by the Local Courts for possession and use are set out in Tables 11 and 12, respectively. As those tables reveal, s 10 bonds (dismissal of charges and conditional discharge of offender) and fines are the two most common sentence outcomes.

[146] Judicial Commission, Judicial Information Research System, *Sentencing Statistics, Children's Court,* as at June 2016.

[147] Judicial Commission, Judicial Information Research System, *Sentencing Statistics, Higher Courts,* as at March 2016.

[148] Based on the Judicial Commission statistics set out at 5.2.4. This is despite the period covered by the higher court statistics (October 2008 to September 2015) being longer than the period covered by the Local Court and Children's Court statistics (January 2012 to December 2015).

Table 11: Type of penalty imposed by the Local Court, by type of drug, to individuals found guilty of possessing a prohibited drug, Jan 2012 to Dec 2015[149]

Drug	Penalty type (most common sentence type highlighted)*										
	No conviction		*Conviction*								
	Dismissal (s 10)	**Bond (s 10)**	**Conviction no other penalty (s 10A)**	**Rise of court**	**Fine only**	**Bond (s 9)**	**Community Service Order**	**Suspended Sentence**	**Intensive Corrections Order**	**Home Detention**	**Prison**
Amphetamines (n = 7224)	5%	11%	3%	0%	**63%**	13%	0%	1%	0%	0%	3%
Cannabis (n = 17052)	7%	8%	5%	0%	**69%**	9%	0%	1%	0%	0%	1%
Cocaine (n = 1875)	11%	**48%**	1%	0%	35%	5%	0%	0%	0%	0%	0%
Ecstasy (n = 5734)	19%	**50%**	1%	0%	28%	2%	0%	0%	0%	0%	0%
Hallucinogens (n = 238)	8%	**47%**	0%	0%	39%	5%	0%	0%	0%	0%	0%
Heroin (n = 1716)	3%	5%	6%	0%	**60%**	19%	0%	2%	0%	0%	6%
Other (n = 99)	8%	20%	1%	0%	**53%**	14%	2%	0%	0%	0%	2%
Sedatives (n = 254)	12%	**44%**	3%	0%	31%	9%	0%	0%	0%	0%	0%

*For more details concerning sentencing options, see the Crimes (Sentencing Procedure) Act 1999. Note: due to the rounding of percentages, a category with 0% may actually contain a small number of cases, and the total percentage may not equal 100.

[149] Judicial Commission, Judicial Information Research System, *Local Court sentencing statistics,* as at June 2016.

Table 12: Type of penalty imposed by the Local Court, by type of drug, to individuals found guilty of using a prohibited drug, Jan 2012 to Dec 2015[150]

Drug	Penalty type (most common sentence type highlighted)*										
	No conviction		*Conviction*								
	Dismissal (s 10)	Bond (s 10)	Conviction no other penalty (s 10A)	Rise of court	Fine only	Bond (s 9)	Community Service Order	Suspended Sentence	Intensive Corrections Order	Home Detention	Prison
Amphetamines (n = 40)	5%	5%	3%	0%	**68%**	15%	0%	0%	0%	0%	5%
Cannabis (n = 75)	9%	9%	1%	0%	**71%**	9%	0%	0%	0%	0%	0%
Cocaine (n = 15)	33%	**40%**	0%	0%	13%	13%	0%	0%	0%	0%	0%
Ecstasy (n = 11)	27%	**45%**	0%	0%	18%	9%	0%	0%	0%	0%	0%
Hallucinogens (n = 1)	0%	0%	0%	0%	**100%**	0%	0%	0%	0%	0%	0%
Heroin (n = 60)	2%	0%	17%	0%	**68%**	12%	0%	0%	0%	0%	2%

*For more details concerning sentencing options, see the *Crimes (Sentencing Procedure) Act 1999*. Note: due to the rounding of percentages, a category with 0% may actually contain a small number of cases, and the total percentage may not equal 100.

5.3 Drug driving

Drug driving refers to driving a vehicle (or attempting to do so) while under the influence of illegal drugs. Due to their stimulatory, depressant and/or hallucinogenic effects, illegal drugs have the potential to impair a person's capacity to drive a vehicle safely.[151] The precise effect of drugs on driving capacity is complex, depending on the interaction between factors such as:[152]

- the type of prohibited drug used;

[150] Judicial Commission, Judicial Information Research System, *Local Court sentencing statistics (as at June 2016)*.

[151] Section 4 of the *Road Transport Act 2013* defines "drive" to include being "in control of the steering, movement or propulsion of a vehicle" and defines "vehicle" to include "any description of vehicle on wheels". On the potential impacts of various prohibited drugs on driving capacity, see: J Mallick, J Johnston, N Goren and V Kennedy, *Drugs and Driving in Australia, 2007: A survey of community attitudes, experience and understanding*, 2007, Australian Drug Foundation, Melbourne; *How do drugs affect driving?*, 2016, Emergency Medical Services Authority; Transport, Centre for Road Safety, *Illegal drugs*, 23 April 2014, Government of NSW.

[152] J Mallick, J Johnston, N Goren and V Kennedy, *Drugs and Driving in Australia, 2007: A survey of community attitudes, experience and understanding*, 2007, Australian Drug Foundation, Melbourne.

- the amount of prohibited drug used;
- whether a combination of prohibited drugs have been taken (polydrug use);
- the time between drug use and driving;
- any interaction between prohibited drugs, legal drugs and/or medication;
- individual physiological differences; and
- individual differences in emotional states.

5.3.1 Drug driving laws

In 2006, concerns about the risk posed by drug driving led the Government to introduce random roadside drug testing and related offences, based on the existing model of random breath testing for alcohol.

Under s 111(1)(a) of the *Road Transport Act 2013* a person must not drive a motor vehicle while any prescribed illicit drug is present in the person's oral fluid, blood or urine. The maximum penalty for an offence against s 111(1) is 10 penalty units ($1100) in the case of a first offence or 20 penalty units ($2,200) in the case of a second or subsequent offence.[153]

Section 4 of that Act defines "prescribed illicit drug" as:

> (a) delta-9-tetrahydrocannabinol (also known as THC),
>
> (b) methylamphetamine (also known as speed),[154]
>
> (c) 3,4-methylenedioxymethylamphetamine (also known as ecstasy).

In the Local Court, between July 2013 and December 2015, there were 5,954 cases where the principal offence was driving with a prescribed illicit drug present in oral fluid, blood or urine (first offence).[155]

5.3.2 Drug driving fatalities

According to the NSW Centre for Road Safety 195 people died in 174 drug driving fatal crashes in the four-year period from 2010 to 2013 (see also Figure 8):

> These crashes involved a driver or rider with at least one of three illicit drugs (cannabis, speed or ecstasy) in their system.
>
> Fatalities from these crashes make up about 13 per cent of the road toll.
>
> The 174 crashes involved 140 drivers and 34 motorcycle riders with one of these illicit drugs found in their system.

---

[153] One penalty unit equals $110: see *Crimes (Sentencing Procedure) Act 1999*, s 17.

[154] While methylamphetamine is expressly equated with speed, there is no reference to ice, the crystalline form of methylamphetamine.

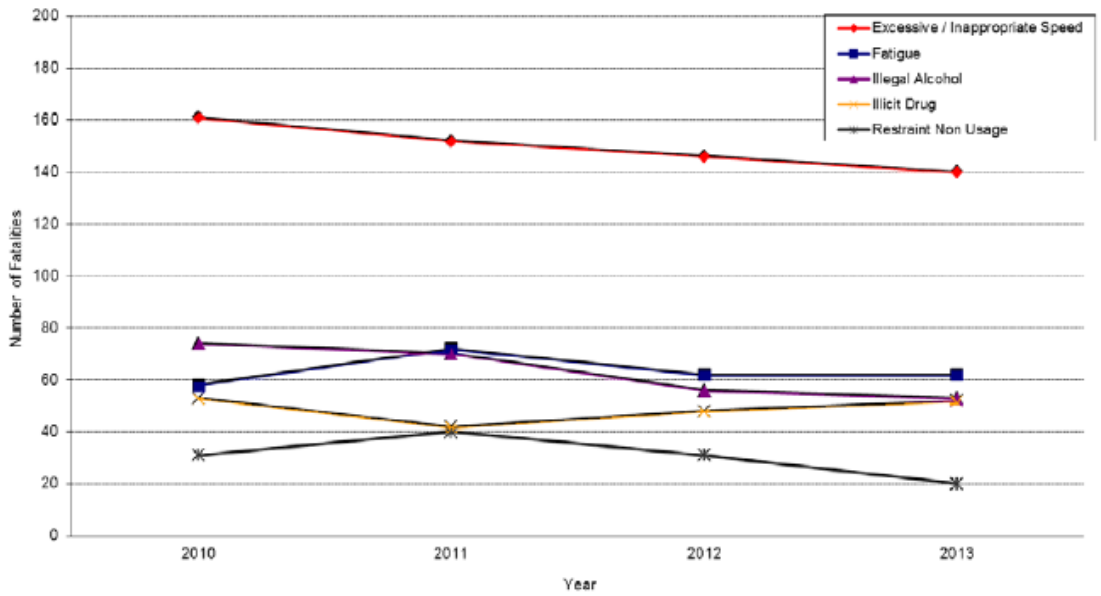
[155] Judicial Commission, Judicial Information Research System, *Sentencing Statistics, NSW Local Courts,* as at June 2015*,* sentences from July 2013 to December 2015.

Of the 140 drug drivers involved in fatal crashes, 20 were heavy truck drivers.

Other contributing factors in these crashes included illegal speeding, alcohol and fatigue.

Over the period from January 2010 to September 2013, there were about 3,900 drivers and riders convicted of drug driving offences on NSW roads.[156]

Figure 8: Number of fatalities by behaviour factor present, 2010 to 2013[157]



5.3.3 Current debate about random roadside drug testing

The current debate about random roadside drug testing concerns the accuracy, interpretation and effect of the following advice provided to the public by the Centre for Road Safety:

> Illegal drugs can be detected in your saliva by an MDT for a significant time after drug use, even if you feel you are OK to drive. The length of time that illegal drugs can be detected by MDT depends on the amount taken, frequency of use of the drug, and other factors that vary between individuals. Cannabis can typically be detected in saliva by an MDT test stick for up to 12 hours after use. Stimulants (speed, ice and pills) can typically be detected for one to two days.[158]

The concern arose after one man was acquitted of a charge of drug driving after mistakenly believing that, having smoked cannabis nine days before being tested by police, he could drive without testing positive.[159] Another man was

[156] NSW Centre for Road Safety, *Drug driving — Fact sheet*, June 2015, Government of NSW. For the current provisions relating to the operation of random roadside drug testing, see Schedule 3 of the *Road Transport Act 2013*.

[157] NSW Centre for Road Safety, *Drug driving — Fact sheet*, June 2015, Government of NSW, p3

[158] NSW Centre for Road Safety, *Drugs and Driving*, 2 February 2016, Government of NSW.

[159] L Knowles and A Branley, "Acquittal of man caught drug-driving nine days after smoking cannabis throws NSW drug laws into doubt", 3 February 2016, *ABC News*.

convicted of drug driving even though he used cannabis for medicinal reasons four days before being tested.[160]

The Government's position on the issue was expressed by Troy Grant MP, Deputy Premier and Minister for Justice and Police, in response to a question without notice on roadside drug testing:

> Drug driving offences are zero tolerance and drivers will be charged if they test positive for any amount of illicit drugs in their system. A safe level of illicit drugs cannot be determined; nor can it be calculated when their effects may wear off, especially if combined with other drugs and/or alcohol.[161]

5.4 Diversion programs

NSW's approach to illegal drugs incorporates a range of diversion programs including formal police cautions[162] and court-based diversion programs.

5.4.1 Young Offenders Act 1997

An offence against ss 10(1) and 12(1) of the *Drug Misuse and Trafficking Act 1985* involving not more than a "small quantity"[163] of drugs "is covered by" the *Young Offenders Act 1997*.[164] The objective of the *Young Offenders Act 1997* is to divert children (persons over 10 and under 18 years of age)[165] from the criminal justice system, by means of warnings, cautions and youth justice conferences.[166] This objective specifically includes addressing the over-representation of Aboriginal and Torres Strait Islander children in the criminal justice system.[167]

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[160] L Visentin, "Mystery' laws: drug-driving push picks up medical marijuana user", 13 February 2016, *Sydney Morning Herald*

[161] NSWPD, 23 February 2016, (T Grant).

[162] While this paper discusses formal caution programs that apply to illegal drug use and possession offences, it should be noted that police in NSW also have a well-established common law discretion not to arrest a person who they suspect has committed an offence and, instead, issue an informal caution: *Sentencing*, 2013, Report 139, NSW Law Reform Commission, 16.3, p 340 and accompanying notes, including *R v Commissioner of Police; Ex Blackburn* [1968] 2 QB 118, 136, 139.

[163] In respect of each type of drug, "small quantity" is defined in Column 2 of Schedule 1 of the *Drug Misuse and Trafficking Act 1985*.

[164] *Young Offenders Act 1997*, s 8(2A). The *Young Offenders Act 1997* applies where the amount of the drug involved is not more than the "small amount" (or, in the case of cannabis leaf, half the small amount, or the small amount where exceptional circumstances also exist), as defined in Column 2 of Schedule 1 of the *Drug Misuse and Trafficking Act 1985*.

[165] Section 4 of the *Young Offenders Act 1997*.

[166] See *Young Offenders Act 1997*: s 3 (objectives), s 7 (principles), Part 3 (warnings), Part 4 (cautions) and Part 5 (Youth Justice Conferences). The NSW Bureau of Crime Statistics and Research has found that the system of cautions and conferences under the [*Young Offenders Act*] has reduced the risk of young people, including Aboriginal people and Torres Strait Islanders, receiving a custodial sentence: W Wan, W Moore and S Moffatt, *The Impact of the NSW Young Offenders Act (1997) on Likelihood of Custodial Order*, 2013, 166 *Crime and Justice Bulletin*, NSW Bureau of Crime Statistics and Research, p 8.

[167] *Young Offenders Act 1997,* s 3(d).

5.4.2 Cannabis Cautioning Scheme

Origins: In response to the NSW Drug Summit, in April 2000 the Government introduced a Cannabis Cautioning Scheme for adult offenders. The scheme aims to use "police intervention to assist offenders to consider the legal and health ramifications of their cannabis use and seek treatment and support".[168] Its main features have been described as follows:

> Prior to the commencement of the Scheme in NSW, police had the option of either informally warning minor cannabis offenders or charging offenders and having the Court determine the matter. No information, treatment services or other structured intervention was available to offenders for their cannabis use.
>
> The Scheme essentially introduces formal cautioning as a third option available to police for dealing with minor cannabis offenders. This affords police a formal, more accountable and transparent way for dealing with minor cannabis offenders. The Scheme also provides cautioned offenders with educational material and access to treatment and support services for their cannabis use.
>
> Police are directed in the Scheme by a set of guidelines (the Cannabis Cautioning Scheme Guidelines). There is no legislative base for the Scheme.[169]

Operation: The eligibility criteria for the Cannabis Cautioning Scheme include the following:

- the offender must possess no more than 15 grams of dried cannabis and/or equipment for the use of cannabis
- the offender must be an adult
- the identity of the offender must be confirmed using normal checks
- sufficient evidence to prosecute the offender must exist
- the drug must be for personal use only
- the offender must not be involved in any other criminal offence at the time, for which a brief of evidence would be submitted
- the offender must have no prior convictions for drug, violent or sexual offences
- the offender must admit to the offence
- the offender must consent to the caution and sign the caution notice
- the caution must be appropriate.[170]

A person can only be cautioned twice; on the second occasion they are required to undertake a mandatory education session on cannabis use:

> The formal NSW Police Force caution warns of the health and legal consequences

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[168] *NSW Drug Summit 1999: Government Plan of Action*, 1999, Government of NSW, 6.7 (p 70); *Cannabis Cautioning Scheme*, 20 June 2014, NSW Police Force.

[169] J Baker and D Goh, *The Cannabis Cautioning Scheme Three Years on: An Implementation and Outcome Evaluation*, 2004, Bureau of Crime Statistics and Research, p 3.

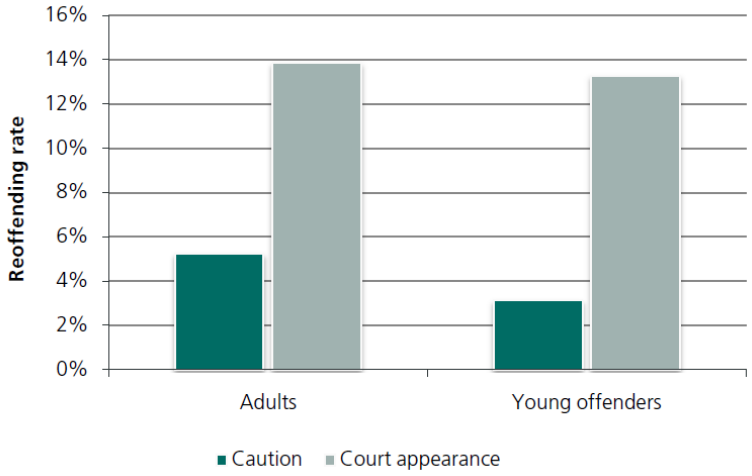
[170] J Baker and D Goh, *The Cannabis Cautioning Scheme Three Years on: An Implementation and Outcome Evaluation*, 2004, Bureau of Crime Statistics and Research, p 3.

> of cannabis use. The caution notice provides contact telephone numbers for the Alcohol and Drug Information Service (ADIS). ADIS provides a dedicated, confidential service to a cautioned offender that includes information about treatment, counselling and support services.
>
> People who receive a second and final caution are required to contact ADIS for a mandatory education session about their cannabis use.[171]

Evaluation: In 2011, the NSW Auditor-General found that, between 2000–2001 and 2009–2010, 31,699 adult and 7,400 young offenders were cautioned for minor cannabis offences (under, respectively, the Cannabis Cautioning Scheme or the *Young Offenders Act*), with an estimated saving of $20 million in court costs.[172] Additional savings will also accrue from the reduced rates of recidivism that the NSW Auditor-General found to be associated with cautioning for cannabis offences (Figure 9):

> [C]autioning also keeps people out of the criminal justice system in the long term. People cautioned for minor cannabis offences are less likely to reoffend than those dealt with by a court. This also shows that cautioning is targeting minor offenders as intended.[173]

Figure 9: Average re-offending rate: 2000–01 to 2006–07[174]



5.4.3 Magistrate's Early Referral into Treatment Program (MERIT)

Origins: The Magistrates Early Referral Into Treatment Program (MERIT) is a

[171] *Cannabis Cautioning Scheme*, 20 June 2014, NSW Police Force.

[172] *The Effectiveness of Cautioning for Minor Cannabis Offences*, 2011, Audit Office of NSW, p 12.

[173] *The Effectiveness of Cautioning for Minor Cannabis Offences*, 2011, Audit Office of NSW, p 15.

[174] *The Effectiveness of Cautioning for Minor Cannabis Offences*, 2011, Audit Office of NSW, p 15. The graph relates to the proportion of adults and young offenders who were cautioned (under, respectively, the Cannabis Cautioning Scheme or the *Young Offenders Act*) or appeared in court for minor cannabis offences, and who later appeared in court for a similar offence within two years.

court-based early intervention program that provides adult defendants who have substance abuse problems with the opportunity to access treatment and rehabilitation services whilst on bail.[175] MERIT commenced in July 2000 on a trial basis at the Lismore Local Court. Operating in 65 Local Courts across NSW, the program is accessible to more than 80 per cent of defendants appearing before magistrates. There is no legislative basis for the scheme.

Operation: Defendants can be identified by the Magistrate, solicitor, police or the defendants themselves as suitable for assessment for the program. To be eligible for the program, a defendant must:

- be an adult;
- be charged with an offence that is not a sexual offence or a strictly indictable offence;
- be eligible for bail or not require bail consideration;
- voluntarily agree to participate in MERIT; and
- be suspected of using drugs or be known to have a history of drug use or alcohol misuse.

Treatment generally occurs prior to any pleas being made and involves an adjournment of court matters and the granting of bail. The final hearing and sentence generally coincide with the completion of the MERIT program, which enables Magistrates to consider the defendant's progress in treatment as part of final sentencing.

Between 1 July 2000 and 30 June 2011, a total of 25,714 defendants were referred to MERIT.[176] Of these, 16,046 (62%) were accepted into the program and a total of 10,156 participants (63% of acceptances) were recorded as having successfully completed it. Howard and Martie note:

> There are considerable differences between the principal penalty outcome for program completers and non-completers. For the 2008 cohort, the most common sentence outcome for MERIT program completers was a bond with supervision (18.2%) or a bond without supervision (17%). The most common sentence outcome for program non-completers was a fine (28.9%) or a term of imprisonment (18.6%).[177]

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[175] See NSW Justice, The MERIT program, 11 November 2014, Government of NSW; M Howard and K Martie, *Magistrates Early Referral Into Treatment: An overview of the MERIT program as at June 2011*, 2012, Crime Prevention Issues Bulletin No 9, NSW Attorney-General and Justice; *Sentencing*, 2013, Report 139, NSW Law Reform Commission, p 345-349; *Department of Police and Justice: 2013-14 Annual Report*, 2014, NSW Department of Police and Justice, p 34.

[176] M Howard and K Martie, *Magistrates Early Referral Into Treatment: An overview of the MERIT program as at June 2011*, 2012, Crime Prevention Issues Bulletin No 9, NSW Attorney-General and Justice, p 2.

[177] M Howard and K Martie, *Magistrates Early Referral Into Treatment: An overview of the MERIT program as at June 2011*, 2012, Crime Prevention Issues Bulletin No 9, NSW Attorney-General and Justice, p 3.

Evaluation: A 2009 BOCSAR paper examined the impact of program participation on re-offending by defendants with a drug use problem.[178] The study evaluated MERIT over the three-year period 1 July 2002 to 30 June 2005. The end date was chosen so that all participants had a minimum two-year follow-up period. The paper stated that "completion of MERIT was estimated to reduce the numbers of defendants committing any offence by 12 percentage points and any theft offence by four percentage points".[179] The paper noted that there were some potential limitations with the study because it was not a randomised controlled trial.[180]

A more recent study by the National Drug and Alcohol Research Centre examined the impact of the program on reoffending within 12 months for offenders who exited the program in 2008. [181] In summary, it reported:

> Our results are consistent with those from the only other study to have examined recidivism outcomes for both program participants and a comparison group … in that exposure to MERIT was found to offer no protective effect against the likelihood of any reconviction, but program completion did.[182]

5.4.4 Drug Court

Origins: Established under the *Drug Court Act* 1998, the Drug Court of NSW aims to address underlying drug dependency that has resulted in criminal offending by facilitating treatment programs as part of the court process.[183] It has been operating at Parramatta since 1999. In 2011, a second Drug Court was set up in the Hunter region and in 2013 a Drug Court was established at the Downing Centre in Sydney. There is currently capacity to assist 280 participants across the three courts.[184]

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[178] R Lulham, *The Magistrates Early Referral Into Treatment Program: Impact of program participation on reoffending by defendants with a drug use problem*, July 2009, Crime and Justice Bulletin No 131, NSW Bureau of Crime Statistics and Research.

[179] R Lulham, *The Magistrates Early Referral Into Treatment Program: Impact of program participation on reoffending by defendants with a drug use problem*, July 2009, Crime and Justice Bulletin No 131, NSW Bureau of Crime Statistics and Research, p 9.

[180] BOCSAR has conducted a review of Alcohol-MERIT but not in relation to re-offending: see S Spratley, N Donnelly and L Trimboli, *Health and wellbeing outcomes for defendants entering the Alcohol-MERIT program*, December 2013, Issue Paper No 92, NSW Bureau of Crime Statistics and Research.

[181] T McSweeney, C Hughes and A Ritter, "Tackling 'drug-related' crime: Are there merits in diverting drug-misusing defendants to treatment? Findings from an Australian case study" (2015) 49(2) *Australian and New Zealand Journal of Criminology* 198.

[182] T McSweeney, C Hughes and A Ritter, "Tackling 'drug-related' crime: Are there merits in diverting drug-misusing defendants to treatment? Findings from an Australian case study" (2015) 49(2) *Australian and New Zealand Journal of Criminology* 198, pp 214-15.

[183] See *Drug Court Act 1998*, s 3; *Sentencing*, 2013, Report 139, NSW Law Reform Commission, pp 320-324.

[184] *Department of Police and Justice: 2013-14 Annual Report*, 2014, NSW Department of Police and Justice, p 39.

Operation: Eligible drug dependent offenders are referred to the Drug Court by the Local and District Courts. To be eligible for the Drug Court program, a person must:

- be an adult;
- be charged with an offence that is not a violent offence, a sexual offence or an indictable offence under the *Drug Misuse and Trafficking Act 1985*;
- be highly likely to be sentenced to full-time imprisonment if convicted;
- have indicated that he or she will plead guilty to the offence;
- be dependent on the use of prohibited drugs; and
- be willing to participate.

After the assessment stage, the offender appears before the Drug Court where he or she enters a guilty plea, receives a sentence that is suspended, and signs an undertaking to abide by his or her program conditions. The Drug Court program lasts for at least 12 months unless terminated sooner:

> A Drug Court program can be terminated when the:
>
> - court decides that the participant has substantially complied with the program
> - participant applies to have it terminated
> - court decides that the participant is unlikely to make any further progress in the program, or that further participation poses an unacceptable risk to the community that the offender will re-offend.
>
> When a program is terminated, the court must reconsider the initial sentence. If appropriate that sentence can be set aside and another sentence imposed in its place. In deciding the final sentence the court will take into consideration the nature of the offenders participation in the program, any sanctions that have been imposed and any time spent in custody during the program. The initial sentence cannot be increased.
>
> When the court finds that a participant has substantially complied with a program a non-custodial sentence is the usual order…[185]

Evaluation: In a 2008 paper, BOCSAR published the results of a re-evaluation of the Drug Court.[186] It compared reconviction rates (time until re-conviction) amongst participants in the Drug Court program with those amongst a statistically matched comparison group deemed eligible for the program but excluded either because they resided out of area or because they had been convicted of a violent offence. The sample consisted of all offenders who made it into the eligibility assessment phase of the program between February 2003 and April 2007. There were 645 offenders in the Drug Court Group and 329 offenders in the Comparison Group. In summary, the study found:

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[185] *When we terminate a program*, 24 March 2015, Drug Court of NSW.

[186] D Weatherburn, C Jones, L Snowball and J Hua, *The NSW Drug Court: A re-evaluation of its effectiveness*, September 2008, Contemporary Issues in Crime and Justice No 121, NSW Bureau of Crime Statistics and Research.

> Compared with those in the Comparison Group, Drug Court participants in the present study 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.[187]

The paper noted a qualification to these results, namely that there may have been some unmeasured factors that influenced both selection into the Drug Court program and the risk of further offending.[188]

In a separate paper, BOCSAR estimated that the Drug Court provides a net saving of $1.758 million per year relative to conventional sanctions (i.e. imprisonment). The paper concluded:

> Since Drug Court participants have demonstrated better effectiveness in terms of time to first offence…and the total cost of the Drug Court relative to conventional sanctions is negative, we can say from a cost-effectiveness perspective the Drug Court program dominates usual incarceration. In other words it is cheaper and produces better outcomes than the alternative. This conclusion means that the NSW Drug Court is likely to be a cost-effective approach.[189]

5.4.5 Law Reform Commission recommendations

In its report *Sentencing*, the Law Reform Commission considered the operation of the Cannabis Cautioning Scheme, MERIT, and the NSW Drug Court. Three recommendations of particular relevance to the current debate concerning illicit drug use and possession are set out in Table 13.

Table 13: Recommendations from the NSW Law Reform Commission's Sentencing report relating to harm minimisation, diversion and treatment for illegal drug use and possession[190]

Cannabis Cautioning Scheme	**Recommendation 16.1(1):** The cannabis cautioning scheme should be expanded to cover possession of small quantities of other prohibited drugs.
MERIT program	**Recommendation 16.3:** Consideration should be given to expanding the operation of the MERIT program as far as is possible given resource constraints.
Drug Court	**Recommendation 15.1:** Consideration should be given to expanding the Drug Court's geographic coverage, as resources permit, especially to areas where drug dependent crime are particularly prevalent.

[187] D Weatherburn, C Jones, L Snowball and J Hua, *The NSW Drug Court: A re-evaluation of its effectiveness*, September 2008, Contemporary Issues in Crime and Justice No 121, NSW Bureau of Crime Statistics and Research, p 1.

[188] D Weatherburn, C Jones, L Snowball and J Hua, *The NSW Drug Court: A re-evaluation of its effectiveness*, September 2008, Contemporary Issues in Crime and Justice No 121, NSW Bureau of Crime Statistics and Research, p 13.

[189] S Goodall, R Norman and M Haas, *The Costs of the NSW Drug Court*, September 2008, Contemporary Issues in Crime and Justice No 122, NSW Bureau of Crime Statistics and Research, p 13.

[190] *Sentencing*, 2013, Report 139, NSW Law Reform Commission.

With respect to its recommendation to expand the Cannabis Cautioning Scheme, the Law Reform Commission said:

> Expanding the scheme would allow a larger number of first time offenders to be diverted from the criminal justice system. The diversion scheme would also apply *consistently across minor possession offences which carry the same maximum penalty*.[191] [emphasis added]

Regarding its recommendations on the Drug Court and MERIT, the Law Reform Commission acknowledged that, while expanding the geographic reach of the Drug Court was desirable:

> [E]xpanding the Magistrates Early Referral Into Treatment (MERIT) program to more locations across NSW … may offer a less resource intensive way of providing intervention for drug dependent offenders.[192]

In addition to providing MERIT in more locations, the Law Reform Commission provided other options for expanding the operation of MERIT, including:

- redesigning aspects of the program so that defendants with limited literacy, limited English, or a cognitive or mental health impairment may participate;
- redesigning aspects of the MERIT program so that it is of more benefit to Aboriginal and Torres Strait Islander defendants; and
- allowing juvenile defendants access to MERIT.[193]

5.5 Harm reduction programs

5.5.1 Needle and Syringe Program

Origins: The first Australian case of an injecting drug user without other risk factors contracting HIV was in 1985.[194] In an attempt to reduce the spread of HIV (and other blood born viruses), a pilot Needle and Syringe Program (NSP) commenced in Darlinghurst in 1986 and was rolled out across the State in 1988.[195] The NSP principally seeks to achieve its objective by distributing sterile injecting equipment and promoting the safe disposal of used injecting equipment; education programs and referrals to other health and welfare services also form part of the program.[196]

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[191] *Sentencing*, 2013, Report 139, NSW Law Reform Commission, Sydney, 16.17, p 343.

[192] *Sentencing*, 2013, Report 139, NSW Law Reform Commission, Sydney, 15.24, p 325.

[193] *Sentencing*, 2013, Report 139, NSW Law Reform Commission, Sydney, 16.40, p 349.

[194] K Dolan, M MacDonald, E Silins and L Topp, *Needle and syringe programs: A review of the evidence*, 2005, Department of Health and Ageing, Government of Australia, Canberra, p 4. At the time more than half of injecting drug users had Hepatitis C.

[195] Commonwealth Department of Health, *Return on investment in needle and syringe programs in Australia*, 2002, Government of Australia.

[196] NSW Ministry of Health, *NSW Needle and Syringe Program: Guidelines 2013*, 28 August 2013, Government of NSW, Sydney, p 3.

In 2012, there were 1,021 NSP outlets, including:

- 346 primary and secondary outlets;
- 141 automatic dispensing machines;
- 46 internal dispensing chutes; and
- 488 community pharmacies administering the NSW Pharmacy Fitpack Scheme.[197]

Legal basis: In 1987, the NSW Government legalised the possession of needles and syringes in order to facilitate the expansion of the NSP.[198] The *Drug Misuse and Trafficking (Amendment) Act 1987* inserted subsection (1A) into s 11 of the *Drug Misuse and Trafficking Act 1985*, which now reads:

> **11 Possession of equipment for administration of prohibited drugs**
>
> (1) A person who has in his or her possession any item of equipment for use in the administration of a prohibited drug is guilty of an offence
>
> (1A) Subsection (1) does not apply to or in respect of a hypodermic syringe or a hypodermic needle.

Further, cl 19 of the Drug Misuse and Trafficking Regulation 2011 exempts persons authorised by the Director-General of the Department of Health to operate a needle and syringe program from criminal liability under the following provisions of the Act:

- s 11: possession of equipment for administering prohibited drugs;
- s 19: aiding, abetting counselling, procuring, soliciting or inciting in NSW an offence in Part 2 Division 1 of the *Drug Misuse and Trafficking Act 1985*; and
- s 20: aiding, abetting counselling, procuring, soliciting or inciting from within NSW the commission of an offence outside NSW that corresponds to an offence against Part 2 Division 1 of the *Drug Misuse and Trafficking Act 1985*.

These legal provisions are supported by police practice, in accordance with the *Needle and Syringe Program Police Guidelines*, which state:

> Without restricting their day to day duties and obligations, police should be mindful not to carry out unwarranted patrols in the vicinity of NSPs that might discourage injecting drug users from attending ….
>
> Exercising discretion in the vicinity of NSPs has at times been thought by police to mean that the immediate vicinity of NSPs are “no go” areas. This is not the case. If drug supply or other criminal activity is occurring in the vicinity of NSPs, police

[197] NSW Ministry of Health, *NSW Needle and Syringe Program: Guidelines 2013*, 28 August 2013, Government of NSW, Sydney, p 2. The Fitpack contains injecting equipment and a personal sharps container, and provides a means of safely disposing of used equipment.

[198] Commonwealth Department of Health, *Return on investment in needle and syringe programs in Australia*, 2002, Government of Australia.

should act appropriately.[199]

Evaluation: The NSP is viewed by NSW Health as being "the single most important and cost effective" harm-minimisation strategy for injecting drug users.[200] Summarising evaluation programs conducted into the effectiveness of NSP programs across Australia, NSW Health states:

> In 2002 the Australian Government released an independent report, *Return on Investment in Needle and Syringe Programs in Australia*. It found that between 1991 and 2000 investment of $130 million (in 2000 prices) by Australian governments on Needle and Syringe Programs had prevented 25,000 cases of HIV and 21,000 cases of hepatitis C. The long term saving to the national health system in avoided treatment costs was approximately $7.8 billion.
>
> This report was followed in 2009 by the *Return on Investment 2: Evaluating the cost-effectiveness of needle and syringe programs in Australia.* This report reinforced the findings of the 2002 report, and concluded that between 2000 and 2009 the NSP had directly averted 32,050 new HIV infections and 96,667 new hepatitis C infections in Australia. In NSW an estimated 23,324 HIV cases and 31,953 hepatitis C cases were averted due to the NSP. The report estimated that the spending of $81 million on the NSP in NSW over this period resulted in a saving of $513 million in health care costs and a net financial saving of $432 million to the NSW Health system.[201]

5.5.2 Medically Supervised Injecting Centre

Origins: Following the NSW Drug Summit, the NSW Government supported the trial of one Medically Supervised Injecting Centre (MSIC).[202] The MSIC began operating in May 2001 as the first service of its type in the English-speaking world.[203]

Legislative basis: A legislative basis for the operation of the MSIC was established by the *Drug Summit Legislative Response Act 1999*, which inserted a new Part 2A into the *Drug Misuse and Trafficking Act 1985*. Part 2A effectively provides that only one licensed MSIC can operate at any given time.[204] As set out in s 36B, the objects of an MSIC are:

> (a) to reduce the number of deaths from drug overdoses,
>
> (b) to provide a gateway to treatment and counselling for clients of the licensed injecting centre,
>
> (c) to reduce the number of discarded needles and syringes and the incidence of

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[199] *The Needle and Syringe Program: Guidelines for Police*, 2013, NSW Police Force. Note that the review date for these guidelines is March 2018.

[200] NSW Ministry of Health, *NSW Needle and Syringe Program: Guidelines*, 2013, Government of NSW, Sydney, p 2.

[201] NSW Ministry of Health, *NSW Needle and Syringe Program: Guidelines 2013*, 28 August 2013, Government of NSW, Sydney, p 2.

[202] *NSW Drug Summit 1999: Government Plan of Action*, 1999, Government of NSW, 3.15, p 47.

[203] *The MSIC story: Our story*, Uniting Church Medically Supervised Injecting Centre.

[204] Section 36A of the *Drug Misuse and Trafficking Act 1985*.

> drug injecting in public places,
>
> (d) to assist in reducing the spread of blood-borne diseases, such as HIV infection or Hepatitis C.

Under s 36I, it is an express statutory condition of a licence for a MSIC that no child (defined by s 36D to mean "a person who is under the age of 18 years") is to be admitted to that part of the centre that is used for the purpose of the administration of prescribed drugs; and that the centre's internal management protocols (which exclude pregnant women)[205] are to be observed.[206]

Division 4 of Part 2A provides for exemptions from liability for users and operators of the MSIC. As set out in s 36N(2), despite any other provision of the *Drug Misuse and Trafficking Act 1985* or any other law, it is not unlawful for a person at an MSIC:

- to possess (otherwise than for supply) no more than a small or exempt[207] quantity of a prohibited drug;
- to possess equipment for use in the administration of a prohibited drug;[208] or
- to administer or attempt to administer to himself or herself no more than a small or exempt quantity of a prohibited drug.

Other exemptions include:

- it is not unlawful for a person "to engage, participate or otherwise be involved in the conduct of a licensed injecting centre" (s 36O); and
- a person is exempt from civil liability for any act or omission done in connection with a licensed MSIC if the person acted in good faith for the purpose of executing Part 2A and was not reckless or grossly negligent (s 36P).

Operation: The Uniting Church operates the sole MSIC, which is located in Kings Cross. As to how the MSIC achieves the legislative objectives set out in the *Drug Misuse and Trafficking Act 1985*, the Uniting Church states:

> [R]egistered nurses and counsellors/health education officers supervise episodes of drug injecting that would otherwise happen elsewhere – often in public, and under more dangerous conditions. There is immediate access to emergency medical care in the event of an overdose or other health issue. Our staff connect with clients and offer them referrals to a variety of services, including specialist addiction treatment.

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[205] See Uniting Medically Supervised Injecting Centre, "Inside the injecting centre".

[206] For a discussion of the recent controversy over whether medically supervised injecting centres should be able to provide their services to a person who is pregnant and to persons under 18, see: A Hitchings, "MP says injecting rooms won't open to kids", 25 July 2016, *news.com.au*; S Nicholls, "Why Troy Grant is so wrong about the Kings Cross injecting room", 25 July 2016, *Sydney Morning Herald*.

[207] Such quantity of the drug as prescribed by the regulations: *Drug Misuse and Trafficking Act 1985*, s 36N(1)(b).

[208] Ordinarily, an offence against s 11(1) of the *Drug Misuse and Trafficking Act 1985.*

> Clients come to the centre with drugs they have already purchased; Uniting MSIC does not supply them. We support the work of the police to reduce the amount of drugs being supplied in Kings Cross, and we do not support drug dealing – selling or buying drugs at MSIC is illegal and not allowed. Anyone attempting these activities is required to leave the centre.[209]

Evaluation: The MSIC has been independently evaluated a number of times since it commenced operation on a trial basis in May 2001.[210] The latest (2010) evaluation stated:

> This evaluation builds on a number of previous independent evaluations and analyses commissioned by the NSW Government since the Trial began, which have concluded that the MSIC positively impacts on clients, has a high level of support from local residents and businesses, has not been shown to cause an increase in local crime or drug use and saves at least $658,000 per annum over providing similar health outcomes through other means in the health system.[211]

In terms of specific outcomes, the 2010 evaluation found that:

- From May 2001 to April 2010, there were 609,177 visits to the MSIC, with an average of 5,641 visits per month.
- From May 2001 to April 2010 the MSIC has managed 3,426 overdose events with no deaths onsite.
- From May 2001 to April 2010 the MSIC provided 8508 referrals to other services, including 3,871 referrals related to drug treatment.
- The proportion of surveyed residents observing public injecting has halved since before the commencement of the MSIC.
- There has been a decline in the proportion of surveyed residents and businesses seeing publicly discarded syringes (from 66% of surveyed residents in 2000 to 46% in 2010; and from 80% of surveyed businesses in 2000 to 46% in 2010).[212]

Proposals to expand service to encompass an inhalation room: Recently there have been proposals to extend the use of the MSIC to include supervised smoking rooms to cater for ice users who smoke, rather than only those who inject, the drug, and to establish such facilities in Western Sydney. The proposals have been supported by a number of drug law reform proponents, including former Premier Bob Carr, who said drug policy should adapt to

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[209] *What we do*, Uniting Church Medically Supervised Injecting Centre.

[210] For a timeline of MSIC developments, see: *The MSIC story: Our story*, n.d., Uniting Church Medically Supervised Injecting Centre.

[211] *Further evaluation of the Medically Supervised Injecting Centre during its extended Trial Period (2007–2011)*, 2010, NSW Health and KPMG, Sydney, p ix. The evaluation covered the period June 2007 to April 2010.

[212] *Further evaluation of the Medically Supervised Injecting Centre during its extended Trial Period (2007–2011)*, 2010, NSW Health and KPMG, Sydney, p ix–xi. An absence of suitable data from before May 2001 meant it was not possible for the evaluation to assess the impact of the MSIC on infection rates for blood-borne diseases.

changing patterns of drug use.[213] Illustrating those changing patterns, the 2014 Enhanced Data Collection Survey conducted as part of the Needle and Syringe Program (NSP) found that:

> among NSP clients in NSW, methamphetamine was the most commonly reported drug last injected (27%) and has overtaken heroin as the most commonly reported substance last injected.[214]

Dr Graham, an addiction medicine specialist, has argued that:

> If people are considering whether to inject or inhale, it is a bit perverse that you can access safe, clean needles but not safe, clean ice pipes … Once you have safe inhalation equipment, you should have a safe space with appropriate links to health services.[215]

Assistant NSW Minister for Health, Pru Goward, has said that the proposal for an ice smoking room is not supported by the Government.[216]

5.6 Methadone maintenance treatment

Origins: Methadone, itself an opiate, is used to treat heroin addiction by means of replacement, maintenance and gradual withdrawal. It has been available in Australia since 1970 but its use was systematically expanded in NSW in 1985, partly in response to concerns relating to HIV.[217] Referred to as "methadone maintenance treatment", today it is a widely used treatment program for illicit opiod use, with approximately 14,355 people in NSW receiving the treatment in 2015.[218] As opposed to more abrupt heroin detoxification or withdrawal, it is intended to assist users "over a period of months or even years".[219] NSW Health outlines the following reasons why methadone maintenance therapy can be effective for both individuals and society:

> There are a number of reasons why methadone is preferable to being dependent on heroin.
>
> First, methadone is swallowed. This cuts out the risk of using shared or dirty

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[213] E Duff, "Former NSW Premier Bob Carr backs calls for ice smoking room trial", 3 July 2016, *Sydney Morning Herald.*

[214] *Crystalline Methamphetamine: Background Paper—NSW Data*, September 2015 (revised), NSW Health

[215] E Duff, "Former NSW Premier Bob Carr backs calls for ice smoking room trial", 3 July 2016, *Sydney Morning Herald.* See also: "Drug experts lobby to open a drug inhalation room in Sydney so addicts can smoke", 29 June 2016, *News.com*

[216] A Park, "Drug experts plan Australia's first ice smoking room despite Government opposition", 8 July 2016

[217] M McArthur, "A history of methadone treatment in Australia: The influence of social control arguments in its development", *History of Crime, Policing and Punishment Conference*, Canberra, Australian Institute of Criminology, Charles Sturt University, 9-10 December 1999.

[218] Australian Institute of Health and Welfare, *National opioid pharmacotherapy statistics 2015 supplementary data*, 2015, Table 4; D Brown, D Farrier, L McNamara et al, *Criminal Laws: Materials and Commentary on Criminal Law and Process of New South Wales* (6th Edition), 2015, The Federation Press, Sydney, p 1062.

[219] NSW Health, *Methadone Maintenance Treatment*, 2012, Government of NSW, p 2.

injecting equipment and becoming infected with hepatitis B or C or HIV.

Second, methadone can be administered in a controlled way. This means that the drug is dispensed in a clinical environment so there is no risk of it being impure.

Third, the effects of methadone last up to 24 hours and this means a person only needs one dose a day to control withdrawal. These factors help stabilise a person's lifestyle. It reduces the stress and anxiety over where the next dose of heroin is coming from and encourages people to look after themselves and others better. A person on methadone is also more likely to hold down a job.

Methadone is also cheaper than heroin and the extra money can further improve the health and lifestyle of a person. Criminal activities to buy illegal drugs are also reduced.[220]

Legal basis: Methadone is legally available on prescription from a medical practitioner, once approval from NSW Health has been obtained.[221] Ordinarily, as provided by s 28(2) of the *Poisons and Therapeutic Goods Act 1966*, a medical practitioner must not prescribe or supply to any person a "Type B" drug of addiction (which expressly includes methadone)[222] for a period exceeding two months. However, under ss 28A and 29 of the *Poisons and Therapeutic Goods Act 1966*, the Secretary of the Ministry of Health may: approve a particular medical practitioner as a prescriber of drugs of addiction; or authorise prescription or supply of drugs of addiction for the treatment of a particular person.

Evaluation: In terms of social benefits, it has been estimated that there is a cost saving of between four to five dollars for every dollar spent on methadone treatment, in terms of reduced health care costs and reduced rates of crime and imprisonment.[223]

[220] NSW Health, *Methadone*, 16 December 2015, Government of NSW. See also: H Joseph, S Stancliff and J Langrod, "Methadone Maintenance Treatment (MMT): A Review of Historical and Clinical Issues" (2000) 67(5 & 6) *The Mount Sinai Journal of Medicine* 347; Rankin and R Mattick, *Review of the effectiveness of methadone maintenance treatment and analysis of St Mary's Clinic, Sydney*, 1997, National Drug and Alcohol Research Centre. See also: *20 Questions and Answers Regarding Methadone Maintenance Treatment Research*, National Institute on Drug Abuse International Program. As to the underlying principles of the treatment, see: *Review of Methadone Treatment in Australia*, 1995, Australian Government, Department of Health, Canberra, Ch 4 "The principles of methadone maintenance therapy"

[221] NSW Health, *Methadone Maintenance Treatment*, 2012, Government of NSW, p 3.

[222] See cl 123(f) of the Poisons and Therapeutic Goods Regulation 2008.

[223] D Brown, D Farrier, L McNamara et al, *Criminal Laws: Materials and Commentary on Criminal Law and Process of New South Wales* (6th Edition), 2015, The Federation Press, Sydney, p 1062–1063. See also B Lind, S Chen, D Weatherburn and R Mattick, *The effectiveness of methadone maintenance treatment in controlling crime: An Aggregate-level analysis*, March 2004, NSW Bureau of Crime Statistics and Research.

6. MUSIC FESTIVALS

6.1 Background

Music festivals are a popular feature of youth culture in Australia and around the world. They have been shown to have an underlying positive impact on the psychological and social well-being of young adults because they provide:

- a sense of belonging and social integration, which often continues after the event;
- a time and space where young people can experience self-discovery and personal growth;
- an opportunity for participants to feel more positive about themselves, others and life in general; and
- an opportunity to disconnect from every-day life.[224]

Music festivals are, however, a social space within which prohibited drug use and possession is common.[225] For instance, in one day 184 people attending the 2016 Field Day festival were charged with drug related offences and 212 people received medical attention.[226] Tragically, music festivals are also associated with drug overdoses and fatalities.[227]

After the Field Day festival on New Year's Day 2016, where one woman was hospitalised in a critical condition, Premier Baird stated that organisers of music festivals may have to comply with stricter requirements for more extensive screening at entry points, or be shut down:

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[224] "Research finds music festivals create good vibes" *UQ News,* University of Queensland, discussing: J Packer and J Ballantyne, "The impact of music festival attendance on young people's psychological and social well-being" (2011) 39(2) *Psychology of Music* 164.

[225] See generally: E Dilkes-Frayne, "Drugs at the campsite: Social-spatial relations and drug use at music festivals" (2015) *International Journal of Drug Policy* (in press); M Castillo, "Explaining the prevalence of drug-related deaths at music festivals," 24/5/2016, *bandwagon SG*; C Cita, "Highs and lows of summer festivals", 25/11/2014, *alt media*; "Ecstasy hidden in my undies: It's easy to smuggle drugs into music festivals, one partygoer reveals", 12/11/2014, *Daily Telegraph*.

[226] T Williams, "NSW Government threatens to shut down music festivals over drug use", 3/1/2016, *Music Feeds* and "Music festival users would 'nearly vomit' if they knew where drugs were kept, Sydney doctor says", 2/1/2016, *ABC News*.

[227] For instance, see: "Six dead, countless overdoses: Why has Australia's music festival culture turned deadly?", 7/12/2015, *Tonedeaf.com*; "Stereosonic music festival: 20 overdose in Brisbane despite extra security after deaths in Sydney and Adelaide", 7/12/2015, *ABC NEWS*; T Ong, "Man dies, eight hospitalised after attending Sydney dance music festival Defqon.1", 21/12/2015, *ABCNews*; S Hadfield, "Georgina Bartter: How can we stop another tragic drug death?", 20/11/2014, *Herald Sun*; B McClellan and J Fife-Yeomans, "Stereosonic music festival: Police despair as Sylvia Choi, 25, dies after taking ecstasy", 30/11/2015, *Daily Telegraph*; M McGowan, "Teens suffer suspected overdoses at Groovin' the Moo Music Festival", 23/4/2016, *SMH*; A Lavoipeirre, "Music festival drug deaths: Parliamentary inquiry proposal", 5/1/2016, *Triple J Hack*; A Benny-Morrison, "Police blast rave organisers' 'disregard' for safety after suspected overdose", 13/6/2016, *SMH*.

> Individuals need to take responsibility for their actions, but so do the organisers of these festivals. …
>
> In the light of this latest distressing and avoidable incident, I will be asking the relevant ministers to review the current system of regulating events held on public land, including the system for granting permits for public events such as music festivals. …
>
> If new rules and procedures place additional burdens and costs on organisers, so be it — and we will also examine denying permits to organisers who have not done the right thing in the past … Enough is enough. This simply has to stop.[228]

Deputy Premier and Minister for Justice and Police, Troy Grant, stated the Government made "no apologies for its strong stance against the use of illegal drugs"[229] and that:

> We will be working together to look at how, if possible, the NSW Government can contribute to making these events more safe for the patrons, but also about putting the onus on these festival organisers to have a better duty of care to the partygoers …
>
> We're not going to say this is going to be an easy task, but it's about working together and getting that message out there. Education is the key.
>
> But ultimately, if the events continue to cause deaths, well the festivals will write their own scripts.[230]

At an underlying level, as with all drug-related issues, the debate about drugs and music festivals does include the question of whether or not prohibition remains appropriate and/or effective. At a more immediate level, and one that is the focus of this chapter, the debate concerns whether the safety of music festival patrons would be improved if pill testing and amnesty bins were introduced at music festivals; and whether the use of police drug detection dogs increases or decreases patron safety.

6.2 Pill testing

6.2.1 Scope and objectives

Pill testing is a harm reduction measure that has been used in a number of overseas jurisdictions, including: the Netherlands, Switzerland, Austria,

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[228] L Harris, "'Enough is enough': Mike Baird calls for crackdown on music festivals over drugs", 3/1/2016, *Daily Telegraph*; T Williams, "NSW Government threatens to shut down music festivals over drug use", 3/1/2016, *Music Feeds*; K Sato, "Baird slams music festival organisers for drug offences", 7/1/2016, *alt media*; M Safi, "NSW Government threatens to close down music festivals after spate of drug overdoses" 4/1/2016, *The Guardian.*

[229] L Harris, "'Enough is enough': Mike Baird calls for crackdown on music festivals over drugs", 3 January 2016, *Daily Telegraph*.

[230] "NSW Government puts music festival on notice after drug overdoses", 3/1/2016, *ABC News*. See also NSWPD, 16 February 2016 (T Grant) where Deputy Premier Troy Grant said: "[W]e are reviewing the risk management for these events, including the process for granting event permits and the regulation and security protocols surrounding these festivals."

Belgium, Germany, Spain, France and the United States.[231] Pill testing involves setting up a mobile pill testing and counselling facility at music festivals (or other events). Samples from pills possessed by patrons are analysed onsite, using a variety of different tests to determine the contents of the pills. Patrons are then informed about the contents of the pills and provided with an opportunity to discuss the test results and related drug-safety issues. A typical pill testing facility is depicted in Figure 10.

Figure 10: Example of a typical pill testing facility at a music festival[232]

The harm reduction objective of pill testing was considered by the Australian Government's Department of Health and Ageing in a discussion paper on ecstasy pill testing kits:

> Ecstasy testing kits are promoted as a harm reduction measure in the belief that knowing something about the content of a pill is better than knowing nothing and that users will refuse to take pills which do not contain MDMA or which contain unwanted substances such as PMA, ketamine, methamphetamine or dextromethorphan. Promoters of the tests recognise that a proportion of people will make decisions to take ecstasy in spite of its illegality and information about possible harms, and regard it as important that these people have as much information as possible on which to base their decisions.
>
> Websites promoting testing kits all include warnings that the kits are not definitive

[231] A Ritter, "Six reasons Australia should pilot 'pill testing' party drugs", 12 November 2014, *The Conversation*; B Brook, "As Australian authorities prevent pill testing, the US is quietly telling festivalgoers all about their drugs", 19 March 2016, *News.com.au*. For a detailed discussion of pill testing, see: W Tregoning, "Drug checking brief", Unharm!, 17 May 2016.

[232] W Tregoning, "Drug checking brief", Unharm!, 17 May 2016, image credit *CheckIt.*

> and that MDMA itself can be harmful. Some also include information about the nature and effects of other drugs commonly sold as ecstasy as well as some legal information. On a number of sites drug testing is likened to other harm reduction strategies such as information giving and clean needle programs.[233]

The Department of Health and Ageing found that:

> Systematic testing programs have the potential to provide an opportunity for a variety of harm reduction interventions. If testing encourages users to avoid pills containing PMA, 4MTA and other substances which are more toxic than MDMA then it is likely that deaths will be avoided. Systematic testing can also enable monitoring of the ecstasy market and the use of targeted public health alerts when toxic substances are identified.[234]

6.2.2. The current debate

The political debate concerning pill testing is polarised. Advocating the broad introduction of pill testing, Dr Faruqi MLC, of the NSW Greens, said:

> Harm reduction also means checking drugs at festivals for adulteration and impurities to identify unsafe pills that can then be discarded. Pill testing does reduce the risk of harm and also provides an opportunity to provide support, information and education to people about the adverse effects of using drugs. … Instead of stigmatising and stereotyping we must listen to and work with drug users and their families. The first step towards this change will be admitting that the prohibitionist and punitive "law and order" model is not working.[235]

Labor's Walt Secord MLC, the Shadow Minister for Health, has opposed pill testing at music festivals, stating that, due to limited evidence concerning its effectiveness, "pill testing is a bridge too far".[236] That position remains party policy. A contrasting position was expressed by Jo Haylen MP at the 2016 State Labor Conference, who called for the introduction of pill testing at music festivals and the decriminalisation of drug use and possession.[237]

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[233] Department of Health and Ageing, *Drug Testing Kits: Detailed discussion paper on social, health and legal Issues,* 2005, Government of Australia, Canberra, p 23.

[234] Department of Health and Ageing, *Drug Testing Kits: Detailed discussion paper on social, health and legal Issues,* 2005, Government of Australia, Canberra, p 32

[235] NSWPD, *Drug Policy and Law Reform*, 10 March 2016, (M Faruqi). See also A Wodak, D Shoebridge, J Leong, K Race, M Faruqi, M Hunt, P Malins and W Tregoning, *Make this a safer summer — Allow pill testing at festivals: Open Letter to Mike Baird and Andrew Scipione*, n.d.

[236] P Begley, E Bagshaw and E Patridge, "Stereosonic security guard investigated" over drug allegations", 2 December 2015, *Sydney Morning Herald.*

[237] C Calcino, "Labor left MP calls for drug decriminalisation", 16 February 2016, *Coffs Coast Advocate.*

The Coalition Government opposes the introduction of pill testing at music festivals. Premier Baird has said: "We are not going to be condoning in any way what illegal drug dealers are doing".[238] The Premier also urged festival goers: "Don't do it. That is the best form of safety you can do."[239]

Deputy Premier and Minister for Justice and Police, Troy Grant MP, has said:

> This Government will not run a quality assurance regime using taxpayers' dollars to prop up drug dealers' businesses. We will not support illegal drugs and an industry that destroys families and young lives. … Knowing what is in illegal drugs does not make them safe, as some who support that argument profess. It also does not stop people feeling the full force of the law if they are caught with those illegal drugs. …
>
> I stress that pill testing is giving those using illegal drugs a very, very dangerous and false sense of security before they pop these pills in their mouth, and it is something we must avoid. … Education and rehabilitation is the path that this Government will be taking in conjunction with the law enforcement effort to protect our young people and our communities, and for that I and this Government make no apology.[240]

6.2.3 Reliability of tests and interpretation of results

Given the life and death stakes involved, it is crucial that pill testing does not lend the appearance of safety when, in reality, the pills remain illegal and (potentially) harmful. Two issues are relevant in this regard. Firstly, the reliability and validity of test results varies according to the type of tests conducted. Secondly, no matter what type of test is used, pill testing results are prone to misinterpretation.

Pill testing kits: As the Australian Government's Department of Health and Ageing said, pill testing kits:

> [S]uffer from a number of limitations so that even after testing there is considerable uncertainty regarding the content of ecstasy pills. The only way to obtain accurate qualitative and quantitative information regarding all the contents of pills is to use laboratory based testing techniques such as thin layer chromatography, high pressure liquid chromatography and gas chromatography.[241]

With older forms of testing, drug users may falsely reason that testing positive for a particular active ingredient (such as ecstasy) makes a pill "good" or "safe". However, such a result provides no information as to the quantity or purity of that ingredient. Nor does it imply that the pill contains that active ingredient alone. As the United States pill testing service *Dance Safe* has informed prospective users:

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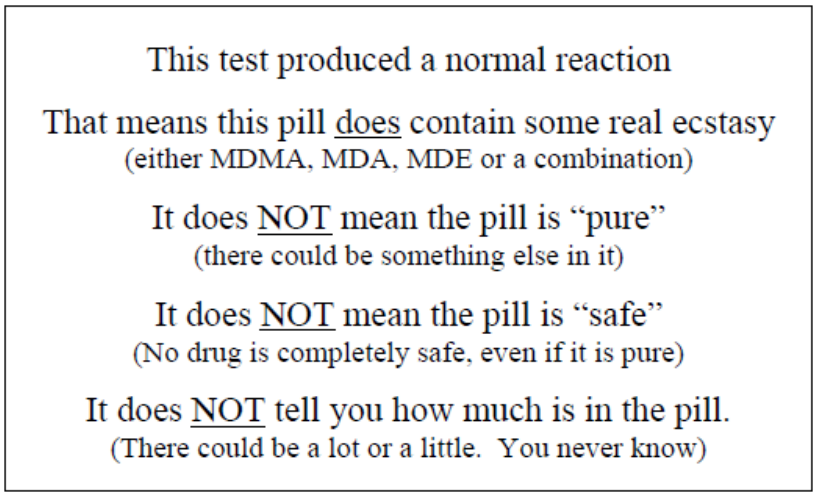
[238] "Pill testing trial 'ridiculous': Baird", 28 February 2016, *Sydney Morning Herald*.

[239] L Visentin, "NSW Premier Mike Baird kills off Stereosonic pill-testing plan", 2 March 2016, *Sydney Morning Herald.*

[240] NSWPD, 16 February 2016 (T Grant).

[241] Department of Health and Ageing, *Drug Testing Kits: Detailed discussion paper on social, health and legal,* 2005, Government of Australia, Canberra, p 31.

Figure 11: Pill testing cautionary notice used by Dance Safe[242]



Laboratory grade testing: Laboratory grade testing would enable identification of especially dangerous substances (such as a poison or bleach). In such cases, all patrons of a festival could be warned about this finding.

Dr David Caldicott, an advocate of pill testing, proposes using laboratory grade equipment, operated by forensic analysts and supervised by doctors.[243] The test would take between 20 and 40 minutes — which provides a possible disincentive to use the service but also an opportunity for drug education and counselling to occur — and returns a detailed scientific analysis of the pill. Comparing laboratory grade testing to earlier forms of testing, which typically use coloured reagents, Dr Caldicott said:

> You can purchase a test kit over the internet, they're not illegal, but it's essentially 19th Century technology. It has quite significant limitations around operator error, misinterpreting the colour, using bad lighting, contaminating the substance — but more crucially it doesn't give you precise info on the strength or quantity of a substance.[244]

The greater accuracy provided by on-site laboratory testing reduces the scope for misinterpretation, as it can identify the presence and quantity of all ingredients in a pill. It may therefore enable drug users to more accurately gauge the likely effects of their pills. Nevertheless, despite the greater reliability of and detail provided by on-site laboratory results, the need for education and counselling remains in order to ensure that test results are not misinterpreted as implying that, at some level, prohibited drugs are inherently safe.

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[242] Department of Health and Ageing, *Drug Testing Kits: Detailed discussion paper on social, health and legal*, 2005, Government of Australia, Canberra, p 21.

[243] J Butler, "Music Festivals and Drugs: How Would Pill Testing Work?", 30 December 2015, *The Huffington Post.*

[244] J Butler, "Music Festivals and Drugs: How Would Pill Testing Work?", 30 December 2015, *The Huffington Post.*

Paul Dillon, of Drug and Alcohol Research and Training Australia, said:

> The whole concept [of pill testing] is based on one of the key prevention messages we have around ecstasy (and other illicit drugs) — "you don't know what you're taking". Pill testing, therefore, allows the user to have a little more information about what it is that they're planning to use.
>
> Unfortunately, the whole concept is based on the false assumption that if you do know what you're taking, it is safe – something that is absolutely untrue. As far as ecstasy is concerned, the substance users are looking for is MDMA. Test a pill and find out that it contains MDMA and many believe that this means that the pill is "safe". MDMA is not a safe drug and many of the deaths that have occurred across Europe this year have actually been due to MDMA overdose. Pill testing for adulterants would not necessarily have assisted in preventing those deaths. …
>
> The tragedy is that we only talk about this issue when we have a death. What we need is an ongoing dialogue between all parties (the dance festival and nightclub industry, government, police and clubbers themselves). Hopefully pill testing is a part of that dialogue but let's not kid ourselves that just one strategy is going to mean we won't see these kind of deaths in the future.[245]

6.2.4 Evidence as to effectiveness

There is insufficient evidence to determine the precise social and health impacts of pill testing. In 2001, a scientific report by the European Monitoring Centre for Drugs and Drug Addiction concluded:

> Due to the lack and difficulties of evaluation, on the one hand there is still no strict scientific proof for the protective impact of on-site pill-testing interventions but on the other hand, there is also no scientific evidence to conclude that such interventions rather promote drug use or might be used by dealers for marketing purposes. Drawing together pieces of evidence is, however, often a first step for deciding on new intervention models.
>
> There is a need for more research and evaluation studies on the whole range of effects of on-site pill-testing interventions.[246]

In a 2005 discussion paper entitled *Drug Testing Kits*, the Department of Health and Ageing found there was insufficient evidence to answer such questions as:

- How do users view the tests?
- What do they expect from them?
- Do users regard contents other than MDMA as undesirable?
- Do the testing kits encourage people who wouldn't otherwise use ecstasy to take it?
- Does testing give a false sense of security and convince users that the tablets are safe?

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[245] P Dillon, "Pill testing isn't a silver bullet to prevent drug deaths, but it is part of the solution", 7 December 2015, *Sydney Morning Herald*.

[246] G Burkart, *On-site pill testing interventions in the European Union*, 2001, European Monitoring Centre for Drugs and Drug Addiction, Vienna, Executive Summary.

- Does it encourage users to take more than they would have previously, or to use more often?[247]

These questions essentially remain unanswered today. The available evidence relies on anecdotes and surveys as to what people would do or have done in particular situations. Moreover, many of the surveys were conducted overseas and may not necessarily reflect Australian attitudes to illegal drug use. Both these limitations are evident in the following, generally supportive, analysis of pill testing:

> [An] [e]valuation of the Austrian project Checkit! found that when presented with a 'bad result', two thirds of people say they will not consume the drug and will warn friends. A recent evaluation of the Portuguese service found that among people who had tested a substance that they thought was LSD, for example, 45% were surprised by the result and 29% reported they would not take the substance. In Australia, a study that asked participants how they would respond in a hypothetical situation where a test indicated an 'unknown' substance found that 76% reported they would not take it.[248]

6.2.5 Call for trial of effectiveness of pill testing

Given the absence of scientifically rigorous evidence, and in line with NSW's approach of empirically evaluating the highly successful Medically Supervised Injecting Centre and Needle and Syringe Program, drug law reform advocates are calling for evidence-based policy making in the form of a trial of pill testing at music festivals. The aim of the trial would be to empirically determine the effectiveness of pill testing in reducing drug-related harm at music festivals by, for instance, measuring the incidence of onsite treatment, hospital presentations and overdoses.[249] Matt Noffs, Chief Executive of the Noffs Foundation, has said:

> Back then, the Government and police didn't like the idea [of the injecting room] but they said 'we're going to stand back and capture that data' and, sure enough, [it] has been a proven tactic in reducing heroin abuse in Australia.
>
> It makes far more sense for the Government to say 'we don't like it, but we're going to see the evidence', instead of arresting [those people] conducting a pill-testing trial or arresting young people who are courageously coming forward to have their drugs tested so they can work out if they are going to kill or poison them.[250]

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[247] Department of Health and Ageing, *Drug Testing Kits: Detailed discussion paper on social, health and legal,* 2005, Government of Australia, Canberra, p 24.

[248] W Tregoning, "Drug checking brief", Unharm!, 17 May 2016. See also: A Ritter and J Cameron, *A Systematic Review of Harm Reduction*, 2005, Turning Point Alcohol and Drug Centre, p 49; J Johnston, M Barratt, C Frya, S Kinner, M Stoové, L Degenhardt, J George, R Jenkinson, M Dunn and R Bruno, "A survey of regular ecstasy users' knowledge and practices around determining pill content and purity: Implications for policy and practice" (2006) 17 *International Journal of Drug Policy* 464.

[249] A Ritter, "Six reasons Australia should pilot 'pill testing' party drugs", 12 November 2014, *The Conversation*; *Sydney Morning Herald*; W Tregoning, "Drug checking brief", 17/5/2016, Unharm!; E Duff, "Path clears for pill testing at summer music festivals – Outside NSW", 30/4/2016, *Sydney Morning Herald*.

[250] B Brook, "Drug experts says politicians need to sit down with pill-testing advocates", 29

6.2.6 Is it a criminal offence to use or supply a pill testing service?

Currently, users of a pill testing service could be charged with possessing a prohibited drug, contrary to s 10 of the *Drug Misuse and Trafficking Act 1995*. While that is straightforward, the position in respect to pill testing service providers is unclear.

Conceivably, depending on the testing processes employed and how long they take, the pill testing service providers could also be charged with possessing prohibited drugs. Alternatively, pill testing service providers could be charged with being an accomplice to the possession and use offences committed by users of their service, contrary to s 19(1) of the *Drug Misuse and Trafficking Act* 1985, which states:

> A person who aids, abets, counsels, procures, solicits or incites the commission of an offence under this Division [which includes the offences of possession (s 10) and self-administration or use (s 12)] is guilty of an offence and liable to the same punishment, pecuniary penalties and forfeiture as the person would be if the person had committed the firstmentioned offence.

However, for an offence against s 19(1) to be committed the Crown would have to prove that the pill testing service providers intentionally assisted or encouraged music festival attendees to possess or use prohibited drugs.[251]

A more remote possibility is that the testing process involves service providers supplying prohibited drugs to drug users, contrary to s 25(1) of the *Drug Misuse and Trafficking Act 1985*. For that to be the case, the testing process must fall within the definition of "supply" in s 3 of the *Drug Misuse and Trafficking Act 1985*, which states:

> "Supply" includes sell and distribute, and also includes agreeing to supply, or offering to supply, or keeping or having in possession for supply, or sending, forwarding, delivering or receiving for supply, or authorising, directing, causing, suffering, permitting or attempting any of those acts or things.

Moreover, the testing process would need to constitute more than mere transfer of physical control of the drug because, as Hunt J (Wood and Finlay JJ agreeing) held in *R v Carey*: [252]

> The word "supply" … does not include the mere transfer of physical control of the drugs from a person who has had the drugs deposited with him to their owner or to the person reasonably believed to be such.

If a trial of pill testing were to be adopted, an exemption from criminal liability could be granted to users of the service and to service providers. Service

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February 2016, *News.com.au*.

[251] *Giorgianni v The Queen* (1985) 156 CLR 473 at 506 per Wilson, Deane and Dawson JJ; also *GAS v The Queen* (2004) 217 CLR 198 at [19]: discussed in A Dyer and H Donnelly, "Sentencing in complicity cases — Abettors, accessories and other secondary participants (Part 2)" (2010) 39 *Sentencing Trends and Issues* No 39.

[252] Unreported judgment, 26/7/1990, NSW Court of Criminal Appeal, p 9.

providers could also be granted an exemption from civil liability. The Medically Supervised Injecting Centre and the Needle and Syringe Program provide two precedents for such an approach.

6.3 Amnesty bins

Amnesty bins enable music festival attendees to discard illegal drugs in designated bins without being arrested.[253] It is claimed that, by providing music festival attendees with an opportunity to safely dispose of drugs before entering music festivals, amnesty bins support drug-free music festivals. It is also claimed that amnesty bins minimise drug-related harm by enabling music festival attendees who see police officers and sniffer dogs to safely dispose of their drugs, rather than panic and ingest all the drugs in their possession as a way of avoiding arrest.[254] Additionally, amnesty bins could enable authorities to analyse the contents of drugs deposited in the bins and warn festival organisers and attendees of especially dangerous drugs in circulation.[255] Like pill testing, whether amnesty bins are effective in reducing drug-related harm is a question that has not been answered by research.

6.4 Drug detection dogs

6.4.1 Legal basis

Use of sniffer dogs without a warrant: The use of drug detection dogs by police at music festivals is authorised by 148(1)(b) of the *Law Enforcement (Powers and Responsibilities) Act 2002*, which states:

> A police officer may, without a warrant, use a dog to carry out general drug detection in relation to … persons at, or seeking to enter or leave, a public place at which a sporting event, concert or other artistic performance, dance party, parade or other entertainment is being held.[256]

Section 148(1)(b) appears to authorise police use of sniffer dogs for general drug detection in relation to people across the whole site of a music festival, as well at points of entry and exit.

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[253] For a discussion of the use of amnesty bins in the United Kingdom following a spate of seven deaths related to fake ecstasy tablets, see: O Duggan, "Drug amnesty bins at T in the Park over deaths linked to 'Rolex' ecstasy", 12 July 2013, *Independent;* S Sowden, "Glastonbury 2011: Drugs success at this year's festival", 26 June 2011, *Bridgwater Mercury*

[254] For instance, in 2009 drug amnesty bins were introduced on a trial basis in Western Australia following the death of 17 year old Gemma Thoms, who swallowed ecstasy tablets in order to avoid detection, although the use of the bins was discontinued a year later: D Guest, "Amnesty drug bins will be provided at music festivals in Western Australia, following the death of Gemma Thoms", 7 February 2009, *The Australian*; and C Bennet, "Sniffer dogs to patrol WA's Big Day Out", 29/1/2010, *Sydney Morning Herald.*

[255] B Preiss, "Pressure mounts to introduce drug amnesty bins at festivals", 31 January 2016, *The Age*.

[256] "Public place" is expansively defined in s 3 of the *Law Enforcement (Powers and Responsibilities) Act 2002* to include: [A] place … or part of premises, that is open to the public or is used by the public … whether or not the place or part is ordinarily so open or used and whether or not the public to whom it is open consists only of a limited class of persons.

The powers granted to police when using drug detection dogs without a warrant are expansive. Ordinarily, as provided by s 21(1)(d) of the *Law Enforcement (Powers and Responsibilities) Act 2002*, a police officer without a warrant requires "reasonable grounds" before being able to lawfully search a person for illegal drugs. But there is no legal requirement for police to establish reasonable grounds before being able to use drug detection dogs in authorised places, such as music festivals.[257]

Whether drug detection dogs effectively circumvent the reasonable grounds safeguard is a matter of contention because, as noted by the NSW Ombudsman, in practice a positive indication from a drug detection dog may be the "sole basis" used by police to establish reasonable grounds for searching a person.[258]

Use of sniffer dogs with a warrant: Police officers may also be authorised by a warrant to use dogs to carry out general drug detection at music festivals, pursuant to s 149(1) of the Act. As set out, respectively, in ss 149(2) and (3):

- A police officer may apply to an authorised officer for a warrant if reasonable grounds exist for believing that "persons at any public place may include persons committing drug offences"; and
- An authorised officer to whom such an application is made may, "if satisfied that there are reasonable grounds for doing so, issue a warrant authorising any police officer to use a dog to carry out general drug detection in the public place during the period or periods specified in the warrant."

The current debate: Jo Haylen MP, of the NSW Labor Party, has called for an end to the use of police drug detection dogs at music festivals, claiming that the dogs are ineffective and "scare young people into ingesting all of their drugs at once, and cause unnecessary overdoses".[259] Jenny Leong MP, of the Greens NSW, has introduced a Private Member's Bill, the Law Enforcement (Powers and Responsibilities) Amendment (Sniffer Dogs—Repeal of Powers) Bill 2016, to remove the legal basis for the use by police of dogs for general drug detection, including at music festivals.

Foreshadowing an increase in the use of drug detection dogs, Troy Grant MP, Deputy Premier and Minister for Justice and Police, said:

> Under existing law, sniffer dogs can be used only on the day of the event and they cannot go past the front gate. That is under active review. …
>
> A user-pays system to allow dogs to sweep the grounds for drugs, including those

[257] Discussed in G Griffith, "Drug detection dogs: The legal position in New South Wales", 2012, e-brief 18/2012, NSW Parliamentary Research Service, p 4.

[258] *Review of the Police Powers (Drug Detection Dogs) Act 2001*, 14 September 2006, Ombudsman NSW, p 47.

[259] R Fitzgerald, "NSW Labor MP Jo Haylen Takes a Stand Against Sniffer Dogs", 16 February 2016, *Howl and Echoes.*

> drugs stashed on site before the festival commences, is a common sense initiative to help us tackle this issue. However, I must correct the dangerous and misleading calls by the member for Summer Hill to stop sniffer dogs. Sniffer dogs do not just find drug users who are breaking the law; they detect the dealers who peddle these cocktails of toxic substances to our young people.[260]

6.4.2 Issues in the debate

There are two main issues in the current debate relating to the use of drug detection dogs at music festivals.[261] Firstly, it is argued that the use of dogs by police can cause harm if, in order to avoid detection, music festival attendees:

- deliberately switch from drugs that are easier for dogs to detect (such as cannabis) to potentially more harmful drugs (such as ecstasy or ice) which are more difficult for dogs to detect;
- deliberately "pre-load" their drugs before arriving at a festival; or
- panic when they see a police dog and take all their drugs at once.

Secondly, it is argued that there are many false positive results that lead to people being searched unnecessarily.

Switching to more harmful drugs: In 2014, Dr Caitlin Hughes, Dr Don Weatherburn and Dr Robert MacCoun surveyed 513 music festival attendees aged 18 years or more in New South Wales about their use of illegal drugs at music festivals.[262] Discussing the study, Dr Hughes said 62% of respondents indicated they would take illegal drugs irrespective of whether or not police used drug detection dogs.[263] Dr Hughes further said that there was:

> [A] 40 per cent increase in the relative amount of consumption of ecstasy, methamphetamine and other drugs, as opposed to using cannabis … So they're switching from cannabis to ecstasy and methamphetamine for reasons we think are to do with reducing their potential risk of detection by the dog.[264]

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[260] NSWPD, 16 February 2016 (T Grant). Also reported in: L McNally, "Festival organisers may have to foot bill for drug sweeps before events, NSW Police Minister says", 16 February 2016, *ABC News;* L Silmalis and L Harris, "Drug dogs to search for drugs hidden at music festivals in lead up to the events", 10 January 2016, *Daily Telegraph.*

[261] For a broad discussion of issues relating to drug detection dogs, see: K Lancaster, C Hughes and A Ritter, "'Drug dogs unleashed': An historical and political account of drug detection dogs for street-level policing of illicit drugs in New South Wales, Australia" (2016) *Australian and New Zealand Journal of Criminology* 1.

[262] C Hughes, D Weatherburn and R MacCoun, "The deterrent effects of drug detection dogs on drug use in NSW, Australia", *Applied Research in Crime and Justice Conference*, Sydney, National Drug and Alcohol Research Centre, 2015 (PowerPoint presentation).

[263] N Bochenski, "Banning sniffer dogs at music festivals could be valuable: experts", 15 August 2014, *Sydney Morning Herald.*

[264] N Bochenski, "Banning sniffer dogs at music festivals could be valuable: experts", 15 August 2014, *Sydney Morning Herald.* For an Australian survey-based study which suggests a low rate of detection of ecstasy by sniffer dogs, and a low deterrence effect, see: S Hickey, F McIlwraith, R Bruno, A Matthews and R Alati, "Drug detection dogs in Australia: more bark than bite?" (2012) 31(6) *Drug Alcohol Review* 778.

Planned and panicked "pre-loading" to avoid detection by police dogs: Drug law reform advocates argue that police use of drug detection dogs can increase the risk of drug-related harm, if only in respect of a small subset of drug users who "pre-load" and take all their drugs before entering a music festival in order to avoid detection by police dogs. Pre-loading can be a deliberate strategy used to avoid possible detection or a panicked response to sight of an approaching drug detection dog. Either way, as it involves people taking higher quantities of prohibited drugs than they otherwise would, pre-loading increases the risk of serious drug-related harm. Outlining the issue, Dr Will Tregoning of Unharm! said:

> One of the real concerns is that people preload — they take all their drugs before attending the event, and that can happen in one of two ways … The first is pre-planned, and that is concerning in itself because it means if people have made that decision to use drugs, rather than spacing it out in a way that can enable them to see the effects of the first pill, for example, before they take the second, they are just taking the lot and hoping for the best. But perhaps even more concerning is the panicked overdose.[265]

False positives: The NSW Ombudsman considered the effectiveness of drug detection dogs in the report *Review of the Police Powers (Drug Detection Dogs) Act 2001*. The NSW Ombudsman found that during 22 February 2002 to 21 February 2004 there were 10,211 searches conducted following drug detection dog indications. In 26% of searches (2664) drugs were found; while in 74% of searches (7547) no drugs were found. [266]

An important factor when considering the effectiveness of drug detection dogs is whether the dogs are detecting actual possession or residual indications of drugs:

> [O]n most occasions the drug detection dogs' indications do not lead to the detection of any drugs. It may be that although actual drugs are not found most of the time the dogs are, on some of these occasions, detecting what is known as a 'residual scent'.[267]

Two international studies have recently considered the effectiveness of drug sniffer dogs. A 2011 American study, by Lit, Schweitzer and Oberbauer,[268] investigated whether handler beliefs affected sniffer dog outcomes. The study involved a total of 18 sniffer dogs and their handlers: 13 drug detection dogs; 3 explosive detection dogs; and 2 dogs that were trained to detect both drugs and

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[265] A Corderoy, "Drug searches: thousands falsely identified by sniffer dogs", 30 November 2014, *Sydney Morning Herald*. See also: W Tregoning, "Drugs at music festivals: we must be smarter, not harder", 15 December 2014, *Unharm!*.

[266] *Review of the Police Powers (Drug Detection Dogs) Act 2001*, 14 September 2006, Ombudsman NSW, p 29.

[267] *Review of the Police Powers (Drug Detection Dogs) Act 2001*, 14 September 2006, Ombudsman NSW, p 48.

[268] L Lit, J Schweitzer and A Oberbauer, "Handler beliefs affect scent detection dog outcomes" (2011) 14(3) *Animal Cognition* 387. See also: R Balko, "Federal appeals court: Drug dog that's barely more accurate than a coin flip is good enough", 4 August 2015, *The Washington Post.*

explosives. The study found that handler beliefs did affect dog performance by increasing the amount of incorrect alerts. In other words, drug sniffer dogs may indicate an alert not because they have actually detected drugs but because they believe that is what their handlers want them to do and that they will be rewarded for doing so.

A 2014 Polish study, by Jezierski, Adamkiewic, Walczak et al, assessed the performance of trained police dogs in different settings that closely resemble real world situations. They used different drugs (hashish, marijuana, amphetamine, cocaine and heroin) and different dog breeds (68 Labrador retrievers, 61 German shepherds, 25 Terriers and 10 English Cocker Spaniels). Their study found that:

> [T]he ranking of drugs from easiest to most difficult to detect was determined to be as follows: marijuana, hashish, amphetamine, cocaine, heroin. German shepherds were superior to other breeds in the percentage of correct indications …[269]

Ultimately Jezierski, Adamkiewic, Walczak et al found that:

> Our results … support the usefulness of drug detection dogs, even if their effectiveness may not be 100%. Also, we have shown how certain factors, such as breed of the detection dog, type of drug, and type of searching environment, may influence canine detection performance. Thus, dogs correctly indicated drugs in 70–91% of cases. German shepherds proved to be best detectors in terms of faultless indications. Marijuana was the easiest and heroin the most difficult to detect in terms of detection speed and accuracy. …The odor of hashish lasted longer, at least for 48 h, whereas the residual odor of heroin was almost not detected by dogs after 48 h.[270]

7. THE LAW REFORM DEBATE: PROHIBITION OR DECRIMINALISATION?

As can be seen from chapter 5, the legal model adopted in NSW for recreational drug use and possession most closely reflects the prohibition model, with exceptions including the Cannabis Cautioning Scheme, and the Medically Supervised Injecting Centre. The Government continues to support this approach but a range of experts and public figures have criticised the prohibition model and called for reform, most commonly decriminalisation.

The first part of this chapter outlines the various legal models that can apply to recreational drug use and possession. The next section summarises the debate on prohibition versus decriminalisation. For brevity, this paper does not discuss in detail the arguments around the "legalisation model". The next part outlines survey findings on public attitudes towards this issue. The final section looks at drug law liberalisation in Australia and overseas jurisdictions.

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[269] T Jezierski, E Adamkiewicz, M Walczak and E Papet, "Efficacy of drug detection by fully-trained police dogs varies by breed, training level, type of drug and search environment" (2014) 237 *Forensic Science International* 112 at 114.

[270] T Jezierski, E Adamkiewicz, M Walczak and E Papet, "Efficacy of drug detection by fully-trained police dogs varies by breed, training level, type of drug and search environment" (2014) 237 *Forensic Science International* 112 at 117–118.

7.1 Legal models

In theory, there are four main legal models that can apply to recreational drug use and possession: (i) prohibition, (ii) depenalisation, (iii) decriminalisation, and (iv) legalisation. Policy debates often refer to these models in their pure form but, in practice, jurisdictions can adopt variations of these models. The table below summarises the models, including the extent to which they allow for treatment services and harm reduction programs.

Table 14: Legal models that can apply to recreational drug use and possession[271]

	Prohibition	Depenalisation*	Decriminalisation**	Legalisation
Approach to drugs	Distinction drawn between legal and illegal drugs.	Distinction drawn between legal and illegal drugs.	Distinction drawn between legal and illegal drugs.	No distinction between legal and illegal drugs. All drugs are regulated in a manner similar to alcohol, tobacco and pharmaceuticals.
Possession and use offences	It is an offence to possess and use illegal drugs. Criminal penalties apply and are imposed.	It is an offence to possess and use illegal drugs. Criminal penalties apply but are not imposed.	It is an offence to possess and use illegal drugs, but these offences no longer carry criminal penalties. Offenders are dealt with by a range of civil and administrative measures.	There is no offence of possessing and using an illegal drug. Offences replaced by regulatory models, including: • prescription model; • pharmacy model; • licensed sales or unlicensed sales.
Treatment	Treatment services are available and can be integrated into the criminal justice system.	Treatment services are available and can be integrated into the criminal justice system.	Treatment services are available and can be integrated into the civil/administrative approach.	Treatment services are available.
Harm reduction	In a pure prohibition model, harm reduction programs do not exist.	Harm reduction programs accord with this approach. Participants could still be charged with drug offences in the absence of police guidelines and/or legislative exemptions.	Harm reduction programs accord with this approach. Participants do not face criminal penalties but may face civil penalties in the absence of legislative exemptions.	Harm reduction programs accord with this approach. Participants do not face criminal or civil penalties.
Supply and manufacture offences	It is an offence to supply and manufacture illegal drugs	It is an offence to supply and manufacture illegal drugs	It is an offence to supply and manufacture illegal drugs	It is not an offence to supply and manufacture drugs if authorised by the regulatory system to do so.

*Also referred to as de facto (in practice) decriminalisation.

**Also referred to as de jure (in law) decriminalisation.

[271] Table based on *Drug Law Reform Discussion Paper*, November 2014, NSW Bar Association

7.2 Summary of the debate

Table 15 summarises the debate on prohibition versus decriminalisation.

Table 15: Summary of the debate

The case for prohibition and against decriminalisation	
Arguments for prohibition	*Arguments against decriminalisation*
Limits legitimate opportunities for illicit drug use, reducing use and subsequent harms	Insufficient evidence that decriminalisation will not increase drug use
Raises both non-monetary and monetary costs associated with illicit drugs, making it more difficult for drug users to obtain these substances	Will lead to an increase in drug use and dependence, including in low socio-economic or minority communities
Results in less overall harm than any other model	Decriminalisation risks unintended consequences, resulting in more overall harm than prohibition
Prohibition is a frequently used policy response to inhibit other types of socially undesirable activity	Does not address drug supply and other illegal activities, which may result in a "worst of both worlds" approach between prohibition and legalisation
The case against prohibition and for decriminalisation	
Arguments against prohibition	*Arguments for decriminalisation*
Does not deter and reduce drug use and dependence	Decriminalisation has no or small effects on rates of drug use
Marginalises drug users which further exacerbates existing personal, social and community problems	Improved health outcomes, with more people accessing treatment services and lower risk of spreading diseases
Criminalisation often fails to recognise and respond appropriately to health and addiction issues	Improves employment and other social prospects for those detected with drugs
Involves substantial law enforcement costs to the detriment of other services	Savings in law enforcement costs can be diverted to prevention and treatment

7.3 The case for prohibition and against decriminalisation

7.3.1 Arguments for prohibition

As discussed in chapter 3, drug use results in substantial harms for both users and communities. These personal, social and financial consequences have been used to justify a prohibitionist response to drugs for many decades in Australia and most other jurisdictions around the world.

Limits legitimate opportunities for illicit drug use and raises associated costs: The main argument for prohibition is that it results in an overall reduction in the number of people exposed to illicit drugs, and lower levels of use. In the 2014 London School of Economics report, *Ending the Drug Wars*, Caulkins explained how prohibition reduces the impacts of drug dependence on both individuals and wider society:

> The benefits of prohibition are reduced 'externalities' and reduced 'internalities'. Externalities are costs one person's consumption imposes on another. For example, to the extent that alcohol prohibition reduces drunkenness, it might count fewer assaults, greater road safety and less domestic violence among its benefits.
>
> 'Internalities' are costs that one person's consumption imposes on oneself … Liberal democratic societies assume that people generally do a fine job of looking out for themselves, or at least a much better job than the government would do … Dependence-inducing substances pose a special challenge to the presumption that consumers consistently act in their own self-interest. Repeated administration of artificial neurotransmitters creates lasting changes in the brain. Dependence is therefore a central consideration. Even though most consumers do not become dependent, dependent users account for a disproportionate share of consumption. Likewise, intoxicants pose special challenges because many decisions to consume intoxicants are made while intoxicated, particularly when 'bingeing' is common, as with crack.[272]

Similarly, Weatherburn argued in a 2014 journal article that, although there are various ways to reduce drug-related harms, "one of the surest is to reduce or limit aggregate levels of drug consumption". According to Weatherburn, prohibition constrains aggregate consumption of illegal drugs in three ways:

1. First, by limiting the legitimate opportunities for illicit drug use;
2. Second, by raising the non-monetary costs associated with drug use; and,
3. Third, by making drug use expensive.[273]

Weatherburn explained that restricting legitimate occasions for illicit drug consumption can have a significant impact on overall consumption rates:

> Prohibiting drug use can be thought of as reducing the legitimate occasions of drug use to zero. If the pattern for tobacco is any guide, we would expect prohibition to reduce illicit drug consumption and we would expect the effects to be most pronounced among frequent users of illicit drugs. Supporting this, in 2001, Weatherburn, Jones, and Donnelly asked a representative sample of 600 18- to 29-year-olds in NSW whether they would use more cannabis if it were legal. About 16% of those who had never used cannabis, 78% of monthly users, and more than 90% of weekly users said they would.[274]

Weatherburn also detailed how both non-monetary and monetary constraints make it more difficult for drug users to obtain these substances, which in turn reduces the prevalence of illicit drug use:

> We now turn to the issue of non-monetary costs. One of the consequences of prohibition is that it forces drug users to expend a lot more effort obtaining the drugs they want. Their burdens include the risk of arrest, the possibility of police harassment, the risk of assault by other drug users who want to ''rip off'' their stash,

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[272] J Caulkins, "Effects of Prohibition, Enforcement and Interdiction on Drug Use", in *Ending the Drug Wars*, May 2014, LSE Expert Group on the Economics of Drug Policy, p 16.

[273] D Weatherburn, "The pros and cons of prohibiting drugs" (2014) 47 *Australian & New Zealand Journal of Criminology* 176 at 178.

[274] D Weatherburn, "The pros and cons of prohibiting drugs" (2014) 47 *Australian & New Zealand Journal of Criminology* 176 at 179.

> and the risk of violence from dealers who want to enforce payment of unpaid debts. These ‘‘non-monetary’’ costs have been said to act as a brake on drug consumption, just as monetary costs do. …
>
> [Regarding monetary costs,] the available evidence suggests that a 10% increase in the price of heroin or cocaine would reduce consumption by between 5 and 6%, while a 10% increase in the price of cannabis would reduce consumption by between 2 and 3%. These effects are comparable to those found for alcohol and tobacco.[275]

Supporters of prohibition argue that the evidence indicates that prohibition has achieved long term reductions in illicit drug use. A 2008 report by the UN Office on Drugs and Crime (UNODC) stated that, over the past century, efforts to contain global illicit drug use have been largely successful:[276]

> The drug control system has succeeded in containing the drugs problem to less than 5% of the adult population (aged 15-64) of the world. This refers to annual prevalence: those who have used drugs at least once in the year prior to the survey. Problem drug users are limited to less than one tenth of this already low percentage: there may be 25 million of them in the world, namely 0.6% of the planet’s adult population. In other words, occasional statements such as “there are drugs everywhere” or that “everybody takes drugs” are just plain nonsense.
>
> Actually, and in comparative terms, these statistics point to an undeniable success. The consumption of tobacco, an addictive psychoactive drug that is sold widely as a legal commodity in open (albeit regulated) markets, has spread to about 30% of the adult population. The proportion of the world population that consumes alcohol, another addictive psychoactive substance freely available in many countries, is even higher. In the absence of the drug control system, it is not fanciful to imagine illicit drug use reaching similar proportions.

Prohibition results in less overall harm than any other model: Although proponents of prohibition acknowledge that this policy brings with it various negative consequences, they nevertheless contend that the benefits of prohibition outweigh the costs. As explained by Caulkins:

> … the benefits of drug prohibition in the US – in terms of reduced dependence – may well exceed prohibition’s combined costs in terms of financial outlays and loss of freedom from incarceration. There is enormous uncertainty surrounding every component of the calculations, and intelligent people can disagree about what value to place on averting a year of dependence vs. a year of incarceration, but it is at least plausible that prohibition is actually succeeding from a US perspective. And if the rather extreme and inefficient version of prohibition implemented in the US has merits, the same may be true for prohibition as implemented in other final market countries.[277]

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[275] D Weatherburn, “The pros and cons of prohibiting drugs” (2014) 47 *Australian & New Zealand Journal of Criminology* 176 at 181-2.

[276] A Maria Costa, Making drug control ‘fit for purpose’: building on the UNGASS decade, 2008, UN Office on Drugs and Crime, pp 3-4.

[277] J Caulkins, “Effects of Prohibition, Enforcement and Interdiction on Drug Use”, in *Ending the Drug Wars*, May 2014, LSE Expert Group on the Economics of Drug Policy, p 25.

Prohibition is a frequently used policy response to other undesirable activity: Weatherburn noted that prohibition is a frequently used policy response to inhibit other types of socially undesirable activity; this response being used despite the fact that many laws are widely flouted, are expensive to enforce and are harmful to those caught and prosecuted:

> The laws against murder, insider trading, environmental pollution, corporate fraud, child sexual assault, and tax evasion are just a few examples. We accept these laws, despite their frailties and the enforcement cost associated with them because we think the social cost would be even higher if we abandoned them. And this is the nub of the matter. The standard against which we should judge any law is whether some other set of laws would produce the same or better outcomes at lower financial and social cost.[278]

7.3.2 Arguments against decriminalisation

Although decriminalisation is often advocated as an alternative to addressing drug-related harm (see chapter 7.4.2), critics have questioned the benefits of decriminalisation, arguing not only that decriminalisation may be ineffective at reducing the harms caused by drug use and dependence, but that it may actually increase the damage associated with these substances.

Insufficient evidence that decriminalisation will not increase drug use: Weatherburn has argued that there is not enough evidence to support the claim that decriminalisation will not result in increased rates of drug use. He noted that studies are often performed at too small a scale to adequately determine the effects of a jurisdiction-wide drug policy change:

> Suppose, for example, we provide heroin to all dependent users. This will improve their health and well-being. But since dependent heroin users account for a large share of all heroin consumption, providing free heroin to them will reduce demand for heroin in the illegal market causing the price of illegal heroin to fall. This may encourage new users into the market and current users to consume more. It might be objected that none of these effects have been observed in evaluations of heroin trials to date. The experimental trials used to test the feasibility of heroin treatment, however, have been comparatively small compared with the population of heroin users. They are, for this reason, unlikely to have impacted on the market for heroin.[279]

Decriminalisation may lead to increased drug use and dependence: Some research has suggested that decriminalisation will lead to increased drug use.[280] For example, a 2004 study by Zhao and Harris found higher probabilities for both possession and consumption of cannabis in the decriminalised jurisdictions of South Australia, the Northern Territory and the Australian Capital Territory:

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[278] D Weatherburn, "The pros and cons of prohibiting drugs" (2014) 47 *Australian & New Zealand Journal of Criminology* 176 at 184.

[279] D Weatherburn, "The pros and cons of prohibiting drugs" (2014) 47 *Australian & New Zealand Journal of Criminology* 176 at 184.

[280] For examples, see: D Weatherburn, "The pros and cons of prohibiting drugs" (2014) 47 *Australian & New Zealand Journal of Criminology* 176 at 180.

> [O]nce differences in prices, income and other personal characteristics have been taken into account, an individual residing in one of the three decriminalised states has, on average, a 1-2 per cent higher probability to be participating in the consumption of each of the three drugs [cannabis, alcohol and tobacco]. …
>
> Although, on average, there are 24 more marijuana users for every 1 000 people in the decriminalised states, other factors being equal, among users there are also proportionally more heavier users in these three states. There are, on average, 38 more daily marijuana users for every 1 000 users in these three states.[281]

Extraneous factors may also contribute to the success or failure of decriminalisation, and, as highlighted by Weatherburn, the failure to recognise the nuances of illicit drug markets could result in additional harm to already vulnerable communities:

> … it is one thing to decriminalize use of a drug where the street price of the drug is very high and rates of initiation into the drug or transitions from casual to dependent use are likely to be correspondingly low. It is quite another to decriminalize where the price of the drug is low and where the drug is cheap and has significant potential to inflict further damage on communities that are vulnerable and/or have already been devastated by alcohol or some other drug (e.g. Indigenous Australians). Even for measurable harms, the optimal policy options are far from clear. [282]

Additional studies examining the correlation between cannabis decriminalisation and rates of cannabis use in several Australian States and Territories are discussed in chapter 7.6.2.

Decriminalisation risks unintended consequences, resulting in more overall harm than prohibition: Caulkins and Lee have contended that, were drug laws to be liberalised, unintended consequences might ensue and thus worsen the harms caused by illicit drugs:

> Both sophisticated social science and old-fashioned common sense warn that even well-intentioned policies can yield unanticipated, and often harmful, consequences. Drug prohibition is no different. It has succeeded in discouraging widespread drug use: None of the illegal drugs — not even marijuana — is used nearly as widely as their two legal counterparts, alcohol and nicotine; illegal heroin, meanwhile, causes far fewer overdoses than do legal prescription opioids. But prohibition has certainly brought its share of undesired side effects: violence and organized crime, corruption, crowded prisons, and heightened racial tensions. These are the effects that have prompted the Global Commission on Drug Policy to so forcefully announce that "the global war on drugs has failed."
>
> But there is every reason to believe that legalization would invite unintended consequences just as harmful, if not more so. Indeed, recognition of this may be what prompts the Global Commission and other advocates to promote what they see as middle paths.

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[281] X Zhao, M Harris, "Demand for marijuana, alcohol and tobacco: Participation, levels of consumption and cross-equation correlations" (2004) 80 *Economic Record* 394 at 401, 404, 406.

[282] D Weatherburn, "The pros and cons of prohibiting drugs" (2014) 47 *Australian & New Zealand Journal of Criminology* 176 at 185.

> The first such path, decriminalization — meaning eliminating criminal penalties for users but not suppliers — combines aspects of the worst of both worlds. While holding obvious appeal to current users, the crime, violence, and high-level corruption that exist under today's prohibition regime could continue, and potentially be exacerbated by somewhat increased use and dependence. (Decriminalization's effects on use would be relatively modest precisely because it keeps production illegal, and so avoids the price collapse that would accompany full legalization.)[283]

One example of unintended consequences was reported in a 2011 study that evaluated the effects of a localised cannabis warning scheme in the London borough of Lambeth, operated by police between 2002 and 2004. Although the aim of the Lambeth trial was to allow police to focus more resources on serious drug crime, the policy resulted in an increase in drug tourists from geographic neighbours; a 6.1% fall in house prices relative to the London wide average; and little change in police activity against serious drug crime.[284]

A 2011 clinical observation warned that growing ease of access to cannabis may create health risks for children, who could face increasing exposure to the drug as a result of greater availability and parental negligence.[285] Another example of unintended consequences, as discussed in a 2015 journal article by Shiner, arose following the UK government's 2004 decision to reclassify cannabis as a less dangerous drug (this was subsequently reversed five years later):

> The reclassification of cannabis exacerbated many of the problems identified by the Independent Inquiry: street warnings and penalty notices have extended police discretion, producing a clear net-widening effect; convictions for drug possession offences have increased; many otherwise law-abiding, mainly young, people are still being criminalised to the detriment of their future; and drug policing continues to be disproportionately targeted at minority ethnic communities. Even in terms of the Government's more limited ambition of diverting resources away from cannabis onto drugs that cause most harm, reclassification did not have its intended effect.[286]

Does not address drug supply and organised crime: Additionally, decriminalisation has even been criticised by supporters of drug legalisation for effectively offering the worst of both prohibition and liberalisation responses to drug use. The NSW Bar Association, which supports the introduction of a regulatory system for illicit drug sale and production, argued that decriminalisation does not address the issue of black markets and associated criminal activity:

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[283] J Caulkins and M Lee, "The Drug-Policy Roulette", 2012, *National Affairs*.

[284] J Adda, B McConnell and I Rasul, *Crime and the depenalization of cannabis possession: Evidence from a policing experiment*, 2011, University College London. Note that the study reported positive findings: notably the police appeared to shift their focus to serious non-drug crime during the trial's duration, with total crime overall falling over the two year period.

[285] I Amirav, A Luder, Y Viner and M Finkel, "Decriminalization of Cannabis: potential risks for children?" (2011) 100 *Acta Paediatricia* 618.

[286] M Shiner, "Drug policy reform and the reclassification of cannabis in England and Wales: A cautionary tale" (2015) 26 International Journal of Drug Policy 696 at 701.

> While moves to decriminalise illicit drugs have been successful at reducing levels of drug-related harm, they allow the black market to continue operation almost completely unaffected. The black market is responsible for the rise of powerful criminal networks, for the provision of 'hard' drugs to 'soft' drug users for the adulteration of drugs and a large proportion of drug-related crime and violence. A comprehensive drug control model should stifle the operations of the black market, as well as ensure that drug users and the community do not suffer avoidable harms.[287]

7.4 The case against prohibition and for decriminalisation

Many stakeholders have criticised the criminalisation of drugs, which they argue make the already challenging problem of drug-related harm reduction even worse. These criticisms (discussed below) have led them to call for the relaxation of drug laws by decriminalising illicit drugs for personal use and possession. For example, in NSW, former Premier Bob Carr and former Director of Public Prosecutions Nicholas Cowdery have called for decriminalisation,[288] while at the Commonwealth level the cross-party Parliamentary Group on Drug Policy and Law Reform held its Parliamentary Drug Summit on 2 March 2016 to discuss harm minimisation and drug law reform.[289]

There is also support for relaxation of drug laws at the international level. Prominent individuals, such as former Secretary-General of the United Nations Kofi Annan, have advocated drug decriminalisation,[290] while organisations such as the World Health Organisation and the Global Commission on Drug Policy (an organisation comprised of former world leaders and intellectuals) have called for increased focus on treatment and health services rather than the criminalisation of drug users.[291]

7.4.1 Arguments against prohibition

A 2016 report on public health and international drug policy by Johns Hopkins University and *The Lancet* concluded that existing drug prohibition policies have exacerbated many of today's most urgent public health crises, while doing little to affect drug markets or drug use:

> Policies meant to prohibit or greatly suppress drugs present an apparent paradox. They are portrayed by policy makers to be necessary to preserve public health and safety, and yet they directly and indirectly contribute to lethal violence, disease, discrimination, forced displacement, injustice, and the undermining of people's right

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[287] *Drug Law Reform Discussion Paper*, November 2014, NSW Bar Association p 24.

[288] "Carr joins calls for rethink of drugs laws", 4 April 2012, *ABC News*; *Drug Law Reform Discussion Paper*, November 2014, NSW Bar Association.

[289] *Parliamentary Drug Summit*, 2016, Parliamentary Group on Drug Policy and Law Reform.

[290] K Annan, "Why I'm Calling to End the War on Drugs", 19 April 2016, *Huffington Post*.

[291] *Public health dimension of the world drug problem including in the context of the Special Session of the United Nations General Assembly on the World Drug Problem, to be held in 2016*, 15 January 2016, EB138/11, World Health Organisation; *War on drugs*, June 2011, The Global Commission on Drug Policy.

> to health. …
>
> Policies that pursue drug prohibition or heavy suppression do not represent the least harmful way to address drugs, the aim they pursue is not well defined or realistic, their interventions are not proportionate to the problem, they destabilise democratic societies, and people harmed by them often have no recourse to remedies to mitigate those harms. The scourge of drugs and the harms of drug use are exaggerated to justify these measures.[292]

A range of experts and observers have given various reasons why prohibition is ineffective at stopping illicit drug use. Each of these reasons is discussed in the sub-sections below.

Prohibition does not deter drug users or reduce dependence: Large numbers of Australians choose to use illicit drugs despite considerable efforts by authorities to enforce prohibition measures. In a 2014 journal article, Wodak argued that, because illicit drugs are sold through what is fundamentally a market system, consumer demand will exist regardless of any punitive measures in place to stop drug use:

> Where there is a strong demand for a particular drug, there is generally a supply, and if no legal source is available, other sources emerge. But black market drug supplies are inherently more dangerous for people who use drugs, their families and communities. Inevitably, societies find appetites for some goods and services unpalatable. If the unpalatable good or service is banned, and demand persists, supply emerges but by default criminals and corrupt police become the gatekeepers.[293]

In a 2014 discussion paper, the NSW Bar Association commented:

> Many people who use drugs are rational consumers insofar as they make a deliberate choice to take a drug or drugs to achieve a desired effect. … Research shows that illegality of a particular drug is rarely taken into consideration by individuals considering whether to use that drug … For whatever reason, it appears that the normative force of the law is of comparatively little importance to illicit drug users.[294]

One factor that may impact efforts at deterrence is low rates of detection and arrest by law enforcement authorities. According to a 2010 paper by NDARC, the probability of a cannabis user being arrested is 1 in 19.6 if used in the last month, and 1 in 34.8 if used in the last year. Other illicit drugs have similarly low, or lower, probabilities of arrest: the likelihood of arrest for heroin users in the previous month is 1 in 14, and 1 in 35.6 for use in the previous twelve months; and the probability of arrest for methamphetamine users in the previous month is 1 in 34.5, and 1 in 86.4 for use in the previous year.[295]

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[292] The Lancet Commissions, "Public health and international drug policy" (2016) 387 *The Lancet* 1427 at 1467.

[293] A Wodak, "The abject failure of drug prohibition" (2014) 47 *Australian & New Zealand Journal of Criminology* 190 at 198.

[294] *Drug Law Reform Discussion Paper*, November 2014, NSW Bar Association, pp 12-13.

[295] A Ritter, K Lancaster, K Grech and P Reuter, *An Assessment of Illicit Drug Policy in Australia*

Cross-jurisdictional studies indicate that the severity of government responses may not necessarily reduce the prevalence of illicit drug use.[296] For example, a 2014 report by the UK drug policy think tank Transform reported that there was no definitive link between prohibition measures and rates of illicit drug use:

> [S]tudies have consistently failed to establish the existence of a link between the harshness of a country's drug laws and its levels of drug use. A 2008 study using World Health Organization data from 17 countries (not including Sweden) found: 'Globally, drug use is not distributed evenly and is not simply related to drug policy, since countries with stringent user-level illegal drug policies did not have lower levels of use than countries with liberal ones.' Many other large-scale studies – including most recently a study by the UK Home Office – have come to the same conclusion.[297]

Prohibition marginalises illicit drug users and fails to recognise and respond to health and addiction issues: Stakeholders have argued that the criminalisation of drug use has created a marginalised underclass, consequently further exacerbating the resultant personal, social and community problems. The NSW Bar Association has outlined a large range of negative consequences arising from the prohibitionist approach to illicit drugs; a key consequence is the stigmatisation of drug users, which in turn affects the ability of the illicit drug user to seek treatment and/or rehabilitation and perpetuates or exacerbates the social conditions that gave rise to drug abuse in the first place.[298]

The stigmatisation of drug users is also discussed by the New Zealand Law Commission's 2011 review of that country's *Misuse of Drugs Act 1975*. The Commission found that criminalisation often fails to recognise and respond appropriately to the health and addiction issues which can underpin illicit drug use:

> The law may deter some sections of the population from experimenting with drugs – axiomatically reducing the potential for harm. But for those who are already using and whose use is associated with addiction or other mental health problems, the criminal law's response can in some circumstances exacerbate rather than reduce drug-related harms. … Crucially too, the illegal status of drugs and the risk of criminal prosecution can create an obstacle to drug users accessing appropriate education and treatment.[299]

Apfel also notes that jurisdictions that assign discretionary power to police authorities to respond to drug possession and use risk enabling discriminatory

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(1985 to 2010): theme and trends, March 2011, Monograph 21, National Drug and Alcohol Research Centre, p 20.

[296] *Cannabis: From prohibition to regulation*, April 2014, Policy Paper No 5, Addiction and Lifestyles in Contemporary Europe Reframing Addictions Project, p 7.

[297] G Murkin, *Drug policy in Sweden: a repressive approach that increases harm*, 15 December 2014, Transform.

[298] *Drug Law Reform Discussion Paper*, November 2014, NSW Bar Association, pp 15-16.

[299] *Controlling and regulating drugs: A review of the Misuse of Drugs Act 1975*, April 2011, Report No 122, New Zealand Law Commission, p 108.

law enforcement:

> Such discretionary power has resulted in discriminatory enforcement. Cannabis laws have been selectively enforced by police officers, for example, who focus on certain groups for cannabis control and "stop and search" checks. In the UK, for example enforcement of drug laws has been shown to be unfairly focused on Black and Asian communities, despite their rates of drug use being four times lower than the white majority.[300]

The New Zealand Law Commission reported that certain groups of New Zealanders, such as youth and the Maori population, are disproportionately affected by drug prohibition and criminalisation. It noted that "criminalisation of drug users can produce a cascading effect that is potentially both disproportionate to the harm associated with the drug use itself and also highly prejudicial for other life outcomes."[301]

According to the NSW Bar Association, even depenalisation approaches within the criminal justice system, such as diversion schemes, can still result in the marginalisation of drug users:

> There are enormous problems with the criminalisation of widespread conduct, then 'softening the blow' of that criminalisation by diverting users into inadequate forms of treatment, punishing failures to maintain total abstinence during treatment with incarceration, and expecting levels of drug use to diminish as a result.
>
> Ultimately, conventional harm reduction measures, however effective, address in large part drug-related harms that result from the current prohibitionist regime. The encouragement of safe injecting practices would not be necessary if drugs did not have to be injected covertly and in dangerous environments. Diversion out of the criminal justice system would not be necessary if we did not criminalise drug taking in the first place. In effect, we are creating the circumstances that cause the harm and then developing harm reduction measures to remedy them.[302]

Prohibition entails substantial law enforcement costs: Various experts have commented that prohibitionist approaches to drug use result in considerable law enforcement costs for governments. According to a 2010 study by the National Alcohol and Drug Research Centre, Australian governments spent approximately $1.7 billion on illicit drug programs in 2009-10. This figure equated to 0.13% of GDP that financial year, and 0.8% of all government spending over that period.[303] As shown in the table below, law enforcement costs comprised close to two-thirds of drug policy expenditure over the 2009-10 financial year:

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[300] F Apfel, *Cannabis: From prohibition to regulation*, 2014, Policy Briefing No 5, Addiction and Lifestyles in Contemporary Europe Reframing Addictions Project, p 8.

[301] *Controlling and regulating drugs: A review of the Misuse of Drugs Act 1975*, April 2011, Report No 122, New Zealand Law Commission, pp 105-6.

[302] *Drug Law Reform Discussion Paper*, November 2014, NSW Bar Association, pp 11-12.

[303] A Ritter, R McLeod and M Shanahan, *Government drug policy expenditure in Australia - 2009/10*, June 2013, Monograph 24, National Alcohol and Drug Research Centre.

Table 16: Funding of Australian drug policy domains, 2009-10[304]		
Policy	**Funding ($m)**	**Percentage of total funding (%)**
Prevention	156.8	9.2
Treatment	361.8	21.3
Harm Reduction	36.1	2.1
Law Enforcement	1123.3	66.0
Other	23.1	1.4
TOTAL	**1701.1**	**100**

In his 2014 journal article, Wodak referred to both Australian and international studies that found drug law enforcement policies were not cost-effective, at least in comparison to treatment and harm reduction measures:

> Benefits per US dollar from interventions to reduce harm to the USA from cocaine in 1992 were estimated to be 52 cents for domestic enforcement (customs and police), 32 cents for interdiction of refined cocaine transported from South to North America, 15 cents for source country control (eradication of coca plants in South America) but US$7.46 for drug treatment of people with problems due to cocaine. US government expenditure in response to cocaine in 1992 was estimated to be US$13 billion of which 73% was allocated to domestic enforcement, 13% to interdiction, 7% to source country control but only 7% to drug treatment, the only intervention to achieve a positive return on investment.
>
> …
>
> A review of the effectiveness and cost-effectiveness of needle syringe programmes in Australia estimated that these had prevented 25,000 HIV and 21,000 hepatitis C infections (by 2000), 4500 deaths from HIV and 90 deaths from hepatitis C (by 2010) resulting in savings (by 2000) of between AU$2.4 and AU$7.7 billion from an investment between 1991 and 2000 of AU$130 million. A subsequent study confirmed these findings estimating that an investment of AU$243 million between 2000 and 2009 achieved short-term health savings of AU$1.28 billion. Thus for every AU$1, invested savings amounted to AU$ 4 in healthcare costs and with overall savings of AU$27.[305]

7.4.2 Arguments for decriminalisation

Stakeholders have made a number of arguments in favour of liberalising laws around recreational drug use. For example, it has been suggested that governments could accrue taxation revenue through the legalisation of illegal drugs,[306] while other advocates of reform argue that adults should be free from government interference if their personal drug use does not inflict harm on

[304] A Ritter, R McLeod and M Shanahan, *Government drug policy expenditure in Australia - 2009/10*, June 2013, Monograph 24, National Alcohol and Drug Research Centre.

[305] A Wodak, "The abject failure of drug prohibition" (2014) 47 *Australian & New Zealand Journal of Criminology* 190 at 195-6.

[306] For further information, see: A Ritter, *Decriminalisation or legalisation: injecting evidence in the drug law reform debate*, n.d, National Alcohol and Drug Research Centre; Parliamentary Budget Office, *Legalising marijuana*, December 2015, Parliament of Australia; *Marijuana Legalization in Colorado: One-Year Status Report*, January 2015, Drug Policy Alliance.

other, non-consenting individuals.[307]

However, the primary arguments in favour of drug decriminalisation are grounded in public health concerns; namely, that decriminalisation does not impede efforts to address drug-related harm the way prohibition does. The 2016 Johns Hopkins University-Lancet Commission report on international drug policy outlined the conflict between prohibition and public health responses to drug use:

> Standard public health and scientific approaches that should be part of policy making on drugs are dismissed in the pursuit of drug prohibition and suppression. The idea of reducing the harm of many kinds of human behaviour is central to public policy in traffic safety, tobacco and alcohol regulation, food safety, safety in sports and recreation, and many other aspects of human life when the behaviour in question is not prohibited. But explicitly seeking to reduce drug-related harms through policy and programmes is regularly resisted in drug control. The idea that all drug use is misuse and that therefore only immediate abstinence is acceptable seems to impede making harm reduction a drug-policy priority.[308]

Public health, employment and other social outcomes will improve under decriminalisation: A key argument made by supporters of decriminalisation is that public health prevention and treatment services will be more effective under a legal model that does not criminalise drug use. For example, the Johns Hopkins University-Lancet Commission report argued that decriminalisation of minor drug offences was shown to improve health and social outcomes for drug users:

> The long experiences in Portugal, the Czech Republic, and other countries with decriminalisation of minor drug offences demonstrate the benefits of treating minor infractions without recourse to criminal sanctions. These benefits include offerings of health and social support to people who might need them, reduction of incarceration of men, women, and young people and all the associated harms, and elimination of the wastefulness of the police's pursuit of minor offenders. Decriminalisation of minor offences also makes harder the use of drug laws as a weapon against racial or ethnic minorities or politically unfavoured groups. Decriminalisation should always be accompanied by measures to ensure the capacity of health and social services to address drug-related harms or problematic drug use as needed.[309]

NDARC also argued that decriminalisation will improve the ability of drug users to obtain employment and have better overall life outcomes:

> *Decriminalisation improves employment prospects and relationships with significant others for those detected with drugs:* Evidence from a number of countries,

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[307] For example, see: *Policies – Cannabis*, n.d., Liberal Democratic Party; D van Mill, "Is the minimal state a reasonable response to the nanny state?", 25 September 2015, *The Conversation*.

[308] The Lancet Commissions, "Public health and international drug policy" (2016) 387 *The Lancet* 1427 at 1468.

[309] The Lancet Commissions, "Public health and international drug policy" (2016) 387 *The Lancet* 1427 at 1468-1469.

> including Australia, shows that decriminalisation can lead to improved social outcomes. For example, individuals who avoid a criminal record are less likely to drop out of school early, be sacked or to be denied a job. They are also less likely to have fights with their partners, family or friends or to be evicted from their accommodation as a result of their police encounter.[310]

Savings in law enforcement costs can be diverted to prevention and treatment: Writing in the *Medical Journal of Australia*, Wodak suggested that drug law enforcement funding could be diverted to prevention and treatment programs if a more liberal drug regime was introduced:[311]

> … the threshold decision now required is to redefine illicit drugs as primarily a health and social problem and then to increase funding for health and social measures towards the levels now spent on drug law enforcement. The additional funding could be used in the community and in prisons to expand the capacity and broaden the range of high-quality drug treatments, while also expanding harm reduction measures such as needle and syringe programs and medically supervised injecting centres. …
>
> Drug treatment should become like any other part of the health system and cease being an adjunct to the criminal justice system. Decreasing the emphasis on drug law enforcement is likely to make the drug market less violent and more stable and to encourage less dangerous drugs to drive out more dangerous drugs. There may have to be a place for the commercial sale of small quantities of selected drugs as there was for edible opium at the turn of the last century. It is now clear that where there is a strong demand for drugs, there will always be a supply.

Decriminalisation will not lead to an increase in drug use and dependence: Supporters of decriminalisation have cited evidence indicating that decriminalisation has little or no impact on overall rates of drug use. NDARC summarised research findings as follows:

> Decriminalisation has no or very small effects on rates of drug use: Drug use rates don't change or dramatically increase when the laws are changed to introduce decriminalisation. Research from across the globe has consistently found that decriminalisation is not associated with significant increases in drug use. And in instances where just cannabis has been decriminalised it has not led to increases in use of other drugs such as ecstasy or heroin.[312]

Looking at decriminalisation across global jurisdictions, UK human rights charity Release conducted a 2013 evaluation of different decriminalisation policies around the world. Although it noted that there were "few broad, unifying conclusions that [could] be drawn" from its analysis, it argued that the concerns

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[310] C Hughes, A Ritter, J Chalmers, K Lancaster, M Barratt and V Moxham-Hall, *Decriminalisation of drug use and possession in Australia – A briefing note*, February 2016, National Alcohol and Drug Research Centre, p 4.

[311] A Wodak, "The need and direction for drug law reform in Australia" (2012) 197 *Medical Journal of Australia* 1.

[312] C Hughes, A Ritter, J Chalmers, K Lancaster, M Barratt and V Moxham-Hall, *Decriminalisation of drug use and possession in Australia – A briefing note*, February 2016, National Alcohol and Drug Research Centre, p 4.

of decriminalisation critics regarding increased drug use and harm were exaggerated:

> Decriminalisation is not a panacea for all of the problems associated with problematic drug use; a country's drug-enforcement policies appear to have but a minor effect on the impact of drugs in a society. But what emerges is that the harms of criminalisation far outweigh those of decriminalisation … [D]ecriminalisation when implemented effectively does appear to direct more people who use drugs problematically into treatment, reduce criminal justice costs, improve public health outcomes, and shield many drug users from the devastating impact of a criminal conviction. Decriminalisation when coupled with investment in harm reduction, and health and social services, can have an extremely positive effect on both individuals who use drugs and society as a whole.[313]

7.5 Public attitudes to prohibition and decriminalisation

While there are a wide range of prominent figures and stakeholders involved in the debate on prohibition versus decriminalisation, public attitudes towards reform is also an important consideration for policymakers. This chapter discusses Australian community attitudes towards drugs as reported in the AIHW's *2013 National Drug Strategy Survey*.

7.5.1 Attitudes toward people possessing or using illicit drugs

Although the vast majority of respondents supported increased penalties for individuals who sold or supplied illicit drugs,[314] the most popular responses to possession of illicit drugs for *personal* use were referral to treatment or education programs, a caution or warning, or no action at all:

- for all drugs except cannabis, most support was for referral to treatment or an education program, while for cannabis the most popular action was a caution, warning or no action and this rose in 2013 (from 38% to 42%)
- a lower proportion thought that possession of cannabis, ecstasy and heroin should result in a prison sentence
- for all drugs, teenagers (aged 14–19) were more likely to support fines than any other age group, and those aged 50 or older were more likely to support referral to treatment or an education program than other age groups.[315]

These findings are set out in more detail in Figure 12, and indicate that a majority of Australians do not believe harsh penalties are an appropriate response for personal use or possession of illicit drugs.

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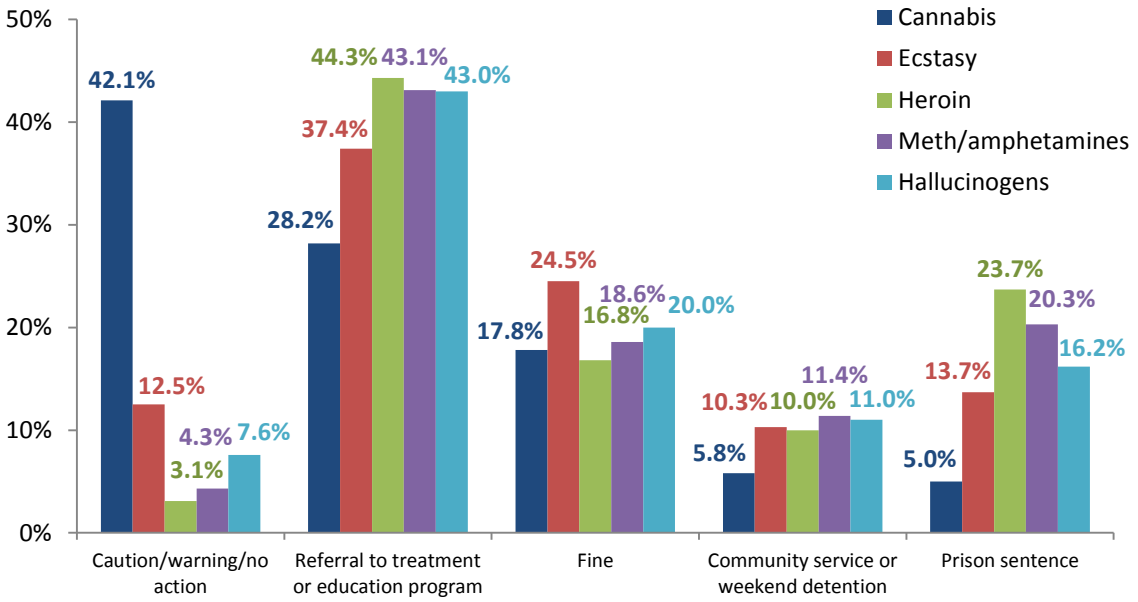
[313] N Eastwood, E Fox, A Rosmarin, *A quiet revolution: Drug decriminalisation across the globe*, March 2016, Release, p 7.

[314] Ranging from 58% of respondents in relation to cannabis supply or sale to 84.4% in relation to heroin or meth/amphetamines: see *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare, Table 9.24.

[315] *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare, p 117.

Figure 12: Support for actions taken against people found in possession of selected illicit drugs for personal use, persons aged 14 years or more, 2013[316]



7.5.2 Attitudes toward liberalisation of drug laws

While most Australians appear to support treatment or education as a means of responding to personal drug use, the AIHW's 2013 Survey and a 2015 poll by Roy Morgan found that most respondents were unsupportive of reforms that legalise drug use. Neither survey distinguished between decriminalisation and legalisation when asking respondents about their support for drug legalisation, and accordingly the results should be used with caution.

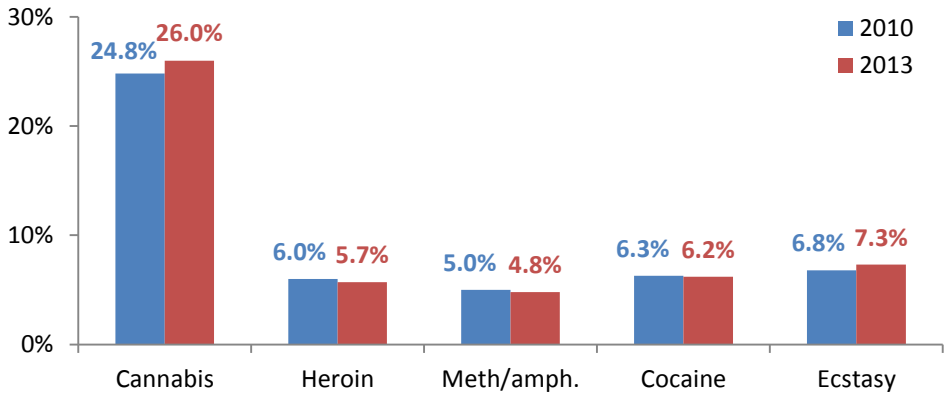
Support for the legalisation of illicit drugs was, in general, extremely low: only 5.7% of respondents supported the legalisation of heroin; 4.8% of respondents for meth/amphetamines; 6.2% for cocaine; and 7.3% for ecstasy. For cannabis, only 26% of respondents believed that the personal use of cannabis should be legal. By way of comparison, 33% of respondents thought that possession of cannabis for personal use should be a criminal offence, although two-thirds of respondents (69%) supported a legislative change permitting the use of cannabis for medicinal purposes.[317]

Changes in attitudes towards illicit drug legalisation between 2010 and 2013 are shown in Figure 13.

[316] *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare, Table 9.22. Values do not add to 100% because the category "Some other arrangement" (values ranging from 1.1% to 2.3%) have been excluded.

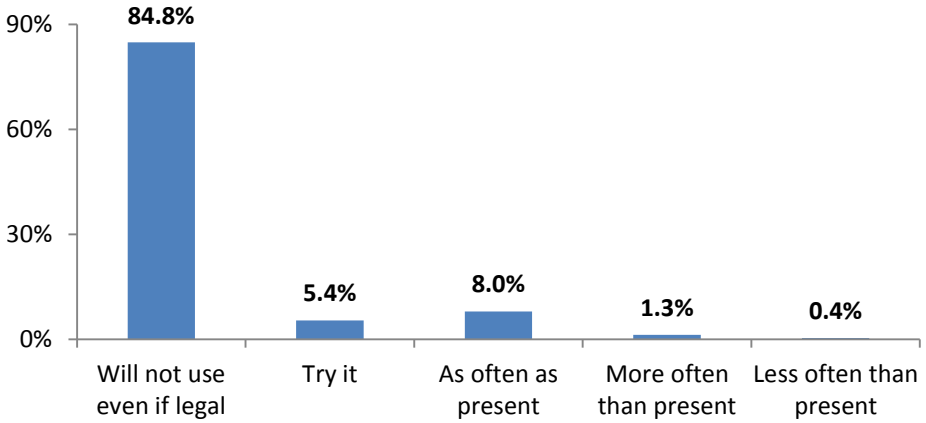
[317] *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare, p 116.

Figure 13: Support for legalisation of illicit drugs, persons aged 14 years or more, 2010 and 2013[318]



The AIHW also asked respondents about the likelihood that they would use cannabis were it legalised and available. Of the respondents, approximately 85% said that would still not use cannabis; 5.4% said they would try it; and 1.3% said they would use cannabis more often than they did at the time (Figure 14):

Figure 14: Likely usage of cannabis if it was legalised, people aged 14 years or older, 2013[319]

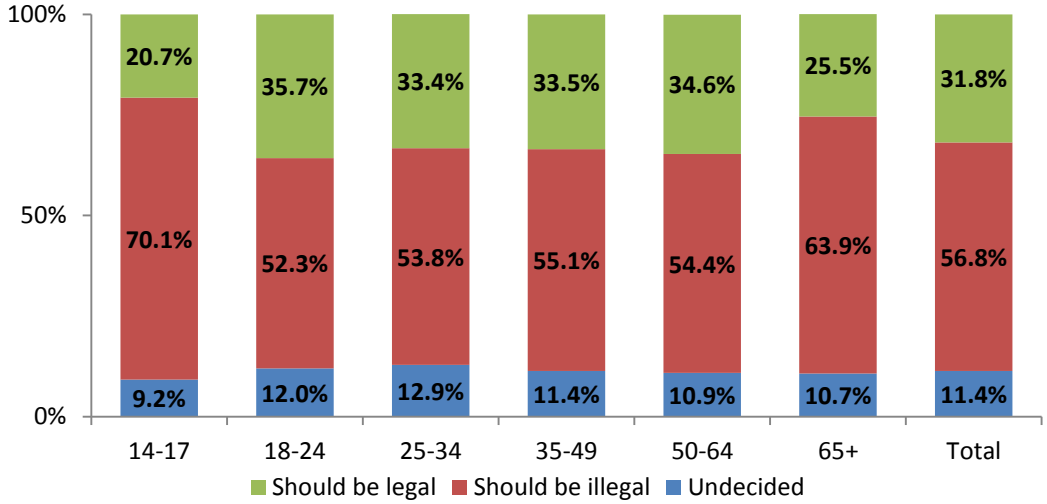


More recently, a January 2015 poll by Roy Morgan Research reported that a majority of respondents in all age brackets believed that cannabis should remain illegal (Figure 15).

[318] *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare, Table 9.23.

[319] *National Drug Strategy Survey 2013*, November 2014, Australian Institute of Health and Welfare, Table 9.15.

Figure 15: Support for legalisation of marijuana by age[320]



However, Roy Morgan Research also noted that the proportion of the population who believed that cannabis should be legalised had increased over the preceding decade, from 26.8% in 2004 to 31.8% in 2014. Additional changes in attitudes over time are described below:

> In this time, the 65+ age bracket has seen the largest proportional increase in favour of legalisation, rising from 16.9% to 25.5% (a 50% growth rate). However, this is still well behind young Australians aged 18-24 (35.7%), the age group with the most support for making smoking marijuana legal.
>
> The belief that smoking marijuana should be made legal has become more widespread across all ages except 25-34 year olds (among whom it has declined fractionally). Even 14-17 year olds, traditionally the least likely to support legalisation, seem to have become more open to the idea in the last 10 years, having gone from 15.5% in favour to 20.7%.
>
> University-educated Australians are more likely than those who didn't complete high school to agree that smoking marijuana should be made legal: 35.8% of people currently at university and 32.3% of tertiary graduates are in favour, compared with 30.9% of people who finished at year 10 and 28.4% of people with 'some secondary' education.[321]

[320] *To legalise or not to legalise? How Australians feel about marijuana*, 28 January 2015, Roy Morgan Research.

[321] *To legalise or not to legalise? How Australians feel about marijuana*, 28 January 2015, Roy Morgan Research.

7.6 Decriminalisation in Australia

7.6.1 Overview

All Australian jurisdictions have depenalised or decriminalised the possession and use of minor quantities of one or more types of illicit drugs. Two of the earliest schemes were introduced in South Australia: the Drug Assessment and Aid Panels (1985) operated as a pre-court diversion program for users of a range of drugs; and the Cannabis Expiation Notice Scheme (1987) provided cannabis users with expiation notices (i.e. infringement notices) as an alternative to prosecution in court.[322] Other States followed, in particular after the 1999 National Illicit Drug Diversion Initiative, which "marked a shift towards a more national approach towards diversion of minor drug users".[323]

A recent paper by the National Drug Alcohol and Research Centre outlines depenalisation and decriminalisation measures across Australia for adult drug possession and use offences. It distinguishes between *de jure* reform (i.e. decriminalisation), where criminal penalties for use and possession are removed in the law, with optional use of non-criminal sanctions; and *de facto* reform (i.e. depenalisation), where criminal penalties remain but can be lessened in practice: e.g. police guidelines to not enforce the law.[324]

In summary:

- Three jurisdictions (South Australia, Australian Capital Territory, Northern Territory) have implemented *de jure* reform (i.e. decriminalisation), in the form of civil penalty schemes, but only in relation to cannabis.
- All jurisdictions have implemented *de facto* reform (i.e. depenalisation) in the form of police referral to education/assessment/treatment. In most jurisdictions, these police drug diversion programs apply to a range of illicit drugs; in two (NSW and Queensland), they only apply to cannabis.
- In the case of both *de jure* and *de facto* reforms, criminal penalties can apply in cases of non-compliance with the scheme/program.

[322] M Bull, "Just treatment: a review of international programs for the diversion of drug related offenders from the criminal justice system", 2003, Queensland University of Technology, p 59; and C Hughes and A Ritter, "A Summary of Diversion Programs for Drug and Drug Related Offenders in Australia", 2008, National Drug and Alcohol Research Centre.

[323] C Hughes and A Ritter, "A Summary of Diversion Programs for Drug and Drug Related Offenders in Australia", 2008, National Drug and Alcohol Research Centre, p 4.

[324] C Hughes, A Ritter, J Chalmers, K Lancaster, M Barratt and V Moxham-Hall, *Decriminalisation of drug use and possession in Australia – A briefing note*, February 2016, National Alcohol and Drug Research Centre, p 7. For a more detailed outline see: C Hughes and A Ritter, "A Summary of Diversion Programs for Drug and Drug Related Offenders in Australia", 2008, National Drug and Alcohol Research Centre.

Table 17: Depenalisation and decriminalisation schemes in Australia[325]

Jurisdiction	Drugs	Scheme	Response	Allowable no of referrals	Response to non-compliance
Decriminalisation (*de jure*) reforms					
ACT	Cannabis	Simple cannabis offence notice	Fine	No limits	May result in criminal penalty
NT		Cannabis expiation scheme			Debt to state; may result in criminal prosecution
SA		Cannabis Expiation Notice	Fine (option to pay via community service)		Reminder notice, additional fee; automatic criminal conviction
Depenalisation (*de facto*) reforms					
ACT	All illicit drugs (inc cannabis)	Police Early Diversion program	Caution plus brief intervention	2 previous	May result in criminal penalty
NSW	Cannabis	Cannabis cautioning scheme	Caution plus intervention	1 previous	Recorded and court advised if re-offends
NT	Other illicits	NT Illicit Drug Pre-Court Diversion Program	Assessment & compulsory treatment	No limits	May result in criminal penalty
QLD	Cannabis	Police diversion program for minor offences	Assessment	1 previous	
SA	Other illicits	SA Police Drug Diversion Initiative	Assessment & referral	No limits	
TAS	All illicit drugs (inc cannabis)	Police diversion	Caution; brief intervention (for 3rd assessment & compulsory treatment)	3 previous (in last 10 years)	
VIC	Cannabis	Cannabis cautioning program	Caution and education; optional referral	1 previous	Nil
	Other illicits	Drug diversion program	Assessment & referral		May result in criminal penalty
WA	Cannabis	Cannabis Intervention Requirement	Assessment & compulsory education		
	Other illicits	Drug diversion program	Assessment & referral	1 only	

[325] C Hughes, A Ritter, J Chalmers, K Lancaster, M Barratt and V Moxham-Hall, *Decriminalisation of drug use and possession in Australia – A briefing note*, February 2016, National Alcohol and Drug Research Centre, p 7.

7.6.2 Australian evidence on outcomes

This chapter looks at studies that relate to several Australian jurisdictions. Studies specific to South Australia are discussed in chapter 7.6.3.

Impacts on drug use: Several Australian studies have examined the correlation between cannabis decriminalisation in three Australian jurisdictions (South Australia, Australian Capital Territory and Northern Territory) and cannabis use. In a 2010 article, Damrongplasit, Hsaio and Zhao summarised the literature:

> Cameron and Williams (2001) and Zhao and Harris (2004) both found a positive and significant marginal effect of decriminalization on prevalence of about 2%, while Williams (2004) found it to be significant only for the subsample of males aged 25 years old and older.[326]

In the same article, the authors presented the results of a further study, which was based on data from the 2001 Australian National Drug Strategy Household Surveys (NDSHS). It attempted to take into account the issue that a person's choice to live in a particular State may be related to that State's laws on cannabis use. In summary, it found that "on average, living in a decriminalized state significantly increases the probability of smoking marijuana, by 16.2%."[327]

In a 2014 article, Williams and Bretteville-Jensen outlined the results of a study on the impact of liberalising cannabis laws on the decision to start using cannabis. The study was based on data from the 1998, 2001, 2004, 2007 and 2010 waves of the NDSHS. In summary, the results were:

> While we find no evidence of any long run effect, we do find that for the first five years following decriminalization, those who start using cannabis tend to do so at an earlier age than would otherwise have been the case…[328]

Impacts on reoffending: A 2008 report by Payne et al examined the impact of Australian police drug diversion initiatives on reoffending.[329] A different methodology for data collection and analysis was undertaken in each jurisdiction under minimum guidelines. The report contained a summary of the nationwide results as well as a summary for each jurisdiction. In relation to the nationwide results, the report stated:

> As a whole, the findings were generally very positive. Across all jurisdictions, the majority of people who were referred to a police-based [drug diversion] program did

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[326] K Damrongplasit, C Hsiao and X Zhao, "Decriminalization and Marijuana Smoking Prevalence: Evidence From Australia" (2010) 28(3) *Journal of Business & Economic Statistics* 344 at 345.

[327] K Damrongplasit, C Hsiao and X Zhao, "Decriminalization and Marijuana Smoking Prevalence: Evidence From Australia" (2010) 28(3) *Journal of Business & Economic Statistics* 344 at 355.

[328] J Williams, A Bretteville-Jensen, "Does liberalizing cannabis laws increase cannabis use?" (2014) 36 *Journal of Health Economics* 20 at 31.

[329] J Payne et al, Police drug diversion: a study of criminal offending outcomes, Australian Institute of Criminology, October 2008

> not reoffend in the 12 to 18-month period after their diversion. In most cases, those who did reoffend did so only once during that time. Perhaps the best indication of changes in criminal behaviour after diversion comes from comparing the pre and post-offending records of each individual. Again, the results were very positive, particularly in relation to those individuals who had a prior offending history. Among this group, the majority were apprehended for either no or fewer post-program offences than before, and this finding was consistent across all jurisdictions. Similarly, of those individuals who had not offended in the 18 months prior to diversion, the majority (ranging from 70% in Tasmania to 86% in New South Wales) remained non-offenders for an equal period after diversion.
>
> Despite these consistent trends, there were marked differences in post-program recidivism levels from one program to another. These are, for the most part, attributable to variations in program structure and client characteristics, with differences in prior offending records being particularly critical to both compliance levels and post-program reoffending.[330]

7.6.3 South Australia: a case study

Cannabis Expiation Notice Scheme: As noted, the South Australian Cannabis Expiation Notice (CEN) scheme was introduced in 1987. Under this scheme:

> …adults coming to the attention of police for "simple cannabis offences" could be issued with an expiation notice. Offenders were able to avoid prosecution by paying the specified fee or fees within 60 days of the issue of the notice. Failure to pay the specified fees within 60 days could lead to prosecution in court, and the possibility of a conviction being recorded.[331]

A 1999 report on the social impacts of the CEN scheme commented that it:

> …appears to have numerous benefits for the community, not the least of which are cost savings for the community as a whole, reduced negative social impacts for offenders, and greater efficiency and ease in having minor cannabis offences dealt with, associated with less negative views of police held by offenders. While there have been problems identified with the administration of the CEN scheme over time, it appears that the purported adverse effects associated with some unintended consequences of the CEN scheme are less problematic than previously thought. A good example is that, while net-widening has occurred under the system, it does not appear to have adversely affected court loads and costs. However, the effect of net-widening on offenders is less clear, as there is likely to be a small group of repeat offenders for whom repeated detection and prosecution may place them in greater financial hardship. One of the more telling findings from this study is that a significant number of CEN offenders will ultimately still receive a conviction as a result of an expiable offence, with the associated stigma and potential consequences…[332]

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[330] J Payne, M Kwiatkowski and J Wundersitz, *Police drug diversion: a study of criminal offending outcomes, Australian Institute of Criminology*, October 2008, Research and Public Policy Series 97, Australian Institute of Criminology, pp x-xi

[331] R Ali, P Christie, S Lenton, D Hawks, A Sutton, W Hall and S Allsop, *The social impacts of the cannabis expiation notice scheme in South Australia*, 1999, Monograph Series No 34, National Drug Strategy, Commonwealth Department of Health and Ageing, Canberra, p 55.

[332] R Ali, P Christie, S Lenton, D Hawks, A Sutton, W Hall and S Allsop, *The social impacts of the cannabis expiation notice scheme in South Australia*, 1999, Monograph Series No 34,

On the issue of whether cannabis use had increased, the report stated:

> National population survey data indicate there has been a national increase in self-reported lifetime cannabis use between 1985 and 1995, with a greater degree of increase in South Australia than in the average of the other Australian states and territories. However, the South Australian increase is unlikely to be due to the CEN system because: (1) similar increases occurred in Tasmania and Victoria, where there was no change in the legal status of cannabis use; (2) there was no differential change in weekly cannabis use in South Australia as compared with the rest of Australia, and (3) there was no greater increase in cannabis use among young adults aged 14 to 29 years in South Australia.[333]

Police Drug Diversion Initiative: The Police Drug Diversion Initiative (PDDI) commenced in September 2001, replacing the Drug Assessment and Aid Panel scheme. The PDDI applies to a range of illicit drugs. In summary:

> The PDDI enables adults or young people detected by police for a simple possession drug offence to be offered assessment with an accredited health worker. This involves the police officer contacting the Drug Diversion Line to make an appointment on behalf of the individual and their attendance and participation in that appointment (usually lasting approximately one hour). If the individual attends the appointment, police are informed by the DDL and no further action is taken. If the individual does not attend, police are also notified and may then initiate the normal criminal justice process. Unlike some of the other States and Territories, South Australian police do not have any discretion over whether or not they will divert an individual detected for a simple possession offence. All offenders must be diverted and there is no limit to the number of times an individual may be diverted.[334]

The PDDI was evaluated in 2008 and the ten-year data was reviewed in 2012.[335] On the number and profile of participants, the 2012 report noted:[336]

- 13,627 individuals were diverted a total of 19,717 times between the inception of the PDDI on 1 September 2001 and 31 August 2011. The number of diversions increased steadily over the ten-year period, with a maximum of 3,002 diversions in 2010.
- The number of diversions per capita in metropolitan areas increased (from 9.80 per 10,000 people in 2002 to 20.87 in 2010) by more than the

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National Drug Strategy, Commonwealth Department of Health and Ageing, Canberra, p 46-47

[333] R Ali, P Christie, S Lenton, D Hawks, A Sutton, W Hall and S Allsop, *The social impacts of the cannabis expiation notice scheme in South Australia*, 1999, Monograph Series No 34, National Drug Strategy, Commonwealth Department of Health and Ageing, Canberra, p xi. It appears that there have been no more recent published evaluations of the CEN.

[334] B O'Brien, F Bruce, N Hudson, *Police Drug Diversion Initiative Final Evaluation Report*, March 2008, Office of Crime Statistics and Research, p 8.

[335] B O'Brien, F Bruce, N Hudson, *Police Drug Diversion Initiative Final Evaluation Report*, March 2008, Office of Crime Statistics and Research; M Millsteed, *Ten years of the South Australian police drug diversion initiative: data analysis report*, May 2012, Office of Crime Statistics and Research.

[336] M Millsteed, *Ten years of the South Australian police drug diversion initiative: data analysis report*, May 2012, Office of Crime Statistics and Research p 1.

number of diversions per capita in regional areas (from 9.38 per 10,000 people in 2002 to 11.12 in 2010).

- The number of diversions occurring in metropolitan areas increased over time (from 1,093 in 2002 to 2,511 in 2010), while the number of regional diversions only increased marginally (from 378 in 2002 to 487 in 2010).
- Amphetamines were the most common drug for which an individual was diverted over the ten year period (47%), followed by cannabis (27%), and drug equipment (20%). Only 2% of diversions involved detection of more than one drug. The majority of youth diversions were for cannabis (70%), and the majority of adult diversions were for amphetamines (75%, though note that adults are not diverted for cannabis offences).

The report also presented data on compliance with diversions and reoffending rates. Compliance was defined as an individual attending a PDDI assessment appointment that they were diverted to by the police (either an initial appointment or a re-scheduled appointment).[337] In summary, the report stated:

> Compliance with diversions is generally very good, with an overall compliance level of 81%. Nevertheless, another important finding is that compliance with diversion tends to decrease the more times an individual is diverted. This indicates that it may be necessary to re-visit the PDDI model and once again consider capping the number of times an individual can be diverted.
>
> Individuals who comply with their diversions have been shown to be significantly less likely to re-offend. Furthermore, survival analysis has been used to show that those who comply with their initial diversion but do eventually re-offend generally take longer to do so. These findings provide some support for the PDDI as a successful intervention for reducing drug use.[338]

7.7 Decriminalisation in other countries

7.7.1 Overview

In 2016, the UK charity organisation Release published a report which reviewed conducted countries with formal decriminalisation (including depenalisation) policies. The report commented:

> Some countries have had decriminalisation policies in place since the early 1970s, while others never criminalised drug use and possession to begin with.
>
> However, in the past 15 years, a new wave of countries have moved toward the decriminalisation model…
>
> The models of decriminalisation vary considerably – some countries adopt a *de jure* model (one defined by law), others have de-prioritised the policing of drug possession through *de facto* decriminalisation.
>
> Furthermore, there is enormous geographical variance, with countries as disparate

[337] M Millsteed, *Ten years of the South Australian police drug diversion initiative: data analysis report*, May 2012, Office of Crime Statistics and Research p 22.

[338] M Millsteed, *Ten years of the South Australian police drug diversion initiative: data analysis report*, May 2012, Office of Crime Statistics and Research p 33.

> as Armenia, Belgium, Czech Republic, Ecuador, Estonia, Mexico, Portugal and parts of the United States all adopting or extending some form of decriminalisation within their jurisdictions in the last 15 years or so.
>
> While the precise number of countries with formal decriminalisation policies is not clear, it is likely slightly above 30, depending on which definitions are used.[339]

It noted that the countries discussed in the report are examples of:

> …both those countries that have adopted good models of decriminalisation and those that have adopted what could be described as hollow examples of decriminalisation; that is, the possession thresholds are so low that the system is effectively unenforceable and most people who use drugs are still criminalised [e.g. Russia].[340]

By region, the countries discussed in the report are set out below. Most of these countries have decriminalised (or depenalised) the use or possession of various illicit drugs but some (e.g. certain US states) have only taken this approach in relation to cannabis.

Table 18: Jurisdictions that have decriminalised (or depenalised) the use of illicit drugs[341]

North America	*South America*	*Europe*	*Asia/Pacific*
• Costa Rica • Jamaica • Mexico • United States (California & Washington DC)	• Argentina • Chile • Columbia • Ecuador • Paraguay • Peru • Uruguay	• Belgium • Croatia • Czech Republic • Estonia • Germany • Italy • Netherlands • Poland • Portugal • Russia • Spain • Switzerland	• Armenia • Australia

7.7.2 International evidence on outcomes

There is only limited evidence on the outcomes associated with drug decriminalisation (and depenalisation) policies in other countries. In a 2001 book, MacCoun and Reuter summarised the evidence of the impact of such policies on drug use prevalence levels in several countries:

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[339] N Eastwood, E Fox, A Rosmarin, *A quiet revolution: Drug decriminalisation across the globe*, March 2016, Release, p 6.

[340] N Eastwood, E Fox, A Rosmarin, *A quiet revolution: Drug decriminalisation across the globe*, March 2016, Release, p 7.

[341] For more information on drug laws in the United States, see *Marijuana Overview*, 15 July 2016, National Conference of State Legislatures. For more information on drug laws in Europe, see the European Monitoring Centre for Drugs and Drug Addiction online tool, *Penalties for drug law offences in Europe at a glance*.

> The American experience with depenalization in 12 states in the 1970s and the Dutch experience (prior to expansive commercialization) each suggest no discernible impact on prevalence levels.
>
> Supporting evidence is also available from Australia where South Australia and the Australian Capital Territory have adopted various depenalization schemes. …The data on Spain, where marijuana and other psychoactive drugs have been depenalized for a generation, provide some support in that Spanish rates are comparable to those for other Western nations.[342]

In a 2011 paper, MacCoun and Reuter updated the evidence on the impact of cannabis decriminalisation on cannabis use:

> Between 1973 and 1978, a dozen states [in the United States] eliminated prison as a possible sanction for the first-time possession of small quantities of cannabis. Various cross-sectional and longitudinal studies in the 1970s and 1980s were unable to detect any reliable association between this policy change and self-report measures of cannabis use. Studies of similar policy changes in Australia and Western Europe raised similar doubts about the impact of marijuana sanctions. But several more elaborate econometric analyses, using data from the 1980s and 1990s, suggested that these [US] laws were associated with small but significant increases in use.[343]

They noted that recent research had raised two issues with the US studies that relied on data from the 1980s and 1990s.[344] First, Pacula and colleagues had shown that when those US studies referred to "decriminalisation states" and "non-decriminalisation states", this failed to accurately characterise actual differences in sanctioning in these states. Second, McCoun et al had found that in more recent surveys (i.e. 2001 to 2003), citizens in decriminalisation states were much less likely than in past surveys (i.e. 1977 and 1980) to be aware of the fact that their State had decriminalised the use of cannabis.

In a 2015 article, Shi, Lenzi and An commented:

> …the empirical research on cannabis use associated with different types of cannabis control policies is surprisingly limited. There is only initial evidence suggesting an increasing trend in the prevalence of cannabis use and its association with the adoption of cannabis liberalization policies within countries such as the United States and Australia. Some other studies, however, did not find such a relationship.[345]

Shi, Lenzi and An reported the results of their study, which assessed the correlation between cannabis control policies in 38 countries and cannabis use by adolescents (aged 15 years). Self-reported cannabis use status was

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[342] R MacCoun and P Reuter, *Drug War Heresies: Learning from Other Vices, Times, and Places*, 2001, Cambridge University Press, p 359.

[343] R MacCoun and P Reuter, "Assessing Drug Prohibition and Its Alternatives: A Guide for Agnostics" (2011) 7 *Annual Review of Law and Social Science* 61 at 65.

[344] R MacCoun and P Reuter, Assessing Drug Prohibition and Its Alternatives: A Guide for Agnostics (2011) 7 *Annual Review of Law and Social Science* 61 at 66.

[345] Y Shi, M Lenzi and R An, *Cannabis Liberalization and Adolescent Cannabis Use: A Cross-National Study in 38 Countries*, November 2015, PLOS ONE.

classified into ever use in life time, use in past year, and regular use. Country-level cannabis control policies were categorized into a dichotomous measure (whether or not liberalized) as well as 4 detailed types:

> 1) full prohibition, or the traditional criminal prohibition regime, 2) depenalization, or prohibition with cautioning or diversion; 3) decriminalization, or prohibition with civil penalties, and 4) partial prohibition, including 'De facto' and 'De jure' legalization.[346]

The results were summarised as follows:

> Overall, cannabis liberalization was associated with higher likelihood of ever use, past-year use, and regular use of cannabis. Significant positive correlations were found between cannabis depenalization and past-year and regular use, and between partial prohibition and regular use. Detailed types of cannabis control policies had no correlation with ever use of cannabis. Those who ever used cannabis but did not use in past year or use regularly were primarily discontinued users or experimental users. The heterogeneities in the impacts of cannabis control policies highlighted the importance of making distinctions between different types of cannabis users.[347]

7.7.3 Portugal: a case study

In 1999, the Portuguese Government adopted a *National Strategy for the Fight Against Drugs*.[348] It contained a multi-faceted policy approach, including decriminalising the use of drugs, redirecting the focus of primary prevention, extending and improving the quality and response capacity of the health care network for drug addicts, extending harm reduction policies, guaranteeing conditions for access to treatment for imprisoned drug addicts, and reinforcing the combat against drug trafficking and money laundering. Funding was to be doubled over five years to implement the strategy, especially in the areas of prevention, research and training, and subsidising families within the framework of the support system for the treatment and social reintegration of drug addicts.

In 2001, drug laws were amended to decriminalise the private use of all types of illicit drugs, and the acquisition and possession of drugs for such use. The law applied to use and possession of up to ten days' worth of a drug (e.g. 0.1 gram of heroin). The criminal offences became administrative offences to be dealt with by Commissions for the Dissuasion of Drug Addiction (CDTs):

> The CDTs are regional panels made up of three people, including lawyers, social workers and medical professionals. Alleged offenders are referred by the police to the CDTs, who then discuss with the offender the motivations for and circumstances surrounding their offence and are able to provide a range of sanctions, including community service, fines, suspensions on professional licenses and bans on attending designated places. However, their primary aim is to dissuade drug use and to encourage dependent drug users into treatment. Towards

[346] Y Shi, M Lenzi and R An, *Cannabis Liberalization and Adolescent Cannabis Use: A Cross-National Study in 38 Countries*, November 2015, PLOS ONE.
[347] Y Shi, M Lenzi and R An, *Cannabis Liberalization and Adolescent Cannabis Use: A Cross-National Study in 38 Countries*, November 2015, PLOS ONE.
[348] *National Strategy for the Fight Against Drugs*, 1999, Government of Portugal.

> this end, they determine whether individuals are dependent or not. For dependent users, they can recommend that a person enters a treatment or education programme instead of receiving a sanction. For non-dependent users, they can order a provisional suspension of proceedings, attendance at a police station, psychological or educational service, or impose a fine.[349]

The workings of CDTs in practice have been described as follows:

> In 2012, 78% of cases referred to [CDTs] involved cannabis only, 8% of cases involved heroin only and 8% involved cocaine only. 6% of cases involved more than one drug, of these, the most common combination was heroin and cocaine. Individuals were predominantly male (93%) with a mean age of 27.
>
> While [CDTs] aim to explore the need for treatment, a recommendation to attend treatment is only made in a minority of cases. In most cases, people referred to the panels are not drug-dependent. The most common outcome of the [CDT] process is a provisional suspension, where the individual is deemed not to be drug-dependent: 67% of rulings in 2012. In these cases education may be a more appropriate intervention. Suspension of proceedings, with a recommendation to undergo drug treatment, accounted for 14% of decisions in 2012 and punitive sanctions accounted for 15% of decisions.[350]

There have been debates about the impact of decriminalisation. A 2009 paper published by the Cato Institute examined the effects of decriminalization in Portugal; both in absolute terms and in comparisons with other countries that criminalise drugs, particularly in the EU.[351] The evidence from Portgual included drug usage rates, drug-related disease transmission rates, and drug-caused mortalities. The evidence from other countries focused on usage rates. The paper concluded that "the data show that, judged by virtually every metric, the Portuguese decriminalization framework has been a resounding success".[352]

A 2010 paper by the US Office of National Drug Control Policy stated that the Cato Institute report "does not present sufficient evidence to support claims regarding causal effects of Portugal's drug policy on usage rates".[353] In addition, Manuel Coehlo, Chairman of the Association for a Drug Free Portugal, argued that the data actually showed that decriminalisation in Portugal had failed.[354]

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[349] C Hughes and A Stevens, "What can we learn from the Portuguese decriminalization of illicit drugs?" (2010) 50(1) *British Journal of Criminology* 999 at 1002.

[350] *Drugs: international comparators*, 2014, UK Home Office, p 23.

[351] G Greenwald, *Drug decriminalization in Portugal: lessons for creating fair and successful drug policies*, Cato Institute, 2009

[352] G Greenwald, *Drug decriminalization in Portugal: lessons for creating fair and successful drug policies*, Cato Institute, 2009, p1

[353] *Decriminalization in Portugal: Challenges and Limitations*, August 2010, US Office of National Drug Control Policy.

[354] M Coehlo, *Decriminalization of drugs in Portugal – The real facts!*, 2 February 2010, World Federation Against Drugs; M Coehlo, *The "Resounding Success" of Portuguese Drug Policy: The power of an attractive fallacy*, August 2010, Association for a Drug Free Portugal.

In a 2012 journal article, academics Hughes and Stevens examined the opposing accounts put forward by the Cato Institute and the Chairman of the Association for a Drug Free Portugal. They concluded:

> 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.[355]

In an earlier article, Hughes and Stevens presented the results of their study into the criminal justice and health impacts of decriminalisation of drug use in Portugal. In summary, they stated:

> … the following changes have occurred:
>
> - small increases in reported illicit drug use amongst adults;
> - reduced illicit drug use among problematic drug users and adolescents, at least since 2003;
> - reduced burden of drug offenders on the criminal justice system;
> - increased uptake of drug treatment;
> - reduction in opiate-related deaths and infectious diseases;
> - increases in the amounts of drugs seized by the authorities;
> - reductions in the retail prices of drugs.
>
> By comparing the trends in Portugal and neighbouring Spain and Italy, we can say that while some trends clearly reflect regional shifts (e.g. the increase in use amongst adults) and/or the expansion of services throughout Portugal, some effects do appear to be specific to Portugal. Indeed, the reduction in problematic drug users and reduction in burden of drug offenders on the criminal justice system were in direct contrast to those trends observed in neighbouring Spain and Italy. Moreover, there are no signs of mass expansion of the drug market in Portugal. This is in contrast with apparent market expansions in neighbouring Spain.
>
> The problem is that it is impossible to state that any of these changes were the direct result of the decriminalization policy. It also remains unclear whether the observed impacts were influenced more by the policy or its implementation. Could better implementation of the CDT model have led to better outcomes? This is an argument put forward by many in government, but it is unfortunately untestable.[356]

[355] C Hughes and A Stevens, "A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs" (2012) 31 *Drug and Alcohol Review* 101 at 111.

[356] C Hughes and A Stevens, "What can we learn from the Portuguese decriminalization of illicit drugs?" (2010) 50(1) *British Journal of Criminology* 999 at 1017-18.

In a 2015 article, Goncalves et al outlined the findings from an assessment of the social cost of illicit drug use in Portugal since the 1999 National Drugs Strategy (NSFAD). It considered the following drug-related social costs:

Table 19: Drug-related social costs in Portugal[357]

Type of cost	Direct cost	Indirect cost
Health-related	• Treatment, prevention and risk and harm reduction of drugs • Health costs associated with the consequences of drug use (hepatitis, HIV/AIDS)	• Lost income and production due to drug addiction treatment • Lost income and production due to drug-related death
Non-health related	• Social rehabilitation • Legal system costs associated with drugs	• Lost income and production of individuals arrested because of drug-related crimes

The study concluded:

> Our results point towards a significant (average) reduction (12%) in the social cost of drugs in the 5 years following the NSFAD's approval (2000–2004), particularly driven by the reduction in indirect health costs caused by the reduction in the number of drug-related deaths. In a longer timeframe (2000–2010), the social cost (average) reduction is more significant (18%), as not only indirect health costs decreased, but also a significant reduction was observed in non-health related direct and indirect costs, namely legal system (direct) costs associated with criminal proceedings for drug-law offences and, particularly, (indirect) costs associated with lost income and lost production of individuals imprisoned for drug-law offences. The latter may be associated with the decriminalization of drug use, which was implemented in 2001, while the former may bear some relationship with the NSFAD's health-oriented rationale. However…it is extremely difficult to establish clear causal relationships between the NSFAD's implementation and this observed evolution of social costs and…we refrain from drawing conclusions in that regard.[358]

[357] R Goncalves, A Lourenco, S Nogueira da Silva, "A social cost perspective in the wake of the Portuguese strategy" (2016) 26(2) *International Journal of Drug Policy* 199.

[358] R Goncalves, A Lourenco, S Nogueira da Silva, "A social cost perspective in the wake of the Portuguese strategy" (2016) 26(2) *International Journal of Drug Policy* 199 at 207.

8. CONCLUSION

Drug use and possession is a complex issue, one that can be viewed from a range of perspectives and affords no simple solutions. The prohibition versus decriminalisation debate is particularly vexed, as domestic and international experience shows that outcomes across a range of measures are often mixed and may be influenced by particular local conditions. What can be stated with confidence, however, is that recreational drug use and its numerous associated harms will remain a reality. The acceptance of this reality forms the basis of Australia and NSW's overarching drug policy goal of harm minimisation, as implemented through demand reduction, supply reduction and harm reduction measures.

What is also clear is that, in concert with law enforcement and criminal justice efforts aimed at personal deterrence and supply reduction, NSW has introduced harm reduction measures (such as the Needle and Syringe Program and Medically Supervised Injecting Centre) which have been shown to be effective. The real focus of the current debate is whether the overarching policy goal of harm minimisation is best achieved under existing policies or whether alternative measures are needed.