

THE AUSTRALIA INSTITUTE

Drug Law Reform

Beyond Prohibition

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Discussion Paper Number 83

February 2006

ISSN 1322-5421

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Table of Contents

Tables and Figures	v
Acknowledgements	vi
Summary	vii
1. Introduction	1
2. Definitional and conceptual issues	4
2.1 What is a drug?	4
2.2 Licit and illicit drugs	4
2.3 Classifying psychoactive drugs	4
2.4 Other useful drug terms	5
2.5 What legislative options exist for drugs?	7
2.6 What do the terms ‘decriminalisation’ and ‘legalisation’ mean?	8
2.7 Diversion programs	9
3. A brief history of Australia’s drug laws	13
4. The theory behind Australia’s drug laws	23
4.1 Why have strict drug laws?	23
4.2 Reducing negative externalities and overcoming market failure	23
4.3 Reducing harm to individuals	28
4.4 Promoting and protecting moral values	30
5. Flaws in the strict prohibition approach	33
5.1 The direct costs of prohibition	33
5.2 The indirect costs of prohibition	34
6. Effectiveness of strict drug laws	43
6.1 Has prohibition substantially reduced drug use and harm?	43
6.2 Does prohibition promote drug use?	60
7. The alternatives to the current approach	64
7.1 The causes of drug misuse problems	64
7.2 The legal options	67
7.3 The non-legal options	74
7.4 The balance between legal and non-legal policy mechanisms	84
8. The inequity of current drug laws and drug law enforcement	90
8.1 Inconsistencies	90
8.2 Punishing victims and those with diminished capacity	96
8.3 Who is punished for drug offences?	96
8.4 Consistency with liberal values	97
9. Conclusion	99
References	104
Appendix A Pre-arrest diversion programs for minor cannabis offences committed by adults	128
Appendix B Health effects of licit and illicit drugs	132
Appendix C Illicit drug arrests in Australia, by drug type and consumer/provider status 1996/97 to 2003/04	136

Tables and Figures

Table 1	Taxonomy of the costs of prohibition	41
Table 2	Proportion of population (aged 14 years and over) using illicit drugs – lifetime and recent use (2004)	44
Table 3	Proportion of people (aged 14 years and over) using any illicit drug by sex and age group – lifetime and recent use (2004)	45
Table 4	Illicit drug use amongst male (2001) and female (2003/04) prisoners (per cent) – lifetime, recent and current regular use	62
Table 5	Illicit drug use according to language spoken at home, persons aged 14 years and over, 2004	65
Table 6	Risk and protective factors for drug use	66
Table 7	Annual prevalence of use of selected drugs in the Netherlands as percentage of population aged 15 – 64 (2001), compared to prevalence in other western and central European countries	69
Table 8	Drug and Non-Drug Specific Prevention Programs	75
Table 9	Efficacy of drug education	78
Table 10	Proportion of young people using tobacco and alcohol (2004)	94
Figure 1	Effect of drug laws on the supply and demand for illicit drugs	24
Figure 2	Trends in recent use of cannabis – proportion of population aged 14 and over, Australia 1993 to 2004	49
Figure 3	Trends in recent use of cannabis – proportion of population aged 14 and over, South Australia, Western Australia, ACT and Northern Territory 1998 to 2004	49
Figure 4	Potential Myanmar Heroin Production, in Metric Tons, 1999 - 2004	54
Figure 5	Sentenced prisoners by type of drug offence, Australia – 1986 to 2004	85

Acknowledgements

This paper has benefited greatly from being reviewed by Dr Wayne Hall, Dr Alex Wodak and John Walker. I thank them all for their thoughtful comments and guidance. Notwithstanding their input, the opinions expressed and conclusions drawn remain the responsibility of the author.

Thanks are also due to Leigh Thomas for valuable editorial assistance.

Summary

Harm minimisation has been the stated objective of the National Drug Strategy since 1985. This goal is supposed to ensure that the focus of drug policy is on minimising the damage that drugs have on society rather than simply minimising drug use. Although this objective has received widespread support, the way in which it has been pursued has been highly contentious, particularly since 1997 when the Howard Government launched the National Illicit Drug Strategy, 'Tough on Drugs', which saw a renewed emphasis on prohibition and drug law enforcement.

A schism emerged between the public position adopted by governments and the policies they pursued. Governments talked tough in public about drug issues and extolled the virtues of prohibition, while tolerating proven and accepted harm reduction initiatives like needle and syringe exchange programs and methadone maintenance treatment. This inconsistent approach has prevented the reform of drug laws and halted the implementation of several innovative harm reduction programs (for example, prescription heroin trials and drug consumption rooms), but it has saved Australia from some of the more extreme consequences of a US-style 'war on drugs'.

It now appears that this compromise is unravelling and that the Howard Government wants to align national drug policy more closely with its 'tough on drugs' rhetoric. In 2005 new laws were passed giving the Commonwealth unprecedented powers to intervene in drug issues that have traditionally been the sole domain of the states. This was followed by a concerted media campaign to 'reveal' the dangers of cannabis, which was backed up by the announcement that the Prime Minister wanted to end the civil penalty regimes that apply to minor cannabis offences in South Australia, Western Australia, the Northern Territory and the Australian Capital Territory.

The shift in emphasis is not confined to the Federal Government. In early February 2006, the Premier of New South Wales, Morris Iemma, took the Prime Minister's cue and pledged to introduce new 'hardline' cannabis laws that would result in up to ten years imprisonment for people found growing as few as five hydroponic cannabis plants. The leader of the opposition in New South Wales, Peter Debnam, has promised to shut down the safe injecting room in Kings Cross if his party is elected to government. Similarly, in South Australia, the Liberal Party has suggested that police be allowed to enter schools with sniffer dogs without obtaining a warrant, while the Tasmanian Liberals are reported to be calling for 'tougher drug laws'.

The evidence indicates that any move away from harm minimisation toward a stricter form of prohibition will worsen the social outcomes from drug policies. Analysis of alternative options suggests that the existing legal and policy framework is already in need of liberal reform. Tightening drug laws and placing even great emphasis on drug law enforcement is likely to undermine some of the gains achieved by harm minimisation strategies and send Australia down a path that history demonstrates can only end in failure.

The information that is available proves that prohibition has been an abysmal failure at addressing illicit drug problems.

Costs of prohibition

The direct costs of prohibition are immense. In 1998/99, almost \$1.5 billion was spent by Australian governments on drug law enforcement; productivity losses associated with drug offences were estimated at an additional \$500 million. There is little doubt these costs have grown significantly since then.

Possibly of greater concern than the direct costs of prohibition are the indirect effects it has on illicit drug markets and drug use. The evidence indicates that strict drug laws encourage users to take more potent drugs and consume them in unsafe ways. Research has also found that prohibition makes drug users reluctant to seek treatment when problems arise. Further, it often forces young and otherwise law abiding individuals to associate with deviant subcultures, which can lead to increased drug use and crime. Studies have also shown that drug law enforcement causes employment and relationship problems that can aggravate substance misuse disorders.

For those drug users who suffer from a mental illness, the costs of prohibition are even more severe. Pressures applied by the criminal justice system can exacerbate mental and substance misuse disorders and create additional barriers to treatment. As the Federal Government has been at pains to emphasise, drug use can cause or exacerbate mental health problems, but harsh drug laws risk making the situation worse. In short, prohibition is the cause of a significant proportion of the health costs associated with illicit drug use and it hinders the achievement of the objective of harm minimisation.

Strict drug laws are also responsible for increased violence, corruption and property crime. Countless government inquiries have identified illicit drug markets as a major cause of corruption. So long as drug markets are the exclusive domain of criminals, corruption will remain a prominent feature of many institutions, including domestic police forces.

Benefits of prohibition

To balance the ledger against the extensive list of drug law-related harms, advocates of prohibition would have to demonstrate that it is substantially better at reducing drug-related harm than the more liberal alternatives. The evidence presented in this paper suggests that it is not.

Illicit drug use is reasonably widespread and shows no signs of abating. In 2004, over 30 per cent of the population reported having tried cannabis, a rate that jumps to almost 60 per cent in the 20 to 39 age group. There has been some positive news in recent times with the decline in heroin use in the early 2000s, yet methamphetamine and other stimulant use has increased dramatically over the same period and is now providing a range of new challenges for law enforcement and health officials alike.

The heroin drought experienced in Australia since the early 2000s has become a central plank in the defence of the existing prohibition-focused drug policies. Previous research found evidence that supply-side drug law enforcement at the international and national levels played a major role in causing the drought. However, more recent evidence has cast doubts on this conclusion. It now seems more likely that the primary cause of the drought was a decision by heroin producers and distributors to switch to methamphetamines and possibly to divert heroin supplies to alternative markets in China. The role of law enforcement in the heroin drought appears to have been limited.

The available data indicate that the introduction of more liberal drug laws may result in a slight increase in drug use (which, if it occurs, is likely to be temporary), but that it is unlikely to increase and may even decrease drug-related health costs. Provided the changes are appropriately designed and implemented, any potential adverse effects are likely to be relatively small. The risk of unwanted side effects could also be mitigated by the expansion of prevention and treatment programs.

Prevention and treatment

Drug prevention and particularly treatment programs have been proven to be cost-effective at reducing drug use and drug-related harm. Despite the wealth of evidence on their benefits, these programs are currently grossly under-resourced and constrained in their reach. This shortfall in services is leading to illness and a loss of life that could easily be avoided.

There is an urgent need to expand and improve the range of treatment services offered to drug users. In recent times, the Federal Government and others have advocated abstinence-based treatment, but the evidence shows that it is often the pharmacological maintenance programs that are most effective in reducing drug-related harm. Existing methadone, buprenorphine and other pharmacological maintenance services should be made more readily available to opiate users, and further research needs to be undertaken on ways to treat disorders related to amphetamines and methamphetamines.

Drug law reform

The starting point for drug law reform should be cannabis. Experience in Australia and overseas indicates that lessening penalties for demand-side cannabis offences, or simply not enforcing them, does not result in a sustained increase in cannabis consumption or any notable increase in cannabis-related harm. In addition, liberal cannabis regimes usually cost less to enforce and generate fewer adverse impacts on users and society.

The case for drug law reform in relation to harder drugs is also compelling, yet governments have been less willing to trial alternatives. This has resulted in a lack of evidence on the likely consequences of more liberal regimes. However, the available evidence indicates that liberal reforms are likely to produce significant benefits. These include reductions in drug-related harm and the economic, social and personal costs associated with drug law enforcement. At the very least, governments should stop enforcing demand-side hard drug offences and establish broad diversion programs for low-level supply offences, particularly where the offences are motivated by a desire to finance a drug habit.

These pragmatic and evidence-based reforms are unlikely to appeal to the current Federal Government or to most state and territory governments. The trend is in the opposition direction; that is to stricter drug laws and law enforcement, tempered by diversion programs aimed primarily at users. While diversion programs are an improvement on previous policies, they are no solution to the flaws in prohibition. They are costly, can be counterproductive and, in so far as they include compulsory or coerced treatment, are generally unproven.

Governments need to admit the deficiencies of prohibition and pursue the changes that the evidence shows will produce better outcomes rather than trying to manipulate drug issues for political purposes.

1. Introduction

Prohibition has been a feature of Australia's drug policies since the late 1800s. Applied initially against Chinese opium smokers for racial reasons, prohibition was gradually extended over the first 60 years of the 20th century to a range of other substances in order to comply with international drug conventions. Despite the increase in the reach of prohibition, drug law enforcement played a limited role during this period due to the low level of substance misuse and the fact that drug problems were usually seen as a health issue. As illicit drug problems escalated in the 1960s and 1970s, so did the prominence of prohibition and drug law enforcement. Before long, drugs had become almost exclusively a legal issue. Drug laws were tightened and millions of dollars were invested in law enforcement initiatives. Yet, strict prohibition proved incapable of containing illicit drug markets. The 'drug problem' continued to grow and people began to question whether the harms caused by prohibition were greater than those associated with drug use.

Recognition of the limits of prohibition and the nature of the threat posed by HIV/AIDS led to a softening in approach in the 1980s. In 1985, this was signified by the adoption of 'harm minimisation' as the stated aim of the National Campaign Against Drug Abuse, later to become the National Drug Strategy. Harm minimisation is the notion that drug policies should aim primarily at reducing drug-related injury rather than simply seeking to reduce or eliminate drug use. The *National Drug Strategy - Australia's Integrated Framework 2004-2009* (NDS Framework) defines harm minimisation as comprised of three elements: supply-reduction, demand-reduction and harm-reduction (Ministerial Council on Drug Strategy 2004). This three pronged strategy is intended to reflect a 'comprehensive approach to drug-related harm' (Ministerial Council on Drug Strategy 2004, p. 2) that attempts to disrupt drug markets while mitigating the damage they cause to individuals and society.

Today, harm minimisation remains the primary objective of the National Drug Strategy. This is made clear in the NDS Framework, which describes its mission as:

[t]o improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society (Ministerial Council on Drug Strategy 2004, p. 1).

While the rationale behind harm minimisation is compelling and the concept has received wide-spread support both domestically and abroad, there has been vigorous debate about how this objective should be pursued.

Prohibition has repeatedly proven to be incapable of providing adequate solutions to illicit drug problems. Worse still, in many cases, it violates one of the most basic tenets of good policy; that the 'harms caused by the control regimes themselves should not outweigh the harms prevented by them' (McDonald *et al.* 1994, p. 18). Despite this, Australian governments have been extremely cautious in their adoption of alternative policy solutions, their hesitancy largely attributable to political factors.

Since the 1960s, drug policy has been dominated by political factors. This is probably attributable to ignorance of substance misuse issues and the fact that drug use has become to be associated with 'deviant' subcultures that are often viewed as posing a threat to traditional social structures and moral values. For many, drug use is the

dominant evil rather than drug-related harm. As substance abuse problems grew in the 1960s and 1970s, politicians were quick to seize upon the issue as a means of attracting electoral support and have been reluctant to relinquish it ever since. Conservative politicians have been the most strident advocates for strict drug laws, yet even those with more liberal leanings have often proven to be unable to resist the temptation to pursue strict drug laws for political advantage. The consensus that has regularly emerged between the major political parties may be the product of fear; those with more liberal views appear unwilling to confront the prohibitionists because of the political potency of ‘talking tough’ on drugs. Recent trends in public opinion towards drug issues suggest these anxieties may be well founded.

Over the past decade, the views of the Australian community have tended to fluctuate according to the prevailing political climate on drug issues. In the mid to late 1990s, at a time when alternative policies were being considered in a number of jurisdictions by Labor and Liberal/National Coalition governments, there appeared to be considerable support for harm reduction initiatives. A Herald-AC Nielsen poll in 1999 found national support for a heroin trial and safe injecting rooms at 45 per cent (Metherell 1999). In more recent times, the pendulum has swung back in favour of strict prohibition, what former Victorian Premier, Jeff Kennett, once described as the ‘old school, head-in-the-sand approach’ (Humphries *et al.* 1999). A recent survey found that the level of public support for legalising cannabis, a prescription heroin trial and safe injecting rooms was only 27 per cent, 25 per cent and less than 40 per cent respectively (AIHW 2005a).¹

This shift in public opinion may be attributable to the two-faced drugs campaign that has been run by the Howard Government (Wodak 2004). Over the late 1980s and early 1990s, there had been a period of relative stability and bipartisan cooperation on drug issues. This ended in 1997, when the Howard Government launched the National Illicit Drug Strategy, ‘Tough on Drugs’. The strategy committed more resources to drug law enforcement and the Prime Minister declared that his Government was committed to ‘a goal of zero tolerance of drugs in schools’ (Howard 1997). Since then, the Prime Minister has continually adopted a stringent line on drug policy in the public domain, at one stage even suggesting he was considered introducing a zero tolerance approach to drug law enforcement (Howard 1999). Despite these public proclamations and posturing, behind the scenes the Howard Government continued to support a cautious brand of harm minimisation and a relatively mild version of prohibition (Wodak 2004). This political strategy has prevented the advance of drug law reform and the adoption of many important harm reduction initiatives (including drug injecting rooms and prescription drug trials). Nevertheless, it has enabled the continuation of existing harm minimisation programs (for example, needle exchange and methadone treatment) and the expansion of certain treatment services and drug prevention activities.

The unstable compromise that has characterised Australia’s version of harm minimisation for the last decade now seems to be in jeopardy. The Howard Government has recently indicated a willingness to roll-back successful law reform initiatives and there are signs that important harm reduction programs may be terminated. In short, while the progress of harm minimisation has stalled in recent years, there is a risk it may now start retreating.

¹ See also AIHW (2002a).

A move away from harm minimisation could increase the already substantial costs associated with illicit drug markets. In the late 1990s, illicit drugs were killing over 800 people each year and costing the community in excess of \$6 billion annually. There is no doubt there are dangers associated with illicit drugs and all efforts should be made to persuade people not to consume them, particularly those in younger age groups. However, history demonstrates that strict prohibition will not stop drug use. Worse still, strict prohibition exacerbates the problems related to illicit drug markets and magnifies the costs they impose on society. Liberal drug reform could help reduce the economic, social and health costs associated with illicit drug markets and lessen the harms suffered by drug users and their friends and families.

In light of the need for changes in drug laws and drug policy, the object of this paper is to review and critique the arguments in favour of strict prohibition and to provide details of some of the more promising alternatives. It is hoped that the presentation of a reasoned argument based on the most up-to-date evidence in favour of liberal drug regimes will help raise greater awareness of the causes and impacts of illicit drug use, lessen the opposition to innovative harm minimisation policies and reduce society's tolerance for emotive and politically motivated responses to drug issues.

The paper is divided into nine sections. Section 2 discusses conceptual and definitional issues that are important to facilitating an informed debate about drug policy. Section 3 provides a brief history of Australia's drug laws. Section 4 outlines the arguments used to justify drug laws. Section 5 lists the problems associated with strict drug laws and scrutinises the costs they impose on society. Section 6 analyses how effective strict drug laws have been in reducing drug consumption and drug-related harm and discusses whether prohibition could promote drug use in certain circumstances. Section 7 looks at the alternatives to strict drug laws and asks whether a different combination of laws and policies could generate better outcomes. Section 8 reviews arguments concerning the inequity of drug laws and whether they conflict with widely held liberal values. Section 9 draws a conclusion and provides recommendations.

2. Definitional and conceptual issues

In order to understand Australia's drug laws and policies, it is necessary to become familiar with the meanings of certain words and phrases and to understand the differences between certain statutory frameworks. This section seeks to provide an overview of some of the more important issues involved before delving into drug policy.

2.1 What is a drug?

The meaning of the word 'drug' will depend upon the context in which it is used. To those in the medical profession, a drug is usually what the Macquarie Dictionary has described as, 'a chemical substance given with the intention of preventing or curing disease or otherwise enhancing the physical or mental welfare of men or animals'. However, in the substance abuse context, the term 'drug' is typically defined as any substance that disrupts normal brain function or alters mental processes by changing the way the central nervous system operates. For example, the NDS Framework defines a drug simply as, 'a substance that produces a psychoactive effect' (Ministerial Council on Drug Strategy 2004, p. 21), psychoactive effects being 'effects that alter mental processes – mood, cognition, thinking or behaviour' (Ministerial Council on Drug Strategy 2004, p. 24). For this reason, in debates concerning drug policy, the phrase 'psychoactive drugs' is often used to describe the broad collection of substances that are of concern.

What is included within the definition of a drug is highly influenced by social factors. When mentioned in a social setting, the user commonly intends to refer only to the illegal psychoactive drugs and not to those that are legal and widely used such as alcohol, caffeine and tobacco. Yet in policy debates concerning substance abuse, the term 'drug' is generally used to refer to both legal and illegal drugs, because they have similar effects on human health and behaviour.

2.2 Licit and illicit drugs

The terms licit and illicit refer to the legal status of a substance. Licit drugs are those that are currently legal to produce, sell, possess or use. They include alcohol, tobacco, caffeine and prescription medicines. Illicit drugs are those that are illegal to produce, sell, possess or use under criminal law. The most widely known of the illicit drugs are heroin, cocaine, speed, ecstasy and cannabis. Other relatively common illicit drugs include ketamine (commonly known as 'special k'), lysergic acid diethylamid (LSD or acid), psilocybin (magic mushrooms), phencyclidine (angel dust or PCP) and gamma hydroxyl butyrate (GHB, grievous bodily harm, GBH, fantasy and liquid ecstasy). There are also a number of prescription drugs that fall into the illicit category when used improperly. These include morphine, methadone, steroids, sleeping pills, tranquilisers and some amphetamines. In this paper, unless otherwise indicated, the phrase 'illicit drugs' is intended to include illegal drugs as well as prescription drugs that are used improperly.

2.3 Classifying psychoactive drugs

Psychoactive drugs are often grouped into three categories according to the effect they have on the central nervous system and mental processes:

- depressants (for example heroin, GHB, alcohol and cannabis), which slow down activity in the central nervous system;
- stimulants or psychostimulants (for example speed, cocaine, ecstasy², crystal meth or ice, nicotine and caffeine), which speed up or stimulate activity in the central nervous system; and
- hallucinogens or psychedelics (for example LSD or acid, PCP and magic mushrooms), which stimulate the central nervous system and distort the user's thoughts and perception of reality.

Some drugs do not fit comfortably into one of these three categories. For example, cannabis is generally defined as a depressant, but it can have stimulant and hallucinogenic effects. Similarly, ecstasy and other related drugs like methylene dioxy-amphetamine (MDA) are often referred to as stimulants. However, they also have hallucinogenic properties and it is not unusual to see them classified as hallucinogens or psychedelics.

2.4 Other useful drug terms

Other terms that are often used in drug literature to describe different types of drugs include the following.

Amphetamines, methamphetamines and meth/amphetamines – amphetamines are a class of synthetic drugs that are central nervous system stimulants. Some amphetamines are prescribed to treat medical conditions, but there are several types of amphetamines that are used as recreational drugs. These include the street drugs known as speed, meth, ice and ecstasy. Methamphetamine is a powerful type of amphetamine that is often called meth, crystal meth, ice, base or glass. The term 'meth/amphetamine' is used in drug literature to refer to the street drugs known as speed and meth, while methylenedioxy-derivatives of amphetamine and methamphetamine such as ecstasy and MDA are usually classified separately (often as designer drugs or simply ecstasy).

Barbiturates – refers to a group of drugs derived from barbituric acid that are central nervous system depressants. Like benzodiazepines, they are prescription drugs that are used to treat anxiety and sleeping disorders, but are also used illegally as recreational drugs (under street names including downers, barbs, peanuts and goofballs).

Benzodiazepines – refers to a group of drugs that are central nervous system depressants, commonly used and referred to as sleeping pills, tranquilizers and muscle relaxants. They are used to treat anxiety, sleeping problems and epilepsy, but are also taken illegally as a recreational drug (under street names like downers and slow). Common prescription benzodiazepines include temazepam (Normison, Euhypnos or Temaze), diazepam (Valium), oxazepam (Serepax), and alprazolam (Xanax).

² Ecstasy (and related drugs like methylene dioxy-amphetamine) also have hallucinogenic properties, and so are often also described as hallucinogens or psychedelics.

Cannabis, marijuana, hashish and cannabinoids – *Cannabis* is a genus of herbaceous plant from which hemp and a group of psychoactive substances are produced. In substance abuse debates, the word cannabis is used to refer to the drugs derived from the plant, the most common forms of which are marijuana, hashish and hash oil. Marijuana refers to preparations consisting of the dried flowers and leaves of the plant; hashish (or hash) refers to solid preparations derived from the resin extracted from cannabis flowers; and hash oil is a liquid preparation made by extracting cannabis resin using solvents and concentrating the extract. These drugs are usually consumed by smoking them in a joint, pipe or bong, eating them (for example, in hash cookies) or inhaling an unburnt vapour produced by heating the relevant material. The cannabis plant contains approximately 60 psychoactive compounds (called cannabinoids), the main one being delta-9-tetrahydrocannabinol (or THC) with the concentration of this compound differing between the different forms of the drug. Hash oil typically has the highest concentration of THC, then hashish and then marijuana. Other prominent cannabinoids in cannabis include cannabitol (CBN) and cannabidiol (CBD). The effects of the drug can differ depending on the characteristics of the user and the concentrations of the various cannabinoids in the preparation.

Cocaine and crack – cocaine is a central nervous system stimulant that comes from the coca plant (*Erythroxylum coca*). Prior to the 20th century, it was widely used in Indigenous cultures in South America and in a variety of western products, including Coca-Cola. It is now an illicit drug that is usually inhaled or injected. Crack (or crack cocaine) is a processed form of cocaine that is smoked. Street names for cocaine include coke, star dust and snow.

Ecstasy – refers to the drug 3,4-methylenedioxy-methamphetamine (or MDMA). It was originally created by a German pharmaceutical company in the early 20th century, but over the past 20 years it has become a widely used recreational drug often associated with dance parties and the so-called ‘rave culture’. It is closely related to another drug known as 3,4-methylenedioxy-amphetamine (MDA). Many of the street drugs purchased under the name ecstasy often contain methamphetamine (McKetin *et al.* 2005), which creates complications for both users and researchers.

Inhalants or solvents – refers to substances that vaporise when exposed to air and, when the vapour is inhaled, have psychoactive effects. Common inhalants include petrol, cleaning fluids, aerosol sprays, paint and paint thinners. The possession of many of these substances is not prohibited by the criminal law; however they are commonly referred to as illicit substances when used to produce a psychoactive effect.

Narcotic – refers to any drug that has the potential to cause narcosis, a state of sleepiness, drowsiness, stupor or unconsciousness. The term sometimes refers to opiates yet it is often intended to include a broader range of psychoactive substances. In particular, the phrase ‘narcotic drugs’ is used in a number of multilateral drug conventions to refer to the extensive list of psychoactive substances in Schedules 1 and 2 of the *United Nations Single Convention on Narcotic Drugs*.

Opioids or opiates – refers to the drugs derived from the opium poppy (*Papaver somniferum*), such as heroin, morphine, methadone and codeine.

2.5 What legislative options exist for drugs?

One of the most useful categorisations of the legislative options for drugs is outlined in the report of the South Australian Royal Commission into the Non-medicinal Use of Drugs (the Sackville Commission) (South Australian Government 1978).³ The report identifies the following five broad options.

- Total prohibition

This involves the total prohibition of the ‘use, possession, cultivation, importation, sale and distribution’ (McDonald *et al.* 1994, p. 4) of the relevant drugs. Violating the prohibition is a criminal offence carrying maximum penalties that can include life imprisonment and, in some countries, death. In Australia, total prohibition regimes apply to all of the well-known illicit drugs, with the possible exception of cannabis.

Total prohibition regimes can take a variety of forms. For example, under some total prohibition regimes, a ‘non-enforcement’ or ‘de-facto decriminalisation’ principle applies under which the police do not investigate cases involving small amounts of relevant illicit substances (Lenton *et al.* 2000, p. 71). The most well-known example of this type of regime is in the Netherlands where minor cannabis offences are not enforced (Lenton *et al.* 2000). Other total prohibition regimes include diversionary elements that enable the police to issue formal and informal cautions for minor drug offences.

- Prohibition with civil penalties

Under a prohibition with civil penalties regime, the use, possession, cultivation, importation, sale and distribution of the relevant drug is not permitted. However, the commission of these acts is not necessarily a criminal offence and may only attract civil penalties. Four jurisdictions in Australia (South Australia, Western Australia, Northern Territory and the Australian Capital Territory) currently have a type of prohibition with civil penalty regimes in relation to minor demand-side cannabis offences.⁴ In these schemes, the police and other prosecutorial authorities generally have the discretion to proceed against minor offenders by issuing the equivalent of a parking ticket. The underlying criminal offence remains but is expiated if the person issued with the notice pays the prescribed fine.

- Partial prohibition

Partial prohibition involves prohibiting certain drug activities and allowing others. To some extent, partial prohibition regimes already apply in Australian jurisdictions in that the use, possession, cultivation and sale of certain drugs is permitted, while other

³ This categorisation has been used in several other places, including McDonald *et al.* (1994) and Lenton *et al.* (2000).

⁴ Details of the diversionary programs (including the civil penalty regimes) that currently apply to cannabis offences in the states and territories are set out in Appendix A. Arguably these regimes constitute total prohibition as criminal sanctions still apply to the relevant offences, but offenders can elect to accept a civil penalty. In three out of the four jurisdictions, the schemes are also discretionary, meaning law enforcement officers can choose to prosecute offenders and seek criminal sanctions rather than offering a civil penalty. Notwithstanding these facts, for ease of reference these regimes are referred to as prohibition with civil penalty regimes in this paper.

drugs are prohibited. However, in this context, ‘partial prohibition’ usually refers to options to remove the criminal sanctions on the personal use and possession of a specific drug, while retaining these sanctions on the production and distribution of the drug. For example, a legislative regime in which the possession and use of small amounts of cannabis is legal, but the production and distribution of cannabis for commercial purposes is illegal, would be a partial prohibition regime. Both the prohibition with civil penalties and partial prohibition options are commonly associated with the notion of decriminalisation.

- Regulation

The regulation option is commonly linked to the notion of ‘legalisation’. It involves the removal of the broad criminal prohibitions on the production, distribution and use of the relevant drug, although the market in the drug would remain regulated by the state. The production or sale of the drug outside the regulatory system would be a criminal offence. Regulatory systems currently apply in Australia in relation to a number of drugs, including tobacco, alcohol and prescription medicines (including the prescription medicines that are used recreationally, for example certain opiates (like codeine and morphine), benzodiazepines (like Valium and Serepax) and steroids).

- Free availability

This option refers to the removal of all restrictions on the use, possession, cultivation, importation, sale and distribution of the relevant drug. The market for caffeine is about as close as Australia currently gets to a free availability regime.

2.6 What do the terms ‘decriminalisation’ and ‘legalisation’ mean?

When discussing drug law reform, it is common to use the words decriminalisation and legalisation to refer to various types of legislative options ranging from free availability to prohibition with civil penalties. The difficulty with these terms is that they are ambiguous and can be misleading (Fox and Matthews 1992).

Decriminalisation is usually used in the context of proposals to replace criminal sanctions with civil penalties. As a result, it is not unusual for people to refer to the prohibition with civil penalty regimes that operate in relation to cannabis in South Australia, Western Australia, the Australian Capital Territory and the Northern Territory as decriminalising cannabis (ACC 2005; Australian Bureau of Criminal Intelligence 1999; Salvation Army RSCPRD 1999; Donnelly *et al.* 1995). By contrast, ‘legalisation’ is most commonly used to refer to regulation options for drug law reform (Fox and Matthews 1992; NSW Council for Civil Liberties 2001). Yet, the use of ‘decriminalisation’ and ‘legalisation’ in these ways is not universal and there are significant differences in usage even in these contexts. For example, decriminalisation is sometimes seen as synonymous with regulation or free availability regimes and the terms are often used interchangeably (Australian Bureau of Criminal Intelligence 1999; International Narcotics Control Board 1998; Salvation Army RSCCRD 1997; Salvation Army RSCPRD 1999).

To avoid the difficulties associated with these terms, the categorisation of drug laws discussed in Section 2.5 is used in this paper.

2.7 Diversion programs

Broadly, the phrase ‘diversion programs’ can be used to describe any policy, program or measure that involves diverting drug users from the criminal justice system and/or to education and treatment programs (Lenton *et al.* 2000). In most cases, diversion programs involve both elements, diversion from the criminal justice system and into education and treatment processes. For the purposes of this paper, diversion programs are confined to criminal justice system diversion programs, whether or not they include an educational or treatment element.

There are a wide variety of diversion programs, which can be placed into six main categories.⁵

- Pre-arrest diversion programs, which focus on the time before a charge is laid, but after an offence has been detected. These include:
 - (a) police discretion, where police detect an offence but no action is taken;
 - (b) infringement notice systems, where police issue on the spot fines but no conviction is recorded (the cannabis expiation notice schemes discussed in Section 2.5 are an example of these);
 - (c) formal cautioning systems, where offenders are given a warning and a record is taken of the warning, but no conviction is recorded and no further action is required; and
 - (d) caution plus intervention, where offenders are given a warning, a record is taken and the offenders are referred to an education or treatment program.
- Pre-trial diversion programs, which focus on the time after a drug charge has been laid but before the matter is heard in court. Pre-trial programs often involve the offender being required to satisfy certain assessment, education and treatment conditions (for example, as bail conditions or as part of an offer made by the prosecutor), after which the offence is struck off the record or satisfaction of the conditions is taken into account during sentencing. Participation in the program could be compulsory or voluntary.
- Pre-sentence diversion programs, which focus on the time after conviction but before sentencing. This usually involves the delay of sentencing (remand) until the offender has been assessed and received drug treatment, and the program may include incentives to encourage cooperation (for example, a reduced sentence).
- Sentence-based diversion programs, which involve the imposition of diversionary measures as part of the sentence handed down by the court. These measures can include suspended sentences conditional on the completion of an education and treatment program and compulsory education and treatment

⁵ For similar categorisation, see McDonald *et al.* (1994); Lenton *et al.* (2000); Spooner *et al.* (2001); AIC (2004).

programs that are supervised by a court (for example, a drug court) or guaranteed by a bond.

- Pre-release diversion programs, which focus on the time after sentencing and before release from detention; for example, transferring offenders to secure residential education and treatment programs while still in custody.
- Post-release diversion programs, which focus on the time after a person is released from detention. These measures may involve people being released from gaol early on the condition they attend treatment or drug education or treatment being integrated into released inmate management programs.

All jurisdictions in Australia have diversion programs, although the types and details of the programs differ considerably. Pre-arrest cannabis diversion programs such as the infringement notice and formal cautioning schemes have tended to receive the majority of media attention – details of these programs are provided in Appendix A. However, the programs currently in operation cover all six of the categories outlined above. They include pre-sentence schemes (for example, the New South Wales Magistrates Early Referral Into Treatment (MERIT) Program and the Victorian Court Referral Evaluation Drug Intervention and Treatment (CREDIT) Program), sentence-based programs (for example, drug courts) and post-release diversion programs that involve the imposition of treatment conditions by parole boards on inmates who are released from detention.

Diversion programs are arguably justifiable on four main grounds. Firstly, they may be able to reduce the drug-related burden on police, court and prison resources. Secondly, it is arguable that they can reduce the adverse economic, social and health impacts that prohibition can have on drug users and their families and friends. Thirdly, when combined with education and treatment programs, diversion programs may be able to reduce problematic drug use and the associated personal and social costs (including crime). Finally, it is arguable that these programs are a more humane and equitable response to drug issues than a rigid, strict prohibition approach because they can reduce the negative impacts that the criminal justice system has on drug users, provide users with an opportunity to overcome the cause of their illegal actions and reduce the inconsistencies between the way illicit drugs and other dangerous behaviour (including licit drug use) is treated.

The argument that diversion programs can reduce substance misuse disorders is often premised on the belief that a person's involvement in the criminal justice system can provide an important opportunity to confront their drug use and associated conduct. For example, when a drug user is arrested, the fear of being prosecuted may provide the necessary motivation for the individual to seek help to address their drug use behaviour or drug dependency. Further, many diversion programs are based on the principle of early intervention, the notion that drug users are more likely to be receptive to change when they have only just started taking drugs (NIDSDI – Victorian State Reference Group 2002). Arguably this principle is the reason why many pre-arrest and pre-trial diversionary programs are not available to convicted drug users.

Although diversion programs offer advantages over strict prohibition, they have a number of problems. These include the following.

- They can be expensive, particularly where they involve compulsory or coerced treatment components.
- There is no clear evidence that compulsory and coerced treatment improves treatment outcomes (Belenko 2001; Bull 2003; Stevens 2004; Stevens *et al.* 2005).
- They often result in the diversion of drug users to treatment when they do not have a substance misuse disorder or any other treatable illness.
- Many of the positive aspects of diversion programs can be undermined due to their limited reach (i.e. they often do not apply to people with a record of drug offences);⁶ net-widening (i.e. the propensity for police to arrest more people following the introduction of diversion programs); and the inability of offenders to adhere to the terms of the program because of the chronic, relapsing nature of most substance misuse disorders.
- Where they include compulsory and coerced treatment components, diversion programs can:
 - (a) result in the displacement of voluntary treatment seekers;
 - (b) create perverse incentives for treatment seekers (for example, users may commit crimes in order to access treatment);
 - (c) undermine treatment outcomes by causing social problems for the offenders; and
 - (d) lead to treatment services being directed towards criminal rather than health priorities (i.e. resources being used to treat non-dependent users rather than containing health risks).
- It is arguable that diversion programs are unjust; they involve the use of the criminal justice system to address a medical illness and they can result in drug-dependent users being forced to undergo compulsory or coerced treatment for longer periods than they would have served if they had accepted a prison term or a community correction order.

These weaknesses raise questions about the cost-effectiveness of diversion programs as a means of offsetting the adverse impacts of prohibition.⁷

⁶ The limitation of diversion programs to individuals with few criminal drug convictions significantly undermines their effectiveness as it results in the exclusion of a large proportion of people with substance misuse disorders. This is because these illnesses are often chronic and relapsing and many sufferers are unable to achieve and maintain abstinence. Restricting diversion programs in this way ensures that their benefits are denied to the body of drug users who cause the most social harm and are usually the most resistant to the deterrent effects of drug laws.

⁷ The weaknesses associated with compulsory and coerced treatment programs are discussed in greater detail in Section 6.

Key points

- Drugs are substances that alter mental processes by changing the way the central nervous system operates.
- In debates and literature concerning drug policy, the term ‘drug’ is used to refer to both legal (licit) and illegal (illicit) drugs. Illicit drugs include heroin, ecstasy, methamphetamines, cocaine and cannabis. Licit drugs include alcohol, tobacco and caffeine.
- Drugs are often placed in three categories: depressants (which slow down the central nervous system), stimulants (which speed up the central nervous system) and hallucinogens (which stimulate the central nervous system and distort perceptions).
- The legislative options for drug control can be placed into five categories: total prohibition, prohibition with civil penalties, partial prohibition, regulation and free availability. Although there are differences in the types of legal systems within each category, this taxonomy is preferred as it is more precise than the alternatives (for example prohibition, decriminalisation and legalisation).
- Diversion programs are initiatives that attempt to divert drug users away from the criminal justice system and usually include educational and treatment components. The perceived advantages of diversion programs are that arguably they can reduce the enforcement burden, drug use and drug-related crime and can result in more equitable outcomes, although the extent to which these advantages are realised is not always clear. The disadvantages are that they can be expensive, inefficient and result in unjust outcomes.
- All Australian jurisdictions currently have regulation regimes for alcohol and tobacco and total prohibition regimes for all of the well-known illicit drugs except cannabis. Total prohibition regimes apply to cannabis in all jurisdictions other than South Australia, Western Australia, Northern Territory and the Australian Capital Territory, which have civil penalty regimes for minor cannabis use, possession and cultivation offences.

3. A brief history of Australia's drug laws

The history of drug laws in Australia can be divided into four phases.

Phase one (1788 – late 1800s and early 1900s)

The first phase comprises the period between 1788 and the later part of the 1800s, when drug use was largely seen as a matter of personal choice (Manderson 1992; McDonald *et al.* 1994; Sinha 2001). There were few laws regulating or controlling the production, supply and use of drugs and those that did exist concentrated on minimising the risks associated with known poisons (Manderson 1992; Manderson 1993).

Phase two (late 1800s and early 1900s – 1912)

The second phase commenced in the late 19th century and ended with the emergence of the international drug control regime in 1912. This phase in the history of Australia's drug laws is marked primarily by the introduction of laws by the states to prohibit opium smoking and the supply of opium suitable for smoking. The Commonwealth also played its part in the creation of this new drug regime by prohibiting 'the importation of opium, suitable for smoking' (Manderson 1993, p. 55) and the possession of opium suitable for smoking without a reasonable excuse (Norberry 1997). These laws were a product of several factors, including racist attitudes towards Chinese immigrants who smoked opium and the growth of the temperance and prohibition movements (Manderson 1992; Manderson 1993; McDonald *et al.* 1994).

Phase three (1912 to 1960s)

The third phase stretches from around 1912 to the 1960s and is characterised by the creation and implementation of international conventions on the prohibition of drugs. Nine multilateral drug control agreements were negotiated between 1912 and 1953, all of which were based on a philosophy of drug prohibition. The United States and the United Kingdom played a critical role in the development of these treaties and Australia was placed under considerable pressure by both governments to sign, ratify and adhere to the agreements (Manderson 1993).

The signing of the conventions and the related diplomatic pressure, together with the association of drugs with 'unsavoury' elements in society (particularly prostitutes and organised crime) and a world-wide movement against illicit drugs led to the introduction of a range of new drug laws. These included prohibitions on the use and supply of cannabis (brought in after the Geneva Convention on Opium and Other Drugs in 1925)⁸ and cocaine (Manderson 1992; Manderson 1993; McDonald *et al.* 1994). Significantly, in 1953 the Commonwealth also banned the importation of heroin and then successfully pressured the states to prohibit its production, distribution and use.

⁸ The importation and use of cannabis in Australia was prohibited under Commonwealth legislation in 1926 and similar cannabis bans were introduced in the states and territories between 1928 and 1953 (McDonald *et al.* 1994).

Prior to the introduction of the ban, heroin had been widely used for medicinal purposes (namely as a pain reliever and an ingredient in cough mixtures), so much so that by 1951 Australia had the highest per capita rate of heroin consumption in the world. Despite insignificant levels of illegal, non-medical consumption, the high usage rate ensured Australia was subject to considerable international pressure to curb the domestic heroin trade. Sensitive to external criticism and swayed by dramatised arguments about the addictive nature of the drug, the Federal Government introduced the heroin laws with little consultation and was later criticised by sections of the Australian medical profession when the consequences of the ban became apparent (Manderson 1993).

The domestic impact of the new drug laws and expanded range of outlawed substances appears to have been limited, mainly due to the fact that very few people used illicit drugs throughout the majority of this period (Manderson 1992; Manderson 1993). Further, as had occurred in the 19th century, many doctors continued to prescribe drugs for the ‘maintenance’ of drug addicts, a practice that was mostly legal and approved by the Commonwealth (Manderson 1993; McDonald *et al.* 1994). The people who felt the brunt of the drug laws were primarily Chinese opium smokers, prostitutes and members of the underworld (Manderson 1992; Manderson 1993). Prescription users, largely ‘middle-class, middle-aged, frequently doctors or other health-care professionals’ (Manderson 1993, p. 106) were either exempt or not prosecuted.

Phase four (1960s to present)

The fourth phase in the history of Australia’s drug laws commenced in the 1960s and has continued through to the present day. Three changes occurred during the 1960s and 1970s that affected the direction of Australia’s drug laws. Firstly, the prevalence of illicit drug use in Australia rose significantly (Manderson 1993; McDonald *et al.* 1994). Secondly, the demography of drug users and drug addicts changed from being predominantly middle-class, middle-aged people and elderly Chinese opium smokers to those in younger age groups (Manderson 1993). Thirdly, the international drug control regime was consolidated and expanded. This began with the *United Nations Single Convention on Narcotic Drugs* in 1961, and was followed by the *Convention on Psychotropic Substances 1971* and the *Protocol Amending the Single Convention on Narcotic Drugs*, which was signed in 1972. Later, the *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988) (often known as the Trafficking Convention) was signed and it rounded out the new international drug control regime.⁹

These changes had a profound effect on social attitudes towards drugs and on Australia’s drug laws and drug policies. Importantly, drug policy quickly became high profile and highly politicised. As Manderson (1993, p. 146) describes:

[t]o be seen to be doing something about drugs was an essential element of every political platform and a short-cut to popularity.

⁹ The signing and ratification of these treaties resulted in the creation of an extensive international drug bureaucracy, which now includes the International Narcotics Control Board, United Nations Commission on Narcotic Drugs and United Nations Office on Drugs and Crime.

Illicit drug use throughout the 1960s and 1970s was seen as being closely linked to a young and decadent lifestyle that posed a threat to the moral fabric of society and the authority of the law.

The response of governments can be broken into two stages. The first stage saw law enforcement become the focus of drug policy. Higher criminal penalties for drug offences were introduced and more resources were invested in drug law enforcement (Manderson 1993; Norberry 1997). Police were also given new powers to investigate drug offences (including expanded monitoring and search powers) and the onus of proof for certain drug offences was reversed to make it easier for prosecutors to obtain convictions (Manderson 1993).

The Commonwealth led the charge on law enforcement policies. Previously, its energies had been focused on controlling the importation of prohibited substances, reflecting the widely accepted view at the time that the Australian Constitution did not give the Commonwealth adequate powers to control the manufacture, distribution and use of illicit drugs within state borders. But the changing profile of drug users, the politicisation of drug policy and the changes in the international drug control regime 'awakened Commonwealth ambition' (Manderson 1993, p. 149). These ambitions saw the enactment of the *Narcotic Drugs Act 1967* (Cwlth), 'to regulate the Manufacture of ... Narcotic Drugs in accordance with the Single Convention on Narcotic Drugs, 1961' (Manderson 1993, p. 150). The Commonwealth bureaucracy, eventually through a newly established Federal Narcotics Bureau, became more actively involved in the implementation of drug laws and strongly advocated drug policies that sought to resolve drug issues through legal processes rather than the health system.

The second stage, which began in the late 1960s and early 1970s, saw a more formal legal distinction drawn between drug users and drug traffickers. Where previously drug users had been vilified, drug traffickers were now supposed to be the primary target of prohibition and drug law enforcement (Manderson 1992; Manderson 1993). By 1970, all states had enacted legislation that made drug trafficking a separate offence to drug use and possession (Manderson 1993). Gradually the penalties for drug trafficking were increased and a split was then made between commercial drug traffickers, who were often depicted as 'Mr Big', and small-time drug suppliers (Manderson 1993). All forms of drug trafficking carried harsh punishments, but extremely large penalties were prescribed for commercial trafficking. In Manderson's words, 'those for whom the drug traffic was not just business, but big business, were clearly being singled out for special treatment' (Manderson 1993, p. 182).

As the drug laws became increasingly directed towards drug traffickers, attitudes and policies towards drug users became more sympathetic. By the late 1970s and early 1980s, dependent drug users began to be viewed as suffering from an illness that needed treatment, even though much of the social stigma of being a drug user remained (Manderson 1992; Manderson 1993). This eventually led to reductions in the penalties for drug use offences and the adoption of harm minimisation as the

stated objective of the National Campaign Against Drug Abuse, which was launched by the Ministerial Council on Drug Strategy in 1985 (Manderson 1992).¹⁰

The shift in focus towards harm minimisation and harm reduction was given further impetus by the emergence of HIV/AIDS as a serious public health issue in the mid to late 1980s (Norberry 1997; Manderson 1993). Needle and syringe exchange programs were commenced in 1987 in an attempt to reduce the spread of the disease amongst injecting drug users. In the same year, the Federal Government began the National AIDS Education Campaign, which included a series of television commercials that warned viewers that ‘sharing needles is like playing Russian roulette’. In Australia at least, the arrival of HIV/AIDS and other blood-borne diseases helped turn drug policy in a more pragmatic direction, although the traditional ties to prohibition remained strong.

Thus far, the National Campaign Against Drug Abuse and its successor, the National Drug Strategy, have led to relatively minor changes being made in the structure and administration of Australia’s drug laws. The formal focus of drug law enforcement efforts has remained on ‘high level’ traffickers (Sutton and James 1996; Green and Purnell 1996).¹¹ There has also been a continuation of the distinction between so-called hard and soft drugs, where offences involving the latter are generally treated more leniently than those involving the former (Norberry 1997).

In an effort to reduce the health risks associated with injecting drugs, an important change was made in the early 1990s when a number of jurisdictions repealed laws that made the possession of needles and syringes for the purpose of administering illicit drugs a criminal offence (Manderson 1993; Norberry 1997). Similarly, although penalties for drug use and possession have been retained, some have been reduced and diversionary programs have been established that include treatment and educational components. Among the more high profile of these initiatives is the Cannabis Expiation Notice scheme that commenced in South Australia in 1987. Similar civil penalty regimes for minor cannabis offences were later introduced in the Australian Capital Territory, Northern Territory and Western Australia.

When the Howard Government was first elected in 1996, the focus of national drug policy remained on harm minimisation and the Coalition continued the practice of pursuing bipartisan support for harm reduction initiatives. Indeed, in both the 1996/97 and 1997/98 Federal budgets, funding for the Australian Federal Police was reduced, suggesting that the Government was placing less faith in the ability of law enforcement to address drug issues (Wodak 2004). Further, in July 1997, the Ministerial Council on Drug Strategy approved a heroin prescription trial in the Australian Capital Territory. However, by late 1997 the tide had begun to turn.

¹⁰ The Ministerial Council on Drug Strategy is comprised of state and territory health and law enforcement Ministers and representatives from the Federal Government (typically the Ministers or Parliamentary Secretaries for health, customs, justice and education and the Attorney-General).

¹¹ Despite drug law enforcement supposedly being directed towards high level suppliers, the burden of drug laws has tended to fall most heavily on users and street traffickers (Sutton and James 1996; Green and Purnell 1996). This appears to be a product of the fact that non-specialist police are responsible for the majority of drug law enforcement and they seem to respond to community pressure rather than the priorities outlined in overarching policies or those pursued by specialised drug law enforcement agencies (Sutton and James 1996; Green and Purnell 1996).

Firstly, the Howard Government stopped the heroin trial in the Australian Capital Territory from proceeding by refusing funding and failing to amend relevant federal legislation, a decision that sparked public debate and criticism by a number of health professionals (Wodak 1999; Wodak 2004). Later, in November 1997, the Prime Minister launched the National Illicit Drug Strategy, called ‘Tough on Drugs’ which placed renewed focus on law enforcement. This led to increases in the budgets of law enforcement agencies and a break away from the cooperative bipartisan approach that had characterised the previous era of the National Drug Strategy.

The political division over drug policy and harm reduction initiatives was illustrated in 1999 when the Prime Minister publicly criticised proposals to establish safe injecting rooms in New South Wales, Victoria and the Australian Capital Territory and indicated that he was considering a ‘zero tolerance’ approach to drug law enforcement (Howard 1999). When the New South Wales Labor Government went ahead with the trial of a safe injecting room in Kings Cross in 2001, the Coalition ensured that the issue received attention in the November 2001 federal election by releasing a policy that declared:

[I]llicit drugs are the greatest scourge facing our society and threatening our children. Unlike Labor’s support of heroin trials and heroin injecting rooms, the Coalition will not compromise in the fight against drugs (Liberal Party of Australia and National Party of Australia 2001, p. 2).

Despite the political split and the Federal Government’s proclamations about being ‘tough on drugs’, harm minimisation has remained the objective of the National Drug Strategy. This is made clear in the NDS Framework, which explains that this principle ‘does not condone drug use, rather it refers to policies and programs aimed at reducing drug-related harm’ (Ministerial Council on Drug Strategy 2004). As noted above, harm minimisation is described as being composed of three parts.

- Supply reduction strategies, which try to disrupt the production and supply of illicit drugs.
- Demand reduction strategies, which seek to prevent the uptake of harmful drug use and help reduce drug use by providing treatment.
- Harm reduction strategies, which seek to reduce drug-related harm to individuals and communities (Ministerial Council on Drug Strategy 2004).

The Howard Government’s ‘Tough on Drugs’ approach has resulted in greater emphasis being placed on the first two of the three components of harm minimisation and it has been particularly keen to extol the virtues of drug law enforcement. The Government has also stopped or impeded the development of several innovative harm reduction programs (including drug injecting rooms and prescription heroin trials) and provided unwarranted levels of support for initiatives that appear to be driven more by an abstinence-based ideology than evidence-based policy (for example, retractable needles and syringes and naltrexone therapy). However, harm reduction has not been expunged and a number of harm reduction programs have been continued and even expanded. These include needle exchange programs, methadone maintenance treatment and diversion programs.

Many of the diversion programs have been developed as part of the Illicit Drug Diversion Initiative, commenced in 1999 and forming part of the National Drug Strategy. This initiative targets ‘illicit drug users who have little or no past contact with the criminal justice system for drug offences, and who have been apprehended by police for possession and/or use of small quantities of any illicit drug’ (Council of Australian Governments 1999). The object of the initiative is to ensure that when drug users meeting this description are apprehended by police they are diverted away from the criminal justice system and towards assessment, education and treatment services (Council of Australian Governments 1999). The initiative is described as an ‘early intervention strategy’, emphasising that the diversionary schemes are not intended to be available to people who are persistent drug offenders (Ministerial Council on Drug Strategy 1999). Diversion programs are only supposed to be available to non-violent offenders and diversion should occur only where the offender has given their informed consent (Council of Australian Governments 1999).

While limitations have been placed on the diversion programs available under the Illicit Drug Diversion Initiative, the fact that the Howard Government supports programs of this nature is an acknowledgment that it recognises the deficiencies of prohibition. Its support for other non-legal prevention strategies and treatment services indicates that the Government is also aware of the importance of a multi-pronged approach to addressing drug issues. Examples of non-legal drug initiatives that have received the Howard Government’s backing include the National Schools Drug Education Strategy, Training Frontline Workers Initiative, Non-Government Organisation Treatment Grants Programme and National Comorbidity Initiative, all of which constitute part of the National Illicit Drug Strategy.

Drug policy under the Howard Government has therefore been characterised by an apparent inconsistency between its public position and its policy. As Alex Wodak (2004, pp. 1-2) has argued:

[t]he major difference between the drug policy pursued by the Howard Government and that of the Australian Labor Party (when in government and opposition) has been political marketing. The Howard Government has been conscious of the views of its constituency and the need for ‘product differentiation’.

Recent events suggest that the Howard Government may be in the process of attempting to align national drug policy more closely with its ‘tough on drugs’ position. Soon after taking control of the Senate in August 2005, the Government passed new laws that expanded the powers of the Commonwealth to deal with drug offences.¹² One of the objectives of the new laws is to ‘increase the uniformity of drug offences in Australia by implementing model serious drug offences developed in consultation with the States and Territories’ (Parliament of the Commonwealth of Australia 2005, p. 103). The laws also created a ‘comprehensive range of drug offences’, which enable the Commonwealth ‘for the first time’ to regulate and control all aspects of drug markets – from users through to ‘Mr Big’ suppliers (Senate Legal and Constitutional Legislation Committee 2005, p. 18).

¹² *Law and Justice Legislation Amendment (Serious Drug Offences and Other Measures) Act 2005* (Cwlth).

While the new laws enable the concurrent operation of state and territory drug laws, concerns have been expressed that they may result in the intrusion of the Commonwealth into areas that have traditionally been the exclusive domain of the states and territories (Senate Legal and Constitutional Legislation Committee 2005). According to the Western Australian Government (Ellery 2005, p. 1):

[t]he new offences do, however, apply to drug dealing interstate and give more flexibility to Commonwealth law enforcement agencies to encroach on matters that were previously for exclusive consideration by the State.

Given the Commonwealth's constitutional powers and the nature of its law enforcement resources, it is unlikely that the new laws signal the start of an attempted takeover by the Commonwealth of drug law enforcement. Yet, they do mark another step in the evolution of the development of the Federal Government's involvement in this field. In particular, the nature of the legislative changes suggests the Government may use the laws as a means of exerting greater influence over the states and territories and pulling national drug policy in a more 'strict prohibitionist' direction.

Already, there are signs the Government will use the process of developing the model drug laws to push for the replacement of cannabis infringement notice schemes with prohibition. In November 2005, the Prime Minister was reported as saying that '[f]ar from embracing further decriminalisation, authorities should be examining going in the opposite direction' (Prime Minister Howard, in Karvelas 2005). The Parliamentary Secretary for Health, the Hon Christopher Pyne MP, was more explicit about his intentions when he reportedly said that he would be asking the Ministerial Council on Drug Strategy to toughen cannabis laws and that:

[t]here's no doubt that the decriminalisation of [cannabis] sent the wrong message to people about the dangers of cannabis, and I would like to see personally a re-criminalisation of personal cultivation and use of cannabis (Pyne, in Karvelas 2005).

More recently, there have been reports that '[a]ll states will be urged to strengthen laws on cannabis use as part of a new national plan to tackle mental illness to be presented by the Prime Minister' to a premiers meeting in February 2006 (Dodson and Clennell 2006).

While the statements made by the Federal Government suggest it wants the states and territories to adopt a more restrictive approach to cannabis offences, it is unlikely that its objective is to abolish all cannabis diversion programs. The Government committed approximately \$325 million to the Illicit Drug Diversion Initiative over the period 1999 to 2007 (Howard 2002). A major revision of cannabis diversion programs would jeopardise this investment and be inconsistent with past policy announcements. Rather, the Government's ire appears to be directed towards cannabis infringement notice schemes and any attempts to move away from prohibition. Presumably the intention is to replace the existing civil penalty regimes with strict prohibition and then soften the impacts of prohibition with diversion.

The move back towards a harsher form of strict prohibition seems to stem from an ideology based on abstinence that sees drug use rather than the harms caused by drug use as the dominant evil. This approach was articulated in the House of

Representatives Standing Committee on Family and Community Affairs report on its inquiry into substance abuse in 2003, called *Road to Recovery* (House of Representatives Standing Committee on Family and Community Affairs 2003). The Committee found that:

... much more effort needs to go into both preventing the uptake of smoking and illicit drug use and providing treatment that leads to abstinence ... [T]he committee is also confused by the use of the term, harm minimisation, particularly its relationship to the tough on drugs approach. The committee is concerned about the way in which the term harm minimisation may appear to encourage maintenance of a drug habit and give rise to the idea that taking drugs is alright (House of Representatives Standing Committee on Family and Community Affairs 2003, pp. 296 - 297).

This led the Committee to recommend that:

... the Commonwealth, State and Territory governments replace the current focus of the National Drug Strategy on harm minimisation with a focus on harm prevention and treatment of substance dependent people (House of Representatives Standing Committee on Family and Community Affairs 2003, p. 297).

At the time of the inquiry, the Committee was controlled by Coalition members and the position adopted in the report is consistent with recent changes in Federal Government policy.¹³ If taken to extremes, this moral position suggests that abstinence is more important than harm reduction and that the lives of users can be traded off in order to guarantee the physical, mental and moral safety of non-users.

The current Federal Minister for Health, the Hon Tony Abbott MP, has been accused of making public statements that appear to align him with this extreme position. The Reverend Tim Costello is reported to have said that:

[a]t The Age's Vision 2000 session, Tony Abbott was asked why he was opposed to supervised injecting facilities, given the number of deaths, and he repeated exactly the same view. He said that people who are on drugs are virtually dead anyway (Family and Friends for Drug Law Reform (ACT) Inc. 2004, p. 14).

Recent reports that the Federal Health Minister intends to expand 'access to rapid detoxification services using the drug naltrexone' in an attempt to reduce the number of people in prescription methadone programs provides further evidence of a shift towards abstinence-focused policy (Robotham 2005). Rapid detoxification therapy involves the use of naltrexone to accelerate withdrawal from opioids, following which the patient is moved on to a course of naltrexone maintenance, usually for between six and 12 months. Its supporters base their advocacy mainly on the fact that it has the capacity to move people to a state of abstinence faster than alternative treatment

¹³ A number of Committee members submitted dissenting reports objecting to 'abstinence-based' recommendations and those concerning harm minimisation (House of Representatives Standing Committee on Family and Community Affairs 2003). Several members of the Australian Labor Party also criticised the report and many of its recommendations when it was tabled in the House of Representatives (Parliament of the Commonwealth of Australia 2003).

programs like methadone, buprenorphine or heroin maintenance. The difficulty with rapid detoxification naltrexone treatment is that the available evidence suggests that it is relatively ineffectual, expensive (due to the accelerated withdrawal process requiring anaesthesia or light sedation), and potentially dangerous (Wodak *et al.* 1997; Bell *et al.* 1999; Wodak *et al.* 2001; Gibson and Degenhardt 2005). Further research is being carried out on ways to improve naltrexone treatment and it appears to have a place as a treatment option. However, given the current evidence, the rising political profile of naltrexone suggests that the Howard Government has taken onboard the recommendations of the House of Representatives Standing Committee on Family and Community Affairs and is seeking to push a national drug policy that places a premium on abstinence, at the expense of harm reduction.¹⁴

The ability of the Federal Government to shape national drug policies will be dependent on how state and territory governments engage with it on this highly political issue. The malleability of public opinion on drug issues and the degree of community apprehension about drugs makes drug policy an area that is ripe for political exploitation. Those who are willing to support alternative solutions leave themselves politically exposed.

At least one state Labor Government has indicated that it supports the move toward stricter drug laws. In early February, the Labor Premier of New South Wales, the Hon Morris Iemma MP, announced plans to introduce new ‘hardline’ cannabis laws that would see people found cultivating as few as five hydroponically-grown cannabis plants facing up to ten years imprisonment (Benson 2006; Dodson and Clennell 2006). Whether the policy adopted by the New South Wales Labor Government is supported by other states and territories remains to be seen, but the Premier’s enthusiasm toward legal approaches suggests that prohibitionist and abstinence-based ideals are not the exclusive domain of the Howard Government or the Liberal/National Party Coalition.

Key points

- There have been four main phases in the history of Australia’s drug laws.
- During the first phase (prior to the late 1800s), drug use was largely a matter of personal choice.
- In the second phase (late 1800s – 1912), laws were introduced in Australia that prohibited the supply and consumption of opium. The laws were largely attributable to racist attitudes towards Chinese immigrants and the growth of the temperance and prohibition movements.
- In the third phase (1912 – 1960s), the international drug control regime emerged, which resulted in new drug laws that prohibited substances like cannabis, cocaine and opium derivatives. These laws were mainly enforced against deviant members of society (prostitutes, vagrants and known

¹⁴ In 2003, the Howard Government tabled the *Disability Discrimination Amendment Bill 2003* (Cwlth), which sought to allow discrimination against people who are addicted to illicit drugs unless they are in treatment. After a Senate inquiry, the Bill was dropped from the legislative agenda. It is unclear whether the Government intends to revive this legislation in the current Parliament.

criminals) and Chinese opium smokers. Drugs continued to be prescribed to a significant number of ‘middle-class, middle-aged’ users.

- In the fourth phase (1960s to present), the prevalence of drug use increased significantly, particularly within younger age groups. The international drug control regime was also consolidated and expanded. These changes prompted intensification of drug laws and drug law enforcement. In the late 1960s and 1970s, a formal distinction was made between users and traffickers. A distinction also emerged between the ‘Mr Bigs’ of the drug industry and small-scale street dealers, with commercial trafficking offences attracting particularly harsh penalties.
- In the late 1970s and early 1980s, there was a softening in attitude towards drug users. This led to the adoption of harm minimisation as the stated goal of the National Campaign Against Drug Abuse (later to become the National Drug Strategy), the lessening of penalties for many drug use offences and the implementation of a number of initiatives that were designed to reduce drug-related harm. The shift toward harm minimisation was given further impetus by the emergence of HIV/AIDS as a public health issue in the mid to late 1980s.
- Over the last decade, governments have often talked tough on drugs while supporting or condoning less controversial harm minimisation policies. This approach has stifled the adoption of promising harm reduction initiatives (for example, heroin prescription and safe injecting rooms). However, it has enabled a number of important harm minimisation programs to be undertaken.
- There is now evidence of a shift away from harm minimisation and a hardening of approach to drug issues. For example, the Howard Government has passed laws enabling it to expand its control over drug policy and has indicated a desire to ensure that all jurisdictions have strict prohibition regimes for all cannabis offences. Similarly, the New South Wales Labor Government has announced plans to introduced new ‘hardline’ cannabis laws.
- The move towards a harsher form of prohibition seems to stem from an ideology based on abstinence; drug use rather than drug-related harm is seen as the dominant evil.

4. The theory behind Australia's drug laws

4.1 Why have strict drug laws?

Three main arguments are often used to promote or defend strict drug laws:

- they reduce the harm that drug users and suppliers impose on society (i.e. they reduce negative externalities and overcome market failure);
- they reduce the harm suffered by drug users and prospective drug users; and
- they promote and protect moral values.

The details of these arguments are outlined below.

4.2 Reducing negative externalities and overcoming market failure

In a liberal society people should have the right to determine how they live their lives. It is only when a person's actions adversely affect the safety and happiness of others that the state should interfere. This is the essence of the so-called 'harm principle' expressed by philosopher John Stuart Mill when he said:

(t)he sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others (Mill 1859, Chapter 1, para. 9).

A broad interpretation of the harm principle is often used to support drug laws.¹⁵ Proponents argue that illicit drugs cause harm to people other than drug users and suppliers and, by prohibiting or regulating the drug market, the government is able to eliminate or reduce the problematic behaviour and associated costs (Wagstaff and Maynard 1988; Salvation Army RSCPRD 1999; Weatherburn *et al.* 2000).

Economists refer to the costs associated with a transaction that are not borne by the supplier or consumer as 'negative externalities'. The negative externalities associated with the drug market include the health care costs of drug treatment, adverse affects on dependent children and family members, transmission of diseases, traffic accidents, lost productivity, reduction in public amenity and safety, and drug-related crime (Wagstaff and Maynard 1988; Weatherburn *et al.* 2000; MacCoun and Reuter 2001; Collins and Lapsley 2002).

The elimination or reduction of negative externalities is a common justification for legislative regimes that restrict individual freedoms (Breyer 1998; Australian Law Reform Commission 2002). Conventional economic approaches to policy development are based on the notion of maximising net social welfare. Where transactions generate negative externalities, there is the potential for free market outcomes to lower net social welfare, as the total costs of the transaction may outweigh the benefits. Laws can be used to modify human behaviour to prevent

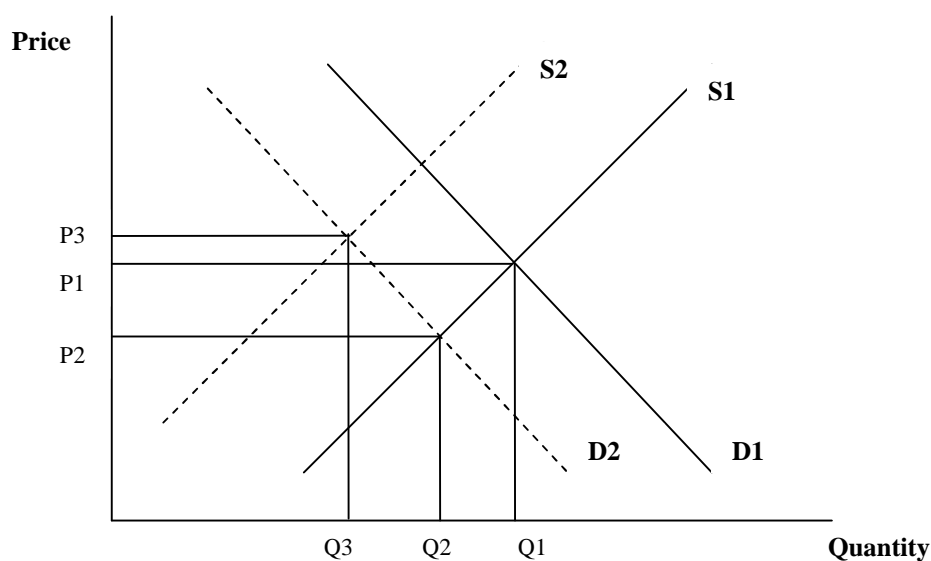
¹⁵ For the contrary view on the consistency between liberalism and prohibition, see Section 8.4.

welfare reducing transactions. In economic jargon, they can be used to overcome market failure – the failure being the inability of the market to produce welfare maximising outcomes.

In the case of drug laws, the general theory is that net social welfare can be increased by eliminating or reducing the size of illicit drug markets or reshaping them (Wagstaff and Maynard 1988). This theory is premised on the assumption that drug laws can reduce drug-related harm, either by decreasing drug use or the harm per unit of use, and that the costs of the drug laws will not exceed their benefits (Wagstaff and Maynard 1988; Kleiman 1992; Weatherburn *et al.* 2000; Caulkins 2002). To achieve this, drug laws generally target both drug users and suppliers in the hope of reducing drug availability, increasing drug prices and deterring people from using and supplying drugs (Kleiman 1992; MacCoun and Reuter 2001; Ministerial Council on Drug Strategy 2001a; 2001b; Caulkins 2002; Loxley *et al.* 2004). This gives rise to two distinct types of drug law enforcement: ‘supply-side’ targeting drug traffickers¹⁶ and ‘demand-side’ targeting drug users (Weatherburn *et al.* 2000; Ministerial Council on Drug Strategy 2001a; 2001b; Loxley *et al.* 2004).

The effect of supply-side and demand-side law enforcement on illicit drug markets is illustrated in Figure 1.

Figure 1 Effect of drug laws on the supply and demand for illicit drugs



In the absence of government intervention, the price of the drug will be P1 and consumption will be Q1 (i.e. the point at which supply (S1) equals demand (D1)). The introduction of laws prohibiting the use and possession of illicit drugs will generally suppress demand, resulting in the demand curve shifting from D1 to D2 (i.e. less of the drug will be demanded at each price). If nothing else is done, the price of the drug

¹⁶ Supply-side drug law enforcement can be broken into three categories: international, national and domestic. International and national drug law enforcement aims to disrupt drug syndicates that are involved in the overseas production and import and export of illicit drugs, while domestic enforcement focuses on stopping the manufacture and marketing of drugs within Australia or a specific state or territory.

will fall from P1 to P2 and the equilibrium level of consumption will be at Q2. When laws are introduced also outlawing the supply of the drug, the costs of supply will increase leading to a shift in the supply curve from S1 to S2 (i.e. less of the drug will be supplied at each price). This will lead to the price of the drug increasing to P3, which will lead to consumption falling from Q2 to Q3. Ultimately, the impact of the drug laws will be to reduce consumption by an amount equal to Q1 – Q3.¹⁷

Traditionally, drug laws have sought to utilise five main mechanisms to achieve the objectives of reducing supply and demand for illicit substances.

- Interception – when drugs are intercepted by law enforcement authorities, there can be a reduction in the amount of the relevant drug that is available for consumption (Caulkins 2002; Loxley *et al.* 2004; Smithson *et al.* 2005; Degenhardt *et al.* 2004).
- Increased costs of supply – drug laws and their enforcement can raise the monetary and non-monetary costs of supplying illicit drugs (Kleiman 1992; Weatherburn *et al.* 2000; MacCoun and Reuter 2001; Clements 2004). The increase in costs can reduce the amount of drugs that are supplied and increase the price at which traffickers are willing to sell, which should then reduce demand (Weatherburn *et al.* 2000; MacCoun and Reuter 2001; Miron 2003; Clements 2004). As Weatherburn *et al.* (2000, p. 25) explain:

The rationale for seller-focused, supply-side DLE [drug law enforcement] is that it reduces the supply or availability of an illegal drug and/or increases the costs and risks associated with its importation and distribution. Conventional economic theory suggests that reducing the supply of a drug should increase its cost, thereby reducing demand.

Additional monetary costs associated with illicit drug markets include those involved in evading law enforcement authorities, losses incurred when drugs are seized and the extra bargaining and search costs associated with drug transactions that are due to the absence of normal commercial legal safeguards.¹⁸ The added non-monetary costs associated with drug trafficking include the risk of detection and punishment, uncertainty associated with transactions and isolation from society.

- Increased costs of consumption – drug laws and drug law enforcement can raise the monetary and non-monetary costs associated with consuming illicit drugs (Kleiman 1992; MacCoun and Reuter 2001; Loxley *et al.* 2004).¹⁹ By driving up the street price of drugs, drug laws and law enforcement can reduce

¹⁷ Drug laws will not increase drug prices above the licit market level if the demand curve moves to the left by a greater amount than the movement of the supply curve.

¹⁸ As drug transactions are illegal, those involved in the transactions are unable to rely on the usual common law and statutory remedies that apply to most legal commercial activities (i.e. breach of contract, fraud, misleading and deceptive behaviour etc.). This may force drug traffickers to invest greater resources in ensuring the reliability of contractors and purchasers than would otherwise be necessary.

¹⁹ The phrase ‘demand-side drug law enforcement’ is often used to refer to efforts aimed at raising the non-monetary costs of drug consumption (for example, search costs and fear of apprehension), rather than efforts to pressure drug suppliers, which have flow-on effects for the price of, and demand for, illicit drugs (Weatherburn *et al.* 2000).

the demand for illicit drugs (Kleiman 1992; Weatherburn *et al.* 2000; MacCoun and Reuter 2001; Caulkins 2002). Drug laws and law enforcement can also create additional non-monetary costs for consumers that can affect their willingness to purchase and consume illicit drugs. These include the fear of detection and punishment, search costs, product uncertainty and social exclusion (Kleiman 1992; Weatherburn *et al.* 2000; MacCoun and Reuter 2001).

- Moral force of the law – drug laws may reduce the number of people who are willing to participate in the drug market simply because some people believe violating the law is immoral (Tyler 1990; MacCoun and Reuter 2001).
- Declarative and expressive function of the law – laws both reflect social values and help shape them. Drug laws help promote the view that drug use and drug trafficking are immoral and socially unacceptable, which may reduce the number of people who are willing to be involved in illicit drug markets (Weatherburn *et al.* 2000; Loxley *et al.* 2004; Spooner *et al.* 2004).²⁰

More innovative approaches to drug law enforcement not only seek to reduce total drug consumption, but also endeavour to reduce drug-related harm and the damage caused by drug laws and their enforcement (Sutton and James 1996; Weatherburn *et al.* 2000; Caulkins 2002; Loxley *et al.* 2004). For example, if a drug market is located in a public place, a police ‘crackdown’ may be able to displace the market to another location where the impacts on third parties are reduced (perhaps because the risk of attracting new drug users is lowered, or because the public amenity effects are reduced) (Weatherburn *et al.* 2000; Caulkins 2002). Similarly, many diversion programs attempt to link the criminal justice system with drug education and treatment, so that drug offenders are able to (or forced to) address any health and behavioural problems they may be suffering (Weatherburn *et al.* 2000; Caulkins 2002). In these two cases, even if drug use does not decline, there may be a decrease in drug-related harm to the users and society.²¹

While past drug laws may have sought merely to stamp out drug markets, all Australian jurisdictions have now adopted drug law enforcement strategies that aim to reduce illicit drug use, drug-related harm and the damage enforcement causes to society. This is reflected in the National Drug Strategy and many of its programs, including the Illicit Drug Diversion Initiative.²²

The economic argument that drug laws and law enforcement can be used to reduce drug use and drug-related harm is usually based on the notion of the rational actor or what some people call the ‘rational choice perspective’ or ‘rational choice paradigm’ (Kleiman 1992; Weatherburn *et al.* 2000; MacCoun and Reuter 2001). This concept

²⁰ The declarative or expressive effects of drug laws can also raise the costs of supply and lower the consumer surplus associated with illicit drugs.

²¹ Other important examples of the application of harm minimisation practices in drug law enforcement include the provision of sterile injecting equipment and condoms to drug users to lower health risks and the practice of police not attending non-fatal drug overdoses (Ministerial Council on Drug Strategy 2001a; Health Outcomes International Pty Ltd *et al.* 2002).

²² Despite formal policies declaring a commitment to harm minimisation, questions have been raised about the extent to which law enforcement agencies are adhering to harm minimisation principles (Sutton and James 1996).

assumes that ‘people are perfectly rational actors able to evaluate the consequences of alternative choices, and to estimate the likelihood of their occurrence’ (Weatherburn *et al.* 2000, p. 12). As perfectly rational actors, people will seek to make decisions that maximise their expected utility. In terms of drug markets, the theory assumes people will take and supply drugs if they believe it will result in a net increase in their levels of happiness.

Drug laws seek to alter the factors and probabilities that are considered by rational actors when determining whether to consume or supply drugs. More specifically, they are intended to ensure that the expected utility (benefit) associated with drug use is lower than the utility resulting from abstinence; or at the very least that the expected utility of regular and heavy drug use is lower than that associated with infrequent and light or moderate use. For consumers, the emphasis is on decreasing availability, raising prices and increasing the non-monetary costs associated with consumption (i.e. punishment, search costs etc.) (Weatherburn *et al.* 2000). In relation to drug traffickers, the theory focuses on interception and increasing the monetary and non-monetary costs of supply. By using these mechanisms, the theory suggests that drug laws and law enforcement will decrease the expected utility associated with involvement in drug markets and, in doing so, ultimately decrease consumption and drug-related harm (Weatherburn *et al.* 2000; MacCoun and Reuter 2001).

The application of the rational choice perspective to laws and criminal behaviour is often called deterrence theory (Weatherburn *et al.* 2000; MacCoun and Reuter 2001). This theory:

... postulate[s] that an actor will engage in a criminal act whenever its expected utility exceeds that of the most profitable alternative. The expected utility of the crime is positively related to the gains from successful completion of the crime multiplied by the subjective probability of obtaining those gains and negatively related to the costs of legal sanctioning if the actor gets caught, multiplied by the subjective probability of legal sanctioning (MacCoun and Reuter 2001, p. 78).

On the basis of this theory, it has been suggested that the effectiveness of law enforcement is dependent on the severity of legal sanctions, the probability of legal sanctioning (i.e. the certainty of punishment) and the swiftness of punishment (called celerity) (MacCoun and Reuter 2001).

Key points

- One of the main arguments used to justify strict drug laws is that they can increase net social welfare by eliminating or substantially reducing the size of illicit drug markets, thus lowering the social costs incurred as a result of illicit drugs.
- The social costs of illicit drug markets include loss of life, illness and transmission of disease, provision of health care, suffering by the family and friends of drug users, traffic accidents, lost productivity, drug-related crime and reduced public safety and amenity. Many of these costs are magnified by strict drug laws (see Sections 5 and 6).
- There are two types of drug law enforcement: demand-side and supply-side. Demand-side drug law enforcement involves the enforcement of prohibitions on the possession and use of drugs. Supply-side drug law enforcement involves the enforcement of prohibitions on the commercial cultivation, manufacture, distribution and sale of drugs.
- The traditional objectives of demand-side law enforcement have been to increase the costs of drug consumption and use the moral force and declarative functions of the law to reduce the demand for illicit drugs. The traditional objectives of supply-side law enforcement have been to reduce the supply and/or increase the price of illicit drugs so as to decrease consumption. Demand- and supply-side drug law enforcement tend to overlap in practice because of the nature of drug markets, specifically the fact that a significant proportion of suppliers are also users and they engage in trafficking to finance their habit or addiction.
- Modern approaches to drug law enforcement often include two additional objectives: to minimise both drug-related harm and the damage caused by drug laws and their enforcement. All Australian jurisdictions have now adopted drug law enforcement strategies that aim to reduce illicit drug use, drug-related harm and the damage enforcement causes to society.
- The argument that strict drug laws can be used to reduce drug use and drug-related harm is based on deterrence theory, which posits that individuals will rationally weigh up the costs and benefits associated with a proposed course of action before undertaking it. According to the theory, drug laws and law enforcement can deter people from participating in illicit drug markets by reducing relevant benefits and the probability of obtaining them and increasing relevant costs and the probability of incurring them.

4.3 Reducing harm to individuals

Another argument used to promote and defend drug laws is that they are able to reduce the harms to drug users and prospective drug users. Most of the arguments, theories and mechanisms that were discussed above in Section 4.2 also apply here. The more fundamental question in this context is why should the state take steps to prevent individuals from harming themselves?

As discussed, liberalism assumes the individual is best placed to determine how to maximise their utility. Subject to the need to prevent negative externalities, liberalism suggests that if each individual is left to pursue happiness in their own way, there is a greater chance that net social welfare will be maximised. If this is the case, how can a liberal society justify intruding on the freedom of the individual to prevent drug use when the majority of drug use does not result in any harm to anybody other than the user?

A common response is that drug laws protect those who do not have a reasonable capacity to engage in rational thought. Mill recognised that the liberal ‘doctrine is meant to apply only to human beings in the maturity of their faculties’ (Mill 1859, Chapter 1, para. 10).²³ As a result, drug laws that protect children, adolescents and the mentally disabled are arguably consistent with liberal ideology. Recent research indicates that young adults may even fall within this category due to the late development of brain functions that are essential in processing information and controlling behaviour (Beckman 2004; Ortiz 2004; Luna *et al.* 2004).

Mature adults who suffer from no debilitating mental illness or handicap will usually have sufficient capacity to engage in rational decision making concerning drug use. Yet, drug use can cause mental illness and inhibit the capacity for rational thought, particularly amongst dependent users (Degenhardt *et al.* 2003a; 2003b; Zweben *et al.* 2004; Hall *et al.* 2004a; Gowing *et al.* 2002). Due to these effects, some may argue that drug laws are justifiable and consistent with liberal concepts. However, not all drugs are addictive and not all drug use will inhibit an individual’s ability to engage in rational decision making when they are not intoxicated.

The standard non-liberal response to questions regarding the legitimacy of the role of the state in regulating individual behaviour is that the state has a responsibility to protect its citizens, both from themselves and others. This concept is often described as legal paternalism (MacCoun and Reuter 2001). One advocate of legal paternalism has argued simply that:

... it is always a good reason in support of a prohibition that it is necessary to prevent harm (physical, psychological, or economic) to the actor himself (Feinberg 1988, p. xix in MacCoun and Reuter 2001, p. 62).

A number of the individuals and groups in Australia that are strongly in favour of prohibition rely heavily on the threat of harm to individuals (Salvation Army RSCPRD 1999; Community Coalition for a Drug Free Society (Vic) 2002). Some have even argued that governments have a moral duty to criminalise the use and supply of drugs because of the threat it poses to human life. As the former Liberal Member for Parramatta, the Hon Ross Cameron MP, stated in Federal Parliament in 1999:

I uphold and support the idea that we make criminal both the sale and the use of drugs which kill people. ... I am not here to pass judgment on the decisions of individuals. What I am here to say is that we as a government have at times an unpleasant and difficult duty to enforce and uphold a principle of life (Cameron 1999).

²³ See also Mill (1859, Chapter 5, para. 5).

Legal paternalism can be expressed as a desire to protect all current and prospective drug users, as encapsulated in the above quotation. It can also be more specific, as in the case where the argument is framed in the context of the need to protect particular groups that are vulnerable to the effects of drugs. As the Salvation Army has stated:

[e]xperiments with legalisation involve risks for society overall, but those most at risk are those most vulnerable in our community, in particular young teenagers and marginalised groups such as street kids (Salvation Army RSCPRD 1999, p. 23).

It has been argued that groups in particular need of protection include young people, the mentally ill, Indigenous Australians, the poor, and certain ethnic or migrant groups (Manderson 1993; Salvation Army RSCPRD 1999; Watters 1999; Ministerial Council on Drug Strategy 2001a). The individuals in some of these groups may have limited capacity to process information (for example, children, teenagers, young adults and the mentally ill). In other cases, the protection is potentially justifiable on the grounds that social disadvantage heightens their vulnerability to the effects of illicit drugs (for example, certain migrant groups and the poor (Loxley *et al.* 2004)).

Key points

- It is often argued that strict drug laws are justifiable on the grounds that they can reduce harm to drug users and prospective users.
- From a liberal perspective, this argument can be based, at least partially, on the notion that certain members of society have a diminished capacity to engage in rational thought (for example, minors and the mentally handicapped) and that certain drugs restrict the capacity of users to engage in rational thought. Two weaknesses in this argument are that not all drugs are addictive and rarely do drugs appear to eliminate the capacity for rational thought when users are not intoxicated.
- From a non-liberal perspective, the argument can be based on the notion that the state has a responsibility to protect citizens from themselves and others (i.e. legal paternalism).
- In order to justify their position, groups that oppose more liberal drug laws in Australia often rely heavily on the threat that drugs pose to individuals.

4.4 Promoting and protecting moral values

The other common justification for drug laws is morality, the notion that taking drugs is inherently wrong (Manderson 1993; McDonald *et al.* 1994). Up until the second half of last century, morality lay at the centre of drugs policy (Manderson 1993). Drug users were often vilified as being morally depraved and their drug use was an evil that needed to be expunged from society (Manderson 1993). Over time, questions of morality have been relegated to a lesser role as economics and social and political influences have come to dominate drug policy (Manderson 1993). Yet, there is little doubt that moral ideals are still influential in drug debates and the development of drug policy.

The influence of moral factors is often concealed behind economic objections to liberal drug laws (McDonald *et al.* 1994). However, many individuals and organisations are unapologetic in their appeal to morality. For example, in the context of debates concerning prescribed heroin, the Salvation Army has stated that it:

... is philosophically opposed to the provision of mind-altering substances that are proven to be physically dangerous, and which we believe to be emotionally, psychologically, and even spiritually harmful (Salvation Army RSCPRD 1999, p. 24).

In a debate in the Victorian Parliament in 1996 concerning drug policy, the Liberal Member for Sandringham, the Hon Murray Thompson MLA, stated bluntly that:

I have an unashamed declared bias on this issue. I seek to assert and advance laws that strengthen family life and advance the intellectual, physical and spiritual wellbeing of the community (Thompson 1996).

During the same debate, Gary Rowe MLA (the then Liberal member for Cranbourne) gave a clear indication of the influence of moral arguments and the depth of feeling some people have towards drug issues when he stated that:

[p]erhaps one of the biggest problems with our society today is too much freedom, too much liberalisation of attitudes to morals. We have only to look at the problems of single mothers and the like to know there is a breakdown of the moral fibre of society. ... I think we need to look at the penalties being imposed on drug traffickers and make sure judges and magistrates have little discretion to provide lenient sentences for those who traffic in illicit drugs. Perhaps our Asian neighbours to our north go a bit far when they use firing squads; but then again, perhaps not. Perhaps as a multicultural society Australia should embrace some of the values on law enforcement of our Asian neighbours (Rowe 1996).

Similar morally-charged sentiments were expressed in the Queensland Parliament in 2001 when the independent member for Nanango, the Hon Dorothy Pratt MLA, stated in the context of proposals concerning retractable syringes that:

[i]n this society we reward all that is morally weak, make legal all that is immoral and pull down all the boundaries that guide society (Pratt 2001).

The Howard Government has also been keen to place its drug policies in a moral framework. For example, in launching the National Illicit Drug Strategy in 1997, the Prime Minister said that the policy was 'all about providing moral leadership on drugs' for the sake of parents and their children (Howard 1997).²⁴ One of his key advisors on drug policy, Major Brian Watters from the Salvation Army, has said that:

I believe addiction is a sin. I know it's a medical and psychological problem, but the Bible tells us that sin is falling short of our potential. It tells us we should not be mastered by things ... it also tells us to keep the body pure as it

²⁴ See also Howard (1999).

is a temple of the Holy Spirit (Watters quoted in Families and Friends for Drug Law Reform (ACT) Inc. 2004, p. 14).²⁵

There is little doubt that moral arguments have played, and will continue to play, a major role in drug policy debates in Australia.

²⁵ See also Watters (1999), p. 36.

5. Flaws in the strict prohibition approach

The principal flaws associated with a strict prohibition approach are encapsulated in five arguments:

- the direct costs of prohibition are extremely high;
- prohibition has adverse side effects that can be just as bad as, and perhaps even worse than, the harms associated with illicit drug markets;
- prohibition is not effective in suppressing illicit drug markets nor in reducing drug-related harm;
- there are alternatives to the strict prohibition approach that are likely to be more effective in reducing the social and personal costs associated with illicit drug markets; and
- the current prohibition approach is unfair: it results in an illogical and inconsistent treatment of different drugs and other dangerous behaviour, it is inconsistent with the values that are supposed to underpin our society, and it punishes victims and people who have a diminished capacity to control their behaviour.

Details of the first two arguments are outlined in Sections 5.1 and 5.2. The remaining three arguments are considered in Sections 6, 7 and 8 respectively.

5.1 The direct costs of prohibition

By any measure, the direct costs associated with strict drug laws are extremely large (Wagstaff and Maynard 1988; Kleiman 1992; Collins and Lapsley 2002). According to Collins and Lapsley (2002), the police, court, and prison costs attributable to illicit drugs in 1998/99 in Australia were \$1.427 billion. To this must be added the loss in productivity that arises when drug users' liberties are restricted as punishment for drug offences. In 1998/99, these losses were conservatively estimated to be \$580 million, which brought the total direct costs to over \$2 billion (Collins and Lapsley 2002). Yet, even this amount is likely to be an underestimation of the real figure as it does not include the expenses incurred in developing and debating drug laws and in monitoring their effectiveness (i.e. research or information costs).

The direct costs associated with prohibition are not limited to productivity losses and the expenses incurred when drug users and dealers are apprehended, prosecuted and punished. They also include such things as court digestion and delays caused by the additional pressure placed on the judiciary as a result of the large volume of illicit drug cases. Prison systems can also become overcrowded, a situation that is particularly evident in the United States.

A further direct cost of prohibition is that it has resulted in people being denied the medical benefits associated with certain illicit drugs. The most well-known example is cannabis, which has legitimate medicinal uses that have not been widely utilised as a result of strict and often illogical drug laws. Although no dollar value has been

calculated for the losses associated with this issue, it is nonetheless a real cost that is attributable to prohibition.

More controversially, the direct costs of prohibition should also include the loss of pleasure to drug users. One of the main reasons people use drugs is for the enjoyment they provide. Prohibition seeks to deny people this enjoyment, even in situations where no drug-related harm will result. Thus, prohibition can result in a loss of pleasure that would otherwise have been derived from illicit drug use.

5.2 The indirect costs of prohibition

Any public policy more complicated than planting flowers by the roadside also has unwanted side effects, and controlling drug use is considerably more complicated than planting flowers (Kleiman 1992).

The above extract from Mark Kleiman's 1992 book *Against Excess: Drug Policy for Results* refers to another of the major flaws associated with prohibition – that it has significant adverse side effects that can be just as bad as, or even worse than, the harms associated with illicit drug markets. Some of the more important indirect costs of prohibition are discussed below.

Prevention of quality control

By removing the drug market from the normal commercial sphere, prohibition prevents the state and consumers from exercising effective control over the purity and quality of illicit drugs.

The nature of illicit drug transactions makes it difficult for consumers to identify the precise nature of the drug until after they have consumed it. Further, as drug transactions are illegal, users have no means of seeking a legal remedy if they find the product is of poor quality. As a result, prohibition acts to increase the capacity for drug dealers to defraud users by 'cutting' drugs with other substances. More importantly, by doing so, prohibition magnifies the risks to drug users as the variability in quality can have adverse health effects.²⁶

Violence and corruption

Illicit drug markets, like most illegal markets, are often characterised by violence and corruption (Kleiman 1992; Wood 1997; Wood 2001; Queensland Criminal Justice Commission 2001; COOPIC 2002; Victorian Ombudsman 2003; Kennedy 2004). This is a product of the absence of legal remedies for those involved in drug transactions and the need for participants to avoid detection by government authorities (Stevenson 2001). The prices and profit margins in illicit drug markets are also usually relatively high compared to those available in licit markets, and they are often

²⁶ Contrary to common belief, the available evidence suggests that variability in the purity of heroin is not a major cause of heroin overdose deaths. More important contributing factors appear to be the tendency of many heroin users to co-administer alcohol and other depressant drugs with heroin and their reluctance to seek medical assistance in emergencies (Zador *et al.* 1996; Hall 1996). However, there is little doubt that variability in the quality of drugs is an important health issue. For example, variability in the products sold as ecstasy has been linked to increases in health complaints and overdoses (Spruit 1999).

well above the levels that would be expected if the drug markets were legal (Kleiman 1992; Miron 2003). This increases the attractiveness of drug production and trafficking to criminals. Further, as the intensity of drug law enforcement increases, prices and profit margins tend to rise, thereby providing a greater incentive for the involvement of organised crime networks that are better able to avoid detection and engage in violence and corruption (Kleiman 1992).

The social disruption that characterises illicit drug markets not only affects users, dealers and the government officials and agencies that are corrupted. Third parties can be injured or killed in drug-related violence (MacCoun and Reuter 2001). Corruption can destabilise the political and legal systems and give rise to flow-on effects that threaten the safety and well-being of the general community (Maher *et al.* 1997; Wood 1997; MacCoun and Reuter 2001; Wood 2001; Victorian Ombudsman 2003). The black market for drugs can also undermine public respect for the law and confidence in those who enforce it (Stevenson 2001; MacCoun and Reuter 2001).

Drug-related corruption is commonly associated with Asian and South American countries where illicit drug production and distribution are often major contributors to local economies. While in Australia the corruption is not on the scale seen in some other countries, a large number of government inquiries (including at least three Royal Commissions into police corruption) have found that it is rife within domestic institutions and that it is extremely difficult, if not impossible, to eradicate (Wood 1997; Queensland Criminal Justice Commission 2001; COOPIC 2002; Victorian Ombudsman 2003; Kennedy 2004).

Increased risk taking by drug users

The legal status of drug use and possession can lead to risk-taking behaviour on behalf of drug users (Kleiman 1992; Weatherburn *et al.* 1999; Malkin 2001). Of considerable concern is the incentive for intravenous drug users to share syringes as a result of the fear of being prosecuted for self-administration or the possession of injecting equipment (Maher *et al.* 1998; Weatherburn *et al.* 1999). Drug laws can also provide an incentive for drug users to dispose of syringes in an unsafe manner which can lead to needle stick injuries (Maher *et al.* 1998; Weatherburn *et al.* 1999). The sharing of syringes and needle stick injuries can lead to the transmission of blood-borne diseases such as hepatitis and HIV/AIDS (Weatherburn *et al.* 1999).

In addition, when acute adverse health problems arise (for example, overdoses), drug laws can decrease the willingness of drug users to seek medical assistance due to their fear of being apprehended (Hall 1996; Darke *et al.* 1996; Spooner *et al.* 2004). An Australian study involving heroin users in Sydney found that an ambulance was called in only 56 per cent of overdose incidents; almost half (44 per cent) of respondents who had been present at an overdose indicated that something had delayed or stopped them from seeking medical assistance; and '[f]ear of police involvement was overwhelmingly the main reason for stopping or delaying seeking help' (Darke *et al.* 1996). This fear of prosecution results in a refusal to seek treatment, or at least a delay in seeking it, and is likely to be a significant cause of mortality and morbidity amongst drug users.

Drug laws and various enforcement tactics can also result in people adopting unsafe consumption practices, including taking large doses in short periods, swallowing

drugs to avoid detection, substituting alternative drugs that may be more dangerous and consuming drugs in situations where they are unlikely to be able to obtain help if difficulties arise (Maher *et al.* 1998; Weatherburn *et al.* 1999; Malkin 2001).

Loss of reputation, self-esteem and socialisation with other drug users and criminals

A further problem associated with drug laws and drug law enforcement is that they stigmatise drug users as criminals, publicly expose their drug habits, potentially reduce their respect for the law and force them to interact with criminals and other drug users. Consequently, drug laws can cause employment, relationship and accommodation problems, exacerbate and even trigger drug misuse issues and increase the risk that drug offenders will be involved in more crime (Lenton *et al.* 1999; Spooner *et al.* 2004; O’Callaghan *et al.* 2004). These negative impacts are most acute when offenders are incarcerated. According to O’Callaghan *et al.* (2004, p. 189):

... incarceration may serve to maintain and in some cases even exacerbate individuals’ drug problems by placing them into a socially isolated subculture where drug use is the norm.

The potential for prohibition and drug law enforcement to cause economic and social difficulties and to worsen drug problems is not confined to those instances when users are imprisoned. The fact that users are forced to interact with criminals to obtain illicit drugs can often be enough to draw them into a criminal subculture which can foster further drug problems (for example, dealers may progressively introduce users to harder drugs). Similarly, interaction with the criminal justice system, even if it does not lead to a custodial sentence, can cause employment and other relationship difficulties and increase the risk of further crime (Lenton *et al.* 1999).²⁷

The risks associated with the enforcement of drug laws are particularly acute for young users. A large proportion of teenagers and young adults experiment with drugs for a short period of time but do not progress to become problematic users. However, prosecution of these users can create or contribute to drug and criminal problems that would not otherwise have occurred. Even where prosecution does not trigger further problems with drugs and the law, it can have consequences for the educational and employment prospects and the personal and social development of these young people. As de Kort and Cramer (1999, p. 481) state in relation to the prosecution of cannabis offences:

[c]riminal prosecution of young cannabis users can lead to stigmatization and various forms of secondary deviance. As a general rule, these negative consequences pose a greater risk than the experimental use of cannabis.

Increase in crime due to higher drug prices

Drug laws and drug law enforcement can increase crime rates due to their impacts on prices. As discussed, this can be a product of high prices and profit margins attracting organised criminals to the drug trade, thus exacerbating problems associated with

²⁷ The potential for prohibition to increase drug problems by socialising users with criminal networks is discussed in greater detail in Section 6.2.

corruption and violence. In addition, by reducing availability and increasing the costs of supply, drug laws and drug law enforcement can increase the price of illicit drugs, thereby motivating greater criminal activity by drug-users in order to finance their drug use (Wagstaff and Maynard 1988; Kleiman 1992; Weatherburn *et al.* 1999; Ministerial Council on Drug Strategy 2001b). As the Ministerial Council on Drug Strategy (2001b, p. 26) has stated:

[u]sers typically resort to drug dealing, property crime and prostitution (in that order) to fund their addiction. Many heroin users are involved in criminal activity before they become addicted, but the effect of drug-law enforcement is to increase greatly the amount of crime they commit.

The severity of this problem is partly dependent on the price elasticity of demand for the relevant illicit drugs. Early drug policy literature often assumed that the demand for illicit drugs is highly price inelastic – a one unit increase in price will result in no change in demand (perfect inelasticity) or a less than proportional decrease in demand (relative inelasticity).²⁸ This assumption was founded on the argument that the addictive qualities of drugs make user behaviour resilient to price changes. On this basis, it was argued that restricting supply and increasing drug prices would increase spending on drugs without resulting in a significant decline in consumption. To meet the additional costs of consumption, drug users would then resort to committing more property crime. Hence, supply-side drug law enforcement may do greater harm than good because it causes more crime than would otherwise have occurred.

The view that the addictive characteristics of illicit drugs necessarily leads to drug demand being highly price-inelastic has faded in recent times in response to new research and analysis.²⁹ The best available evidence indicates that the demand for illicit drugs is often responsive to price, but that price elasticities vary between substances and the types of users. According to the addiction theory, the demand for ‘hard drugs’ like heroin and cocaine should be highly price inelastic, while demand for ‘soft’ drugs like cannabis should be more price elastic. The weight of evidence suggests that the reverse is likely to be true, cannabis demand being price inelastic and heroin and cocaine demand being inelastic in the short-term, but elastic in the long-term.³⁰ This may be due to the relationship between drug prices and the disposable incomes of users.

As heroin and cocaine are relatively expensive, the money spent on purchasing them is likely to constitute a significant proportion of a user’s disposable income. Price

²⁸ See White and Luksetich (1983), Wagstaff and Maynard (1988), United Nations International Drug Control Programme (1997), United Nations Office on Drugs and Crime (1998), and Caulkins (2002) for details of relevant earlier research.

²⁹ See White and Luksetich (1983); Wagstaff and Maynard (1988); Weatherburn and Lind (1997); United Nations International Drug Control Programme (1997); United Nations Office on Drugs and Crime (1998); Rhodes *et al.* (2000); Caulkins (2002); Clements (2004).

³⁰ There is also evidence that the price elasticity of demand for illicit drugs varies depending on the types of users and the prices involved. For example, a United States study found that the initiation of cannabis use was responsive to price increases (although this may have been due to decreased availability rather than price), as was demand amongst people who were arrested for drug use. Yet, the study found demand for cannabis amongst existing weekly and occasional users was price inelastic, with demand becoming progressively more elastic as the frequency of use increased (Rhodes *et al.* 2000). These findings are consistent with the notion that the relationship between price and disposable income is an important determinant of the price elasticity of demand for illicit drugs.

risers are, therefore, more likely to impose a greater burden on users' lifestyles. Immediately following a price increase, users may maintain use at previous levels and resort to additional crime to finance their addiction. But in the long-term, the price rise may motivate users to alter their behaviour, either by reducing usage, abstaining altogether, or switching to other drugs.

The Australian heroin shortage that began in the early 2000s displayed an apparent consistency with this pattern. Price rises caused by the decrease in supply of heroin appeared to cause an initial increase in acquisitive crime. As the shortage persisted however, acquisitive crime rates fell, along with heroin overdose rates and heroin related deaths (Day *et al.* 2004; Hall *et al.* 2004b; Collins *et al.* 2004; Smithson *et al.* 2004; Degenhardt *et al.* 2005). The drop in heroin availability and purity, along with the increase in price, also appears to have prompted a significant number of heroin users to switch to other illicit substances such as cocaine, methamphetamine and benzodiazepine (Topp *et al.* 2003; Baker *et al.* 2004; Collins *et al.* 2004; Roxburgh *et al.* 2004; McKetin and McLaren 2004).³¹

The fact that the demand for illicit drugs is more responsive to prices than first believed does not dispel the link between drug laws and crime. Drug laws cause drug prices to be higher than they would be in a legal market, which motivates drug users to commit crime.³² Further, so long as the demand for some illicit drugs is relatively price inelastic (even if only to some users in certain price ranges), any enforcement measures that increase the price of the pertinent drugs will result in a less than proportional decrease in use and an increase in drug spending amongst the relevant user group, with a consequent increase in the motivation to engage in acquisitive crime.

Drug substitution

The evidence that the Australian heroin shortage resulted in heroin users switching drugs is consistent with research that has been carried out on the relationships between other legal and illegal intoxicating substances, including cannabis and alcohol (Chaloupka and Laixuthai 1997; Jones and Weatherburn 2001; Cameron and Williams 2001; Dickert-Conlin *et al.* 2002). This raises the prospect that any decrease in drug use and drug harm associated with law enforcement efforts targeted at one drug may be offset by increases in the consumption of another drug and the harm caused by it. This may have occurred in the case of the heroin shortage where rising rates of methamphetamine and cocaine use have coincided with an increase in the incidence of stimulant-related drug harms (for example, psychosis and violence) and demand for stimulant treatment (Collins *et al.* 2004). There is also evidence that greater stimulant use has led to an increase in violent crime and the proportion of violent offenders testing positive for cocaine and methamphetamine (Degenhardt and Collins 2004; Collins *et al.* 2004), which has had negative consequences for the police.

³¹ Drug traffickers may have reacted in a similar manner to the shortage by simply shifting to the supply of other drugs, particularly potent forms of methamphetamine (for example, crystal meth or ice), or to other criminal activity (Degenhardt and Collins 2004; McKetin *et al.* 2005).

³² See Section 5.3 for more details of the effect of drug laws and drug law enforcement on drug prices.

The behavioural consequences of the use of cocaine and methamphetamine had significant implications for police, who needed to deal with an increase in incidences involving violent and aggressive individuals ... (Degenhardt and Collins 2004, p. 88).

While there is evidence of substitution between illicit and licit drugs, the nature of the relationships between specific drugs is far from clear. For example, there is a considerable amount of conflicting evidence regarding the question of whether alcohol and cannabis are substitutes or complements (Williams *et al.* 2001; Clements 2004; Williams and Mahmoudi 2004). If the two drugs are substitutes, strict cannabis laws with relatively lax alcohol laws will, all things being equal, result in higher alcohol use and lower cannabis use. Conversely, if cannabis and alcohol are complements, any measure that reduces the consumption of one substance will also lower consumption of the other. The nature of the linkages between drugs is of considerable importance as it will influence the pattern of harm that results from particular drug policies.

Mental illness

Although there are significant gaps in the current research regarding comorbidity of mental health and substance use disorders, what is available strongly suggests that the overlap between these issues is considerable (RachBeisel *et al.* 1999; Teesson and Proudfoot 2003; Andrews *et al.* 2003; Loxley *et al.* 2004). This relationship is extremely important, as individuals presenting with both illnesses have been found to be associated with poor treatment outcomes and high service utilisation (Teesson and Proudfoot 2003; Loxley *et al.* 2004). There is also evidence that certain mental illnesses can be worsened and extended by substance misuse disorders and *vice versa* (RachBeisel *et al.* 1999; Proudfoot *et al.* 2003). Further, sufferers of mental and substance use illnesses can be difficult to treat and pose unique problems for those involved in the delivery of prevention and treatment services (Dadds and Atkinson 2003; Loxley *et al.* 2004).

The question of why there is such a striking overlap between mental illness and substance use disorders remains to be answered definitively (Degenhardt *et al.* 2003a). Some people with mental illnesses tend to self-medicate with licit and illicit drugs, only to find that the drug use leads to a substance disorder. There is also evidence that certain drugs cause mental illness, or precipitate mental illness in individuals that are already susceptible to these diseases (Loxley *et al.* 2004). Another contributing factor appears to be the fact that mental and substance use illnesses share common risk factors. As Degenhardt *et al.* (2003a, p. 19) explain:

[w]hile at present there remains much that is not known about the causes of comorbidity, there is increasing evidence to suggest that simple causal hypotheses may not easily explain the association. There is a broad convergence of risk factors for both problematic substance use and mental disorders; a plausible hypothesis for the comorbidity between these disorders is that substance use and mental disorders ... share common risk factors and life pathways.

The prevention and treatment services currently provided to people suffering from mental health and substance use disorders in Australia is grossly inadequate

(Proudfoot *et al.* 2003). This is attributable both to underinvestment in relevant health services and the strict division that exists between the mental health and substance use health sectors, which has led to a lack of coordination and poor service delivery (Proudfoot *et al.* 2003; Teesson and Proudfoot 2003). The dearth of appropriate services has left a significant proportion of the population in a vulnerable position, a situation that is only made worse by prohibition.

Drug law enforcement can exacerbate the causes of mental health and substance use disorders, inhibit the ability and willingness of sufferers to seek and obtain treatment and reduce the chances of recovery. Imprisoning people suffering from these illnesses is the most obvious way that prohibition aggravates their causes and impedes recovery because it results in the severance of social ties which are often important to overcoming mental health and substance use disorders (Kawachi and Berkman 2001; Hoffman and Kupper 2002; Liberman 2002; Treloar *et al.* 2004). In addition, inmates are subject to additional stresses associated with prison life (for example, threats of violence) and often have reduced access to health services; both factors being detrimental to recovery (Herbert 1997; Treloar *et al.* 2004). Even where drug offenders are not imprisoned, the negative effects of drug laws and drug law enforcement work against the treatment of those suffering from these disorders. Drug law enforcement places additional pressures on sufferers trying to obtain and consume drugs, and when they are apprehended, aggravates the factors that contribute to mental illness and substance disorders (for example, family dysfunction, social and economic disadvantage and stress (Degenhardt *et al.* 2003a)), thus creating additional barriers to recovery.

Given the negative effects that prohibition and drug law enforcement have on mental health and substance use disorders, and the lack of appropriate treatment services, it is not surprising to find that inmate populations have disproportionately high rates of these illnesses (Butler and Milner 2003; Makkai and Payne 2003; Johnson 2004; Prichard and Payne 2005). While incarceration may serve to remove these issues from the view of the broader community temporarily, the long-term effect of prohibition is to magnify the severity of the comorbidity problem and the costs that it imposes on society.

Key points

- The direct costs associated with strict drug laws are extremely large. The police, court, and prison costs that were attributable to illicit drugs in 1998/99 in Australia have been estimated at \$1.427 billion. During the same year, productivity losses due to the punishment of drug offenders were estimated at \$580 million.
- Strict drug laws and drug law enforcement have many adverse side effects that can be just as bad as, or worse than, the harms associated with drug use. These include corruption, violence and increased risk-taking behaviour on behalf of drug users due to the desire to avoid detection and prosecution. By stigmatising drug users as criminals, publicly exposing their drug habits, reducing their respect for the law and forcing them to interact with criminals, drug laws can also cause employment, relationship and accommodation problems, exacerbate drug misuse problems and increase the risk that drug

offenders will be involved in more crime. A summary of the direct and indirect costs of prohibition are outlined in Table 1.

Table 1 Taxonomy of the costs of prohibition

Category	Harm/cost	Who bears the harm/cost?			
		Users	Dealers	Family and friends	Society
Health	Prevention of quality control	v		v	
	Increase risk of unsafe consumption	v		v	
	Increase risk of disease transmission	v		v	v
	Inhibit pursuit of drug treatment	v		v	
	Cause or exacerbate drug use and dependency problems	v		v	
	Cause or exacerbate mental illness	v		v	
	Restrictions on beneficial uses of drugs				v
Social and economic	Acquaintance with criminal networks	v	v	v	v
	Harm reputation and self-esteem	v	v	v	
	Employment problems	v	v	v	
	Relationship problems	v	v	v	
	Accommodation problems	v	v	v	
	Financial problems due to higher prices	v		v	
	Restrictions on personal freedom	v	v	v	v
Safety and public order	Increase in acquisitive/property crime			v	v
	Increase in violence	v	v	v	v
	Fear and sense of public disorder				v
	Expansion of organised crime				v
Criminal justice	Increase in police, court and prison costs				v
	Corruption of government				v
	Undermine respect for law				v
	Invasion of privacy	v	v	v	
	Court congestion and delay				v
	Pressure on prison system				v
	Financial problems due to fines	v	v	v	
	Loss of income and time	v	v	v	
	Loss of tax revenues and output				v

Source: Based on the 'taxonomy of drug-related harms' contained in MacCoun and Reuter (2001, pp. 106 - 107).

- Drug law enforcement can result in drug substitution, meaning that any decrease in drug use and drug harm that is associated with law enforcement

efforts targeted at one drug may be offset by increases in the consumption of another drug and the harms caused by it.

- Previous assumptions that the demand for drugs is necessarily price inelastic appear to be incorrect. The available evidence suggests the demand for many drugs is price sensitive, at least at current drug prices, and that the demand for ‘hard’ drugs like heroin and cocaine is more price elastic than the demand for ‘soft’ drugs like cannabis. Notwithstanding this evidence, drug laws and law enforcement continue to have the potential to increase crime because they result in drug prices being higher than they would otherwise be and there is evidence that the demand for many drugs is relatively price inelastic (at least for some users in certain price ranges).
- Drug law enforcement can exacerbate the causes of mental health and substance use disorders, inhibit the ability and willingness of sufferers to seek and obtain treatment and reduce the chances of recovery.
- Given the extent of the direct and indirect costs associated with drug laws, there is a risk that the total cost associated with drug law enforcement may exceed the associated social benefits (i.e. drug laws may be a net cause of harm). There is also a risk that the harm to individual drug users caused by drug laws may exceed or exacerbate the harms associated with drug practices.

6. Effectiveness of strict drug laws

The great argument of anti-prohibitionists is a practical one: “Prohibition doesn’t work” (Kleiman 1992).

This relatively simple statement sums up many peoples’ opposition to strict drug laws and their enforcement. Their view is that drug prohibition has not substantially reduced the supply of illicit substances, nor has it significantly reduced consumption or drug-related harm (Cowdery 1999; Wodak 1999; Wodak and Moore 2002). For example, Alex Wodak has described Australia’s law enforcement-based drug policies as a ‘comprehensive and resounding failure’ (Wodak 1999, p. 203). Some go further, arguing that drug laws generate a ‘forbidden fruit’ effect, which may result in an increase rather than a decrease in demand (Filley 1999).³³ There is also a possibility that the criminalisation of drug use and associated punishments could increase the size of drug markets in certain circumstances by perpetuating social disadvantage and socialising people with criminals.

These arguments give rise to two main issues concerning the efficacy of prohibition.

- Has prohibition substantially reduced illicit drug use and drug-related harm?
- Does prohibition promote drug use?

6.1 Has prohibition substantially reduced drug use and harm?

There is little doubt that illicit drug markets have grown significantly over the past 50 years despite stringent drug laws and drug law enforcement (Manderson 1993; Wodak and Moore 2002; United Nations Office on Drugs and Crime 2005). According to the United Nations Office on Drugs and Crime, in 2005 around five per cent of the world’s population aged 15 to 64, or 200 million people, had used illicit drugs at least once in the last 12 months (United Nations Office on Drugs and Crime 2005). In Australia, a significant proportion of the population have used and regularly use illicit drugs – see Table 2.

³³ See MacCoun and Reuter (2001) for a discussion of the details of the forbidden fruit hypothesis.

Table 2 Proportion of population (aged 14 years and over) using illicit drugs – lifetime and recent use (2004)

Illicit drug	Ever used*	Recent use**
Cannabis	33.6	11.3
Pain-killers***	5.5	3.1
Tranquillisers***	2.8	1.0
Steroids***	0.3	-
Barbiturates	1.1	0.2
Inhalants	2.5	0.4
Heroin	1.4	0.2
Methadone****	0.3	0.1
Other opiates***	1.4	0.2
Meth/amphetamine (e.g. speed and ice)***	9.1	3.2
Cocaine	4.7	1.0
Hallucinogens	7.5	0.7
Ecstasy	7.5	3.4
Ketamine	1.0	0.3
GHB	0.5	0.1
Any illicit	38.1	15.3

* Ever used – used at least once in lifetime.

** Recent use – used in the last 12 months.

*** For non-medicinal purpose.

**** Non-maintenance.

Source: AIHW 2005a.

Although the proportion of the total population that regularly uses drugs is small, it is nonetheless significant. Further, as Table 3 shows, a far greater proportion of people under 50 years of age are illicit drug users.

Table 3 Proportion of people (aged 14 years and over) using any illicit drug by sex and age group – lifetime and recent use (2004)

Age Group	Ever used			Recent use		
	Males	Females	Total	Males	Females	Total
14-19	28.2	30.4	29.3	20.9	21.8	21.3
20-29	61.1	55.1	58.1	37.5	25.6	31.5
30-39	62.6	53.6	58.0	25.5	15.1	20.2
40-49	51.0	40.4	45.6	15.0	9.5	12.2
50-59	31.6	20.9	26.3	7.6	4.8	6.2
60+	12.2	8.9	10.4	4.1	4.0	4.0
Aged 14+	41.8	34.4	38.1	18.2	12.5	15.3

* Ever used – used at least once in lifetime.

** Recent use – used in the last 12 months.

Source: AIHW 2005a.

In 2004, around one-quarter of people aged between 14 and 39 reported recently using illicit drugs and almost 50 per cent of people aged between 14 and 49 reported having used them at least once in their life. Most of the illicit drug use in these younger age groups involves cannabis (around 20 per cent of 14 to 39 year olds reported recent use of cannabis in 2004), although the use of meth/amphetamines and ecstasy is also significant (recent use of these drugs in the 14 to 39 year age bracket in 2004 was 6.4 per cent and 6.8 per cent respectively) (AIHW 2005a). There has been a slight decline in the reported use of illicit drugs in Australia since 1998, which appears to be attributable mainly to a fall in the reported use of cannabis (AIHW 2005a). However, overall, the figures demonstrate that the use of illicit drugs is reasonably widespread, particularly amongst younger age groups.³⁴

The prevalence of illicit drug use in Australia indicates that prohibition is incapable of eliminating illicit drug markets or even reducing them to an inconsequential size. If there were any doubt about this conclusion, it is expelled by the evidence from other countries, particularly the United States, where a fanatical ‘War on Drugs’ has failed to prevent widespread illicit drug problems (McDonald *et al.* 1994; Maxwell *et al.* 1997; Schiraldi *et al.* 2000; Schiraldi and Zeidenberg 2003).

In addition, as discussed in Section 5.2, there is evidence that prohibition can promote risk taking behaviour on the part of drug users, including needle sharing, binge consumption, drug switching, refusing to seek medical assistance and consuming drugs in situations where they are unlikely to be able to obtain help if difficulties arise. This type of behaviour can ultimately increase the individual and social costs of illicit drug use.

³⁴ There is even evidence that drug use is becoming normalised (i.e. a common and accepted behaviour) in younger age groups (Duff 2003).

Given the limitations of deterrence theory, it is not surprising that strict drug laws have failed to resolve illicit drug problems. The theory suggests that people will methodically weigh up the probabilities of success and failure and the likely gains and losses from engaging in, or abstaining from, criminal behaviour. Having done so, they will choose the outcome that is most likely to maximise their utility. In reality, people rarely process information in this manner (MacCoun and Reuter 2001).

Studies have shown that individuals often evaluate only one of the factors that are relevant to the determination of the most 'rational' course of action (MacCoun and Reuter 2001). There is also research indicating that many people tend to place greater emphasis on potential gains than on losses when determining whether to engage in a given activity (MacCoun and Reuter 2001). As a result, they often choose to sell or use drugs when it is clearly not in their best interests. Further, as MacCoun and Reuter (2001, p. 85 - 86) note:

... the rational choice paradigm is also unrealistic in its assumption that actions are necessarily reasoned at all. Like many behaviours, repeated drug use comes under the control of unconscious physiological and cognitive influences.

This works both ways. Some people reject drug use on the basis of morality or their self-image without engaging in a rational evaluation of the likely outcomes (MacCoun and Reuter 2001). Others may participate in illicit drug markets with limited rational thought. The most obvious example of unthinking drug behaviour is provided by drug addicts who suffer withdrawal symptoms, craving and other compulsive behaviour when they abstain from drugs, effects which can reduce addicts' capacity to engage in rational decision making. Even when drug users are not clinically addicted, drug use behaviour can become habitual, with little rational contemplation of the possible consequences (MacCoun and Reuter 2001). On this basis, MacCoun and Reuter (2001, p. 86) suggest that:

... legal sanctions should have the most influence on a person's initial decision to use drugs and then steadily diminish as use becomes more frequent.

The flaws in deterrence theory and the fact that illicit drug use is still widespread do not prove that strict drug laws have failed to reduce illicit drug use or drug-related harm substantially. The only way to prove categorically that prohibition is a failure is to establish what the patterns of drug use would be like under alternative legal regimes (i.e. how many people would use illicit drugs, how often and how they would use them). Unfortunately, the evidence concerning this issue is not conclusive (Ministerial Council on Drug Strategy 2001b; Loxley *et al.* 2004).

Evidence on demand-side drug law enforcement

There is now a considerable amount of evidence to suggest that the introduction of more liberal demand-side drug laws is unlikely to result in a significant long-term increase in cannabis consumption and cannabis-related health disorders (Johnson *et al.* 1981; Single 1989; Donnelly *et al.* 1999; Cameron and Williams 2001; Korf 2001; Loxley *et al.* 2004). Amongst the most compelling evidence concerns the patterns of cannabis consumption in the Netherlands.

In 1976, the Dutch Government created a formal legal distinction between hard and soft drugs. Cannabis was assigned to the latter category and, under government policies, minor cannabis offences were ‘assigned a low priority for prosecution’ (Boekhout van Solinge 1999, p. 513). The practical effect of these changes was that the possession and use of small quantities of cannabis were tolerated and ‘house dealers’ (who were later replaced by coffee shops) were allowed to sell cannabis (Boekhout van Solinge 1999; Korf 2001).³⁵ This approach and the broader Dutch drugs policy are based on four main principles (Boekhout van Solinge 1999; de Kort and Cramer 1999). The first is harm minimisation. The second is normalisation, which aims for the ‘depolarisation and integration of deviance’ rather than its ‘isolation and removal’ (Boekhout van Solinge 1999, p. 512). The third is ‘cultural integration’ – the idea that drug issues should be treated as part of a broader collection of social problems, including crime, disadvantage and poverty. The fourth is the desire to separate the cannabis and other ‘soft’ drug markets from those associated with harder drugs, an approach that has become known as the ‘separation of markets’. Authorities hoped in this way to reduce the incidence of soft drug users ‘graduating’ to harder drugs and decrease the adverse effects of drug law enforcement. Although changes have been made to Dutch drug laws over the past 30 years, the structure of the system has remained intact and the Netherlands still has a liberal approach to cannabis issues.³⁶

Despite vehement criticism from prohibition advocates and defenders of the international drug control regime, the liberal approach taken by the Dutch Government to the regulation of the cannabis market has not led to a marked increase in cannabis abuse (de Kort and Cramer 1999; Korf 2001). The incidence of cannabis use in the Netherlands is similar to that found in other European countries, as are the patterns of use since the 1970s (de Kort and Cramer 1999; Korf 2001; Ministerie van Volksgezondheid, Welzijn en Sport 2002; International Narcotics Control Board 2005; United Nations Office on Drugs and Crime 2005). The most recent United Nations’ *World Drug Report* places the Netherlands fourteenth out of 30 western and central European countries with respect to the annual prevalence of cannabis use (United Nations Office on Drugs and Crime 2005).³⁷ Until recently, all of the countries with higher prevalence rates have had stricter cannabis laws and enforcement policies than those in the Netherlands. Similarly, the rates of cannabis use are well below those in the United States, which has a strict prohibition regime, although the Netherlands, like the United States and many other countries, experienced significant increases in cannabis use during the 1990s (United Nations Office on Drugs and Crime 2005). The research that has been undertaken also indicates that most cannabis use in the Netherlands is of an ‘experimental and recreational’ nature (usually involving young adults) and that the rate of dependency

³⁵ Drug use is not illegal in The Netherlands. Therefore, the only crime a person commits if they consume a drug is that of possession of a prohibited substance (Spruit 1999).

³⁶ In 2002, the Dutch Government decided to make cannabis available as a prescription drug for medicinal purposes. These new provisions came into operation in September 2003 (Ketelaars *et al.* 2002; International Narcotics Control Board 2004).

³⁷ Comparing prevalence rates between countries is problematic because of differences in the methods used to measure drug use. Cultural differences can also account for different drug use patterns. Notwithstanding these issues, the available data consistently shows that cannabis use in the Netherlands is in the mid-range for European countries and there is no evidence that the non-enforcement of minor cannabis offences has had a notable impact on cannabis use or cannabis-related harm (de Kort and Cramer 1999; Korf 2001).

and abuse is low (de Kort and Cramer 1999; Korf 2001; Ministerie van Volksgezondheid, Welzijn en Sport 2002).³⁸

The experiment with more liberal cannabis laws in the Netherlands clearly supports the thesis that demand-side drug laws do not have a significant impact on cannabis use or the harms that the drug imposes on users and society. As Korf (2001) explains:

... trends in cannabis use in the Netherlands are rather similar to those in other European countries, and Dutch figures on cannabis use are not out of line with those from countries that did not decriminalise cannabis. The US figures consistently appear to be higher than those in the Netherlands. Over time prevalence of cannabis use show a wave-like trend in many countries, including the Netherlands. This supports Reuband's earlier conclusion that trends in cannabis use evolve rather independently from drug policy, and that countries with a 'liberal' cannabis policy do not have higher or lower rates than countries with a more repressive policy. Consequently, it is unlikely that decriminalisation of cannabis will cause an increase in cannabis use.³⁹

Korf's (2001) conclusion that more liberal cannabis laws are unlikely to result in an increase in use is supported by research conducted on the Cannabis Expiation Notice (CEN) scheme introduced in South Australia in 1987, which found that more liberal laws did not lead to a noticeable increase in cannabis use (Donnelly *et al.* 1999). According to Donnelly *et al.* (1999, p. v):

There has been a greater increase in self-reported lifetime cannabis use in South Australia between 1985 and 1995 than in the average of the other Australian states and territories. However, it seems unlikely that this increase is due to the CEN system because: similar increases occurred in Tasmania and Victoria (where there was no change in the legal status of cannabis use); the rate of increase in cannabis use among young adults aged 14 to 29 years was not significantly greater in South Australia than the other jurisdictions; and there was no increase in the rate of weekly cannabis use in South Australia between 1985 and 1995.

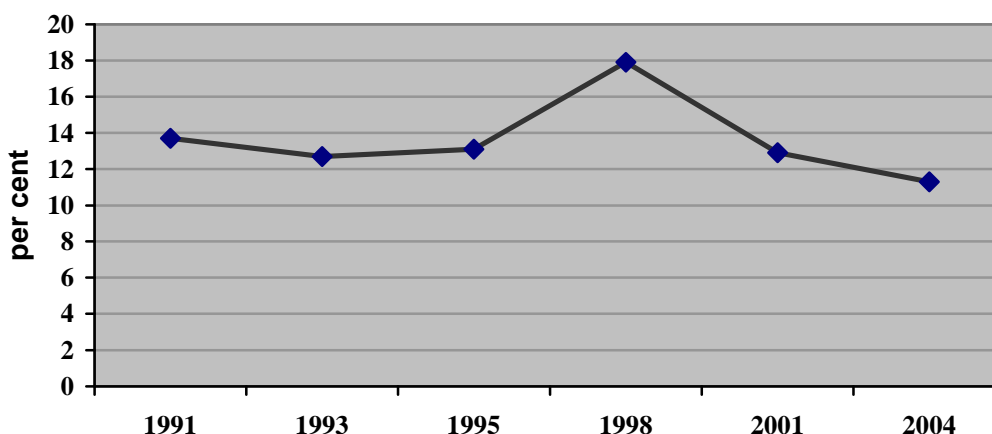
Other research on the impacts of the CEN scheme found that while its introduction led to an increase in the prevalence of cannabis use, this increase was short-lived and explained by the fact that it appeared to have temporarily delayed older users from giving up the drug rather than enticing new younger users (Cameron and Williams 2001). Within seven years of the introduction of the scheme, the increase in the probability of an individual from South Australia using cannabis had dissipated (Cameron and Williams 2001).

³⁸ In the early 2000s, studies revealed an increase in the monthly prevalence of cannabis use in the Netherlands. This trend was also seen in other European countries but the rates in the Netherlands remained below those seen in other countries (Ministerie van Volksgezondheid, Welzijn en Sport 2002; International Narcotics Control Board 2004; United Nations Office on Drugs and Crime 2005).

³⁹ It has been argued that increases in the prevalence of cannabis use during the 1990s (particularly in younger age groups) is attributable to an increase in the availability of the drug, which was allegedly brought about by an increase in the number of coffee shops (de Kort and Cramer 1999). Given the trends witnessed in other countries, this hypothesis seems unlikely.

The findings on the effects of the CEN scheme are consistent with a number of other studies that have looked at the impact of the introduction of more liberal demand-side cannabis laws on the prevalence of cannabis use in other countries (Johnson *et al.* 1981; Single 1989). Further, while prohibition with civil penalty regimes have been operating in four states and territories in Australia, and pre-arrest and pre-trial diversion programs have been expanded in the other jurisdictions, it appears the prevalence of cannabis use has fallen – see Figure 2.

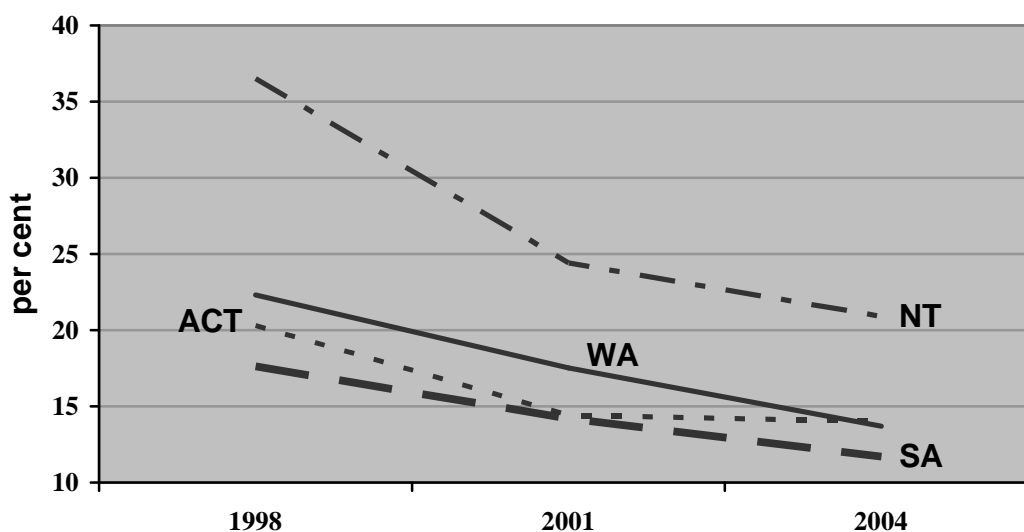
Figure 2 Trends in recent use of cannabis – proportion of population aged 14 and over, Australia 1993 to 2004



Source: AIHW 2005b

Not only has the prevalence of cannabis use fallen nationally, but it has also fallen in those states and territories that have cannabis expiation notice schemes – see Figure 3.

Figure 3 Trends in recent use of cannabis – proportion of population aged 14 and over, South Australia, Western Australia, ACT and Northern Territory 1998 to 2004



Source: AIHW 2005d; AIHW 2002b; AIHW 2000.

On the basis of this evidence, it appears that either strict demand-side drug laws have little impact on the prevalence of cannabis use or that the distinction between more liberal drug laws and prohibition is not of a sufficient magnitude to affect significantly the number of people using cannabis. As Loxley *et al.* (2004, p. 45) state:

[t]here is little evidence that the different legislative models in place in Australia and overseas have any significant effect on levels of cannabis use. This introduces the attractive possibility that reducing penalties might reduce harms while not increasing the rates of use.

Despite this, there is some research suggesting that demand-side drug laws may play a part in reducing the prevalence and frequency of cannabis use. A survey conducted in New South Wales in 2001 found that the illegal status of cannabis was the third most frequently endorsed reason for people not using or ceasing to use cannabis behind dislike (or suspected dislike) of the drug and concern about the health effects (Weatherburn and Jones 2001).⁴⁰ The same survey also found that although two-thirds of respondents said they would not use more cannabis if it was legalised, four per cent said they definitely would use more, 9.8 per cent said they probably would and 18.7 per cent said they probably would not (Weatherburn and Jones 2001). Importantly, the more frequently the respondents currently used cannabis, the more likely they were to say they would consider using more cannabis if it was legalised (Weatherburn and Jones 2001). On this basis, the authors concluded that:

[t]he present results suggest that, even if decriminalisation did not influence the prevalence of cannabis use, it could increase the frequency of cannabis use among existing cannabis users. They raise the possibility, moreover, that the effect of decriminalisation on consumption would be larger for those who presently use cannabis a lot than for those who use it only frequently (Weatherburn and Jones 2001, p. 7).

There are several reasons why the survey results may not be an accurate reflection of peoples' actual behaviour if demand-side cannabis laws were to be liberalised. These include the fact that the survey question asked respondents about their reaction to legalisation, not decriminalisation or prohibition with civil penalties. Yet, the results do raise an issue that should be considered by policy makers.

The other important result of the research undertaken by Weatherburn and Jones (2001) was that only a very small proportion of respondents listed fear of apprehension, fear of being imprisoned, the cost of cannabis or difficulty in obtaining it as reasons for not using or ceasing to use cannabis. These results raise questions about the validity of deterrence theory and the usefulness of drug law enforcement activities that seek to drive up the price and reduce the availability of cannabis.

Later survey work conducted by the same researchers on cannabis users found that over 70 per cent of respondent users said they would stop using or use less cannabis if they were imprisoned and around 58 per cent said they would stop using or use less

⁴⁰ A more recent national survey found that 'reasons related to the law' constituted the fourth most popular reason for never using illicit drugs, behind 'just not interested', 'reasons related to health or addiction' and not liking to 'feel out of control' (AIHW 2005b). However, the proportion of people citing legal reasons for abstinence (25 per cent) was well below the percentages attributed to no interest (76 per cent) and health and addiction issues (55 per cent).

cannabis if arrested (Jones and Weatherburn 2001). Yet, the results indicated that it was infrequent users rather than frequent users who were more likely to respond in this way to these circumstances (Jones and Weatherburn 2001). This is significant as most of the harm related to cannabis use is associated with frequent users (Weatherburn and Jones 2001; Jones and Weatherburn 2001). Further, there is evidence that cannabis users who are apprehended and penalised (either by way of a criminal or civil penalty) generally do not tend to alter their cannabis consumption, at least not in the short-term (Lenton *et al.* 1999; O'Callaghan *et al.* 2004). Evidence concerning the high rate of drug use amongst prisoners provides another reason to question the validity of the answers provided by the survey respondents (Butler and Milner 2003; Makkai and Payne 2003; Johnson 2004; Prichard and Payne 2005).⁴¹

Other arguments that could be used to defend the role of demand-side drug law enforcement include the following.

- Surveys of drug users have found that they often identify involvement in the criminal justice system as a reason for seeking treatment (Weatherburn and Lind 1997; Weatherburn *et al.* 1999). Despite these results, the magnitude of the role played by drug law enforcement in motivating drug users to seek treatment is unclear. Weatherburn and Lind (1997) were unable to find a statistically significant relationship between the price of heroin and contact with police and the willingness of heroin users to seek treatment. In contrast, Weatherburn *et al.* (1999) were able to find some statistically significant links between drug law enforcement and treatment, although the results were far from conclusive. For example, after controlling for age and time spent as a regular heroin user, their regression analysis did not find a significant relationship between arrest or imprisonment and methadone treatment experience. One complicating factor associated with the relationship between the criminal justice system and treatment is the high rates of acquisitive crime committed by drug users. The fact that drug users cite involvement in the criminal justice system as a factor for treatment may therefore have more to do with non-drug offences and lifestyle factors than with drug law enforcement.
- Formal and informal diversion programs may be able to link illicit drug users with treatment and prevention services, and could ultimately reduce the social costs associated with illicit drug use (Spooner *et al.* 2004). The most obvious way this could occur is through compulsory or coerced treatment programs. There is a distinct lack of data on the efficacy of compulsory and coerced treatment (Weatherburn *et al.* 1999; Bull 2003; Stevens 2004; Stevens *et al.* 2005). What is available presents an equivocal picture with respect to its effectiveness (Belenko 2001; Bull 2003; Stevens 2004; Stevens *et al.* 2005). Some studies have found that these programs can reduce drug misuse, health problems and crime,⁴² while others have found less promising results.⁴³ A broad review of international literature on the subject was able to conclude

⁴¹ There is also very little evidence that detection and deterrence programs result in reduced drug use in prisons (Loxley *et al.* 2004), which suggests that not only do a significant proportion of prisoners use drugs, but that their drug use behaviour is not affected by law enforcement while incarcerated.

⁴² See Hubbard *et al.* (1988); Hall (1997); Lind *et al.* (2002); Freeman (2002); Passey (2003); Barnes and Poletti (2004); Baker and Goh (2004); Hales *et al.* (2004); and Payne (2005).

⁴³ See Belenko (2001); Stevens (2004); Stevens *et al.* (2005).

only that ‘it cannot be said that coerced treatment inevitably produces worse outcome[s] than does voluntary treatment’ (Stevens *et al.* 2005, p. 275). Questions have also been raised about the methods used in a number of the studies that have produced positive results for these programs (Bull 2003; Stevens 2004; Stevens *et al.* 2005). Further problems include the fact that these programs are extremely expensive, have limited reach (i.e. they only capture users who are arrested), can undermine social ties amongst users that are important for recovery, displace voluntary treatment seekers and create perverse incentives for users (for example, users may feel compelled to commit a crime in order to get treatment) (Boekhout van Solinge 1997; Weatherburn *et al.* 1999; Stevens 2004). By shifting the focus of treatment services from health issues to crime, compulsory and coerced treatment programs could also undermine attempts to control epidemics (for example, HIV and hepatitis C) and limit the ability of treatment to reduce social harms (Stevens 2004). There are also ethical issues that arise in relation to these programs regarding whether liberal societies should be forcing people to receive treatment and how long the coercion or compulsory requirements should be maintained (Stevens *et al.* 2005).

- There is evidence that targeted interventions (for example, police crackdowns) may be able to disrupt markets and prevent drug epidemics (Caulkins 2002; Loxley *et al.* 2004).

Evidence on supply-side drug law enforcement

The available evidence suggests that supply-side drug law enforcement has suppressed drug consumption to some extent and that it may be able to reduce drug-related harm in certain circumstances. It also indicates that there are significant deficiencies in supply-side law enforcement and that beyond a relatively low level of investment it yields few tangible results in terms of reducing the social costs associated with illicit drug markets. The evidence on the effect of supply-side drug law enforcement on drug prices illustrates these points.

The research that has been done on the relationship between drug law enforcement and drug prices suggests that strict drug laws and supply-side drug law enforcement do result in drug prices being higher than they would be if the market were legal.⁴⁴ Given the evidence that the demand for illicit drugs is often responsive to price (see Section 5.2), it is likely that the higher drug prices have reduced drug consumption. However, it seems unlikely that drug prices would be noticeably lower than they currently are under liberal drug regimes with the exception of radical proposals involving open access. In a regulated market, drug prices could even be higher due to state-imposed taxes. Similarly, under civil penalty, partial prohibition and modified prohibition regimes, prices need not fall and they could actually increase if tight restrictions are imposed on supply.

The available evidence also suggests that beyond a certain point, supply-side drug law enforcement exerts very little influence on drug prices, with numerous studies failing to find measurable links between drug law enforcement and changes in retail drug

⁴⁴ See Weatherburn and Lind (1997); Caulkins and Reuter (1998); Yuan and Caulkins (1998); Rhodes *et al.* (2000); and Miron (2003).

prices (Weatherburn and Lind 1997; Caulkins and Reuter 1998; Best *et al.* 2001a; Wood *et al.* 2003). Research has also demonstrated that as the intensity of law enforcement in the United States increased after President Nixon declared ‘War on Drugs’, prices have fallen (Yuan and Caulkins 1998; Rhodes *et al.* 2000; Basov *et al.* 2001). Defenders of prohibition may argue that despite this fact, strict drug laws will have ensured that the decrease in price is less than it may otherwise have been and there may be an element of truth to this, although again it seems unlikely that there would be significant price differences under more liberal regimes that do not involve open access.

One explanation of the trends identified in drug prices is that prohibition combined with a degree of enforcement generates costs (including the risk of detection) not incurred in legal markets, for which suppliers seek to be compensated through higher prices (Weatherburn and Lind 1997; Yuan and Caulkins 1998; Rhodes *et al.* 2000). However, once the level of enforcement exceeds a certain point, there are diminishing marginal returns because it becomes less capable of affecting supply due to the fact that the quantities seized are generally insignificant and the markets are sufficiently flexible to adapt to any interceptions that may occur (Weatherburn and Lind 1997; Yuan and Caulkins 1998; Rhodes *et al.* 2000).

An important weakness identified with supply-side drug law enforcement is its ability to prompt drug switching. For example, the research undertaken by Jones and Weatherburn (2001) found that almost 60 per cent of respondent users said they would stop using or use less cannabis if the price doubled and 48 per cent said they would stop using or use less cannabis if it became harder to obtain. These results support the conclusion that drug law enforcement could reduce cannabis consumption if it substantially decreased supply – something that appears to be unlikely. However, in the event that supply-side drug law enforcement could substantially reduce availability, a significant proportion of respondents said their response to these circumstances would be to switch to alternative licit and illicit drugs (Jones and Weatherburn 2001).

As discussed in Section 5.2, there is evidence that drug substitution has occurred as a consequence of the heroin shortage that began in Australia’s major heroin markets (predominantly New South Wales and Victoria) in or around January 2001 (Topp *et al.* 2003; Baker *et al.* 2004; Collins *et al.* 2004; Roxburgh *et al.* 2004; McKetin and McLaren 2004). Faced with higher heroin prices and declining availability, many heroin users appear to have resorted to using other drugs like methamphetamines, cocaine and benzodiazepine, a substitution that is likely to have contributed to the rising social costs linked to the growth in Australian stimulant markets (particularly methamphetamines).

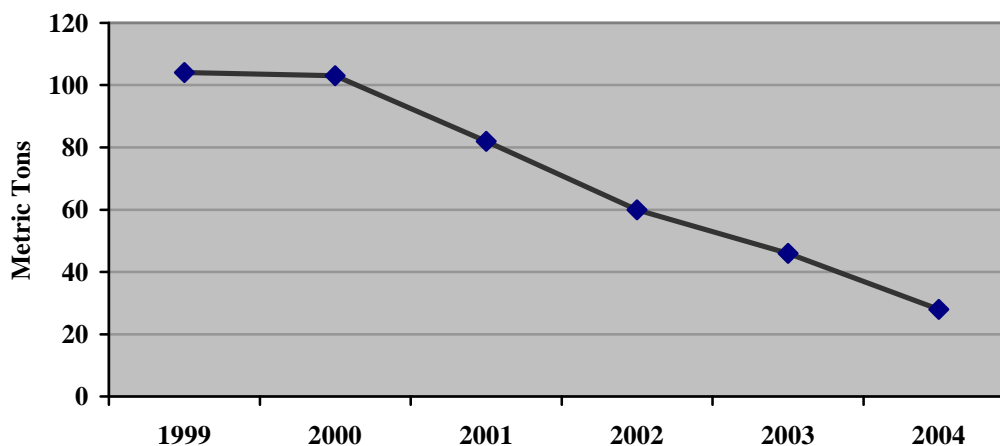
Notwithstanding drug switching and associated social costs, a number of commentators have argued that the aggregate effect of the heroin shortage on drug-related health outcomes has been positive (Hall *et al.* 2004b; Degenhardt *et al.* 2005). Research on the shortage has found that it resulted in a marked decline in fatal and non-fatal opiate overdoses and a probable reduction in the extent of injecting drug use and regular heroin users (particularly amongst younger age groups) (Day *et al.* 2004; Hall *et al.* 2004b; Smithson *et al.* 2004; Degenhardt *et al.* 2005). There is also evidence that the shortage led to a decrease in acquisitive crime, following an initial

spike at the height of the heroin drought (Collins *et al.* 2004; Smithson *et al.* 2004; Degenhardt *et al.* 2005).

A number of researchers have argued that one of the principal causes of the heroin drought is likely to have been an increase in supply-side drug law enforcement and consequent heroin seizures (Degenhardt *et al.* 2004; Hall *et al.* 2004b; Smithson *et al.* 2005). This has led some to claim that the heroin shortage is an illustration of ‘law enforcement’s success’ (House of Representatives Standing Committee on Family and Community Affairs 2003, p. 228). However, there are a number of reasons why the role of law enforcement in the heroin drought is questionable and why the event cannot be relied upon to support law enforcement’s prominent place in drug strategies.

Firstly, the heroin drought coincided with a marked decline in heroin production in Myanmar, which has been the primary source of heroin in Australian markets for at least a decade (Gibson *et al.* 2004; Degenhardt *et al.* 2004; United States Department of Justice 2005). The available information indicates that opium cultivation and heroin production in Myanmar has been on the decline since 1996, decreasing rapidly since the early 2000s (Gibson *et al.* 2004; United States Department of Justice 2005). Data compiled by the United States Department of Justice indicates that potential heroin production in Myanmar fell by approximately 42 per cent between 1999 and 2002 and that it has continued this sharp downward trend through 2003 and 2004 – see Figure 4 (United States Department of Justice 2005).

Figure 4 Potential Myanmar Heroin Production, in Metric Tons, 1999 - 2004



Source: United States Department of Justice 2005.

The sharp and sustained decline in heroin production in Myanmar over this period casts considerable doubt on the extent of the role played by law enforcement agencies in the drop in supply of heroin in Australian markets.

Secondly, there has been a significant increase in the production and importation of methamphetamines since the late 1990s and evidence that criminal groups, previously involved in the heroin trade, shifted their focus to methamphetamines (Degenhardt *et al.* 2004; ACC 2005). According to Degenhardt *et al.* (2004, p. 58):

[a] shift from heroin to methamphetamines trafficking among South East Asian organised criminals supplying Australia was reported by law enforcement officials prior to the onset of the heroin shortage in Australia.

They also state that (at p. 59):

[r]elatively high level distributors in Australia have reportedly shifted to methamphetamine distribution.

Similarly, the Australian Crime Commission has reported that:

Chinese trafficking groups previously associated with heroin importations to Australia and crystal methamphetamines importations to Japan appear to have consciously sought, with some success, to create a market for crystal methamphetamine in Australia ... (ACC 2005, p. 5).

One of the primary reasons provided for doubting the hypothesis that a switch in production and trafficking from heroin to methamphetamines was the primary cause of Australia's heroin shortage is that there were apparently 'no reports of dramatic decreases in South East Asian heroin production in recent years' (Degenhardt *et al.* 2004, p. 56). The critique suggests that producers and traffickers added methamphetamines to their product range rather than switching products.

This argument does not appear to hold up against more recent evidence. As the data collated by the United States Department of Justice indicates, heroin production in Myanmar plummeted over the last six to seven years and there is also evidence of a decline in heroin production in recent times in Laos, the other major heroin producing nation in the region (United States Department of Justice 2005). Meanwhile, increasing levels of amphetamine-type substances have been detected leaving Southeast Asia and there has been a sharp rise in methamphetamine seizures in Australia since 2000/01 (ACC 2005). Not only does the production and trafficking data fit with the 'drug switch' hypothesis, it also makes commercial sense. By the late 1990s, the profit margins on heroin in Australia were low, while the return on investment in meth/amphetamines markets is reportedly quite high (Degenhardt *et al.* 2004; ACC 2005).

Thirdly, the argument that drug law enforcement played a major role in causing the drought is predicated on the notion that there was an increase in the efficacy of Australia's drug enforcement agencies in intercepting imports. Apparently, increased funding for the Australian Federal Police (AFP), improvements in intelligence and greater cooperation between agencies 'may have improved the ability of the AFP and Customs to interdict large shipments of illicit drugs and to disrupt the activities of organised criminal networks involved in high level drug importation' (Degenhardt *et al.* 2004, p. 61). This is a possibility, but the concomitant increase in methamphetamine imports and use suggests it is unlikely.

Since the late 1990s, there has been a large increase in the number of methamphetamine users, use of methamphetamine amongst the dance party scene and intravenous drug users, and an increase in the more potent forms of methamphetamine (for example, crystal meth and base) (Baker *et al.* 2004; McKetin and McLaren 2004; McKetin *et al.* 2005; AIHW 2005b). There is also evidence of a significant jump in

the number of dependent methamphetamine users, to the point where researchers have estimated that in Sydney the scale of dependent methamphetamine use is ‘in the same league as dependent heroin use during the peak of the heroin problem in the late 1990s’ (McKetin *et al.* 2005, p. xviii). All this has occurred against a backdrop of increasing amphetamine-type stimulant seizures (McKetin and McLaren 2004; Stafford *et al.* 2005; ACC 2005) and, despite the best efforts of drug enforcement agencies, methamphetamine has remained readily available with relatively stable street prices (McKetin and McLaren 2004; Stafford *et al.* 2005).

Importantly, the majority of methamphetamines in Australia are imported using methods similar to those in heroin importation. The Australian Crime Commission has stated that:

[I]like the heroin market, the crystal methamphetamine market is supplied by a small number of very large shipments and a large number of small imports (ACC 2005, p. 6).

Consequently, at the same time as Australia witnessed a decline in heroin imports and availability, it also experienced a sharp increase in the availability of a drug that is imported in a manner similar to heroin and by the same or similar criminal networks. These facts suggest strongly that the heroin drought was more likely to be due to the marketing and production decisions of criminal syndicates rather than anything to do with the efforts of drug enforcement agencies.⁴⁵

Finally, even those who argue that law enforcement played an important role in triggering the drought acknowledge that it is a ‘very rare occurrence in the history of illicit drug use in developed countries’ (Hall *et al.* 2004b, p. 97) and that the event appears to be attributable to a unique collection of factors that are extremely difficult, if not impossible, to replicate (Hall *et al.* 2004b). The research undertaken by Smithson *et al.* (2005) that established a statistical association between heroin seizures and the shortage is one of the only times a link of this nature has been identified. As discussed, numerous other studies on supply-side drug law enforcement have been unable to find measurable links between drug law enforcement and reductions in availability, retail drug prices and drug-related harm (Weatherburn and Lind 1997; Yuan and Caulkins 1998; Best *et al.* 2001a; Wood *et al.* 2003). Even if it is assumed that drug law enforcement did play a significant role in bringing about the heroin shortage (which now seems unlikely), the rarity of the event and circumstances surrounding it should serve as more of an indicator of the futility of the vast majority of supply-side drug law enforcement efforts than the flag bearer of its success.

Without strict drug laws and drug law enforcement, there is the prospect that the trends in drug use and harm could be significantly worse. Yet, the available evidence

⁴⁵ Several other production and marketing related theories have been put forward to explain Australia’s heroin drought. These include the suggestion that traffickers diverted heroin supplies to Chinese markets, that the growth in the heroin market through the 1990s was unsustainable and that the shortage was illustrative of the inherent variability in illicit drug markets (Degenhardt *et al.* 2004; Hall *et al.* 2004b; Dietze and Fitzgerald 2002). In support of the latter two arguments, there is evidence that heroin availability has stabilised and that it may gradually be edging towards the levels seen before the marked spike in the late 1990s (Stafford *et al.* 2005). There may be an element of truth in all of these theories, but the available evidence suggests that the primary cause was a switch in drugs from heroin to methamphetamines by organised criminal networks.

suggests that above a relatively low level, supply-side drug law enforcement has very little impact on drug availability and drug-related harm. As the Commonwealth Parliamentary Joint Committee on the National Crime Authority concluded in 1989:

[d]espite the substantial resources afforded to drug law enforcement and the success of agencies in making seizures of drugs in unprecedented quantities, it is questionable whether there has been any marked effect in terms of the reduction of the supply of drugs reaching the marketplace. The foregoing analysis suggests that importations which are intercepted can readily be replaced and that even if major traffickers are apprehended this will not have a dramatic effect on the drug trade. Given the profits to be made, others will be prepared to take their places and increasingly they will be drawn from the ranks of professional criminals who are not deterred by the prospect of going to gaol. The best that law enforcement can probably hope for, therefore, is to keep drug abuse in society within acceptable limits. Even that prospect has disappeared in the United States of America (Parliamentary Joint Committee on the National Crime Authority 1989, paragraph 4.27).

Overall effectiveness of strict drug laws and drug law enforcement

As the above discussion illustrates, there is no conclusive evidence as to the effectiveness of prohibition and drug law enforcement in reducing the availability and consumption of illicit drugs and drug-related harm. Loxley *et al.* (2004, p. 198) allude to this difficulty when they suggest that:

... the size that the drug market would be without enforcement cannot be known, and so the true measure of the success of drug law enforcement cannot be gauged.

To a large extent, the effects of more liberal drug laws would depend on the nature of the legislative changes and how they were enforced. Further, if changes were made, it is unlikely that the same legal regime would be applied in a uniform manner to the different categories of drugs. The effects of drugs on human health differ considerably, as do the characteristics of drug markets, so it is only logical that drug laws and policy account for these differences (Kleiman 1992; McDonald *et al.* 1994). This increases the complexity associated with evaluating the likely impacts of legislative changes on use and harm.

The impacts of any changes in drug laws would also be dependent on what other policy measures are put in place to address drug use and drug-related harm. For example, if criminal sanctions were lifted for the use and possession of illicit drugs, any possible increase in demand may be able to be offset by increasing treatment services and social marketing campaigns.

Although there is insufficient evidence upon which to draw definitive conclusions about the effectiveness of drug law enforcement, federal prohibition of alcohol in the United States between 1920 and 1933 provides some valuable insights into its net effect on social welfare. The ban spawned an extensive illicit alcohol market that was associated with far reaching corruption and violence (MacCoun and Reuter 2001). Murder rates provide one indication of the extent of the social disruption caused by prohibition. In the years leading up to the federal alcohol prohibition murder rates

were gradually increasing. However, the introduction of the new laws coincided with a sharp spike in the homicide rate that was sustained throughout the prohibition years. After the laws were repealed, the homicide rate dropped abruptly and only rose to similar levels in the 1970s with the advent of President Nixon's war on illicit drugs. Other factors appear to have contributed to the trends in the 1920s and 1930s, but most analysts agree that alcohol prohibition was a major contributing factor (Miron 2001; MacCoun and Reuter 2001).

Some have argued that the social and political disruption caused by alcohol prohibition was at least partially offset by a decline in alcohol use and alcohol-related health costs (Kleiman 1992; MacCoun and Reuter 2001). For example, MacCoun and Reuter (2001, p. 157) argue that:

[p]rohibition may have reduced alcohol-related disease, notably liver cirrhosis, quite sharply and had a moderate effect on drinking.

The research on the beneficial health effects of prohibition usually relies on the death rate from liver cirrhosis as a proxy for alcohol misuse (Kleiman 1992; MacCoun and Reuter 2001; Miron 2001; Dills and Miron 2004). Between 1920 and 1933, this rate was at historically low levels and it rose after prohibition ended. A number of commentators have argued that prohibition was a major cause of this trend (MacCoun and Reuter 2001). The most troubling aspect of this argument is that the incidence of cirrhosis had been declining since 1908 and reached its historical low in 1920, the year prohibition took effect. Further, there was no dramatic jump in the death rate from cirrhosis following the repeal of the alcohol laws. Rather the cirrhosis death rate increased gradually through to the middle of the 1960s.

On the basis of this and other evidence, it now appears that alcohol prohibition had a relatively limited impact on drinking patterns and adverse health effects. In particular, the evidence suggests that:

- alcohol misuse experienced a temporary decline but then returned to previous levels; and
- the positive health effects were of a minor nature, especially when compared to other factors that influence alcohol-related health outcomes and the countervailing social costs of prohibition (Thornton 1991; Miron 1999; Miron 2001; Dills and Miron 2004; Dills *et al.* 2005).⁴⁶

Amongst those who claim that federal alcohol prohibition in the United States resulted in a substantial reduction in alcohol-related health costs, very few maintain that prohibition was a success. As MacCoun and Reuter (2001, p. 157) emphasise, 'it is almost universally seen as a great social disaster'.

There are notable differences between alcohol prohibition in the United States and current illicit drug laws in Australia. The American experiment does however highlight a number of the weaknesses in the theoretical foundations of law-based

⁴⁶ There is some evidence to suggest that prohibition may have actually increased the death rate from cirrhosis – possibly because of changes in drinking patterns (for example, binge drinking or consuming potent forms of alcohol) (Dills and Miron 2004).

approaches to drug issues and the capacity for drug law enforcement to impose negative impacts on society.

Acknowledging the limitations in the available data, the following key points concerning the efficacy of existing drug laws and drug law enforcement can be drawn from the prevailing evidence.

- Despite prohibition and increasing levels of drug law enforcement, illicit drug use both in Australia and internationally has grown considerably over the past 50 years.
- In 2004, around 15 per cent of Australians over the age of 14 reported using drugs in the last 12 months. Like most western countries, the vast majority of illicit drug use in Australia involves cannabis. A very small proportion of the population use harder drugs on a regular basis, but this use is significant because these drugs cause considerable harm to individuals and society.
- Prohibition has failed to reduce illicit drug markets to an insubstantial size and illicit drug markets continue to impose substantial costs on society. Recent increases in the reported use of methamphetamines and ecstasy are of concern.
- The available evidence suggests that both demand-side and supply-side drug law enforcement have a limited impact on drug use and drug-related harms, particularly in relation to softer drugs like cannabis.
- There is good evidence that the removal of criminal sanctions for the use, possession and minor cultivation of cannabis will not lead to a significant increase in drug use or drug-related harm.
- The impact of supply-side drug law enforcement on drug prices and drug consumption appears to be limited. The evidence suggests that drug prices would be lower if the market were legal, yet it seems unlikely that they would be noticeably lower under more liberal regimes (with the exception of open access). Beyond a fairly low level, supply-side drug law enforcement seems to have very little impact on drug availability, drug prices and drug-related harm.
- There is evidence that increases in drug prices and decreases in availability can lead to drug substitution. This suggests that even if drug law enforcement is successful in reducing the consumption and harms associated with one drug, these benefits could be offset by an increase in the use of other drugs and harms associated with them.
- The available evidence suggests that drug law enforcement played a limited role in bringing about the conditions that led to the Australian heroin drought. The main contributing factor appears to have been the marketing and production decisions of organised criminal networks, more particularly a decision to switch from producing and trafficking heroin to methamphetamines.
- It appears the current level of investment in drug law enforcement is excessive and that very little has been achieved by policies focused on legal solutions.

- There is no evidence either that availability would increase or prices would decline significantly as a result of the introduction of more liberal drug laws, particularly if the emphasis of the changes were on demand-side measures.

6.2 Does prohibition promote drug use?

An argument against prohibition more damaging than mere ineffectiveness is that it may actually promote drug use. There are three main processes by which this could occur:

- the forbidden fruit effect, which suggests that the criminal status of illicit drugs may increase their attractiveness to certain people;
- causing or perpetuating social and economic disadvantage and social isolation, which may increase the risk of a person misusing illicit drugs; and
- exposing people (particularly those who are at risk of problematic drug use) to social networks that are involved in illicit drug markets.

The forbidden fruit effect

According to MacCoun and Reuter (2001), there are three psychological mechanisms that could produce a forbidden fruit effect:

- reactance theory, which suggests that restrictions on the ability to choose to behave in a certain way can increase the attractiveness of the behaviour;
- scarcity principle, which suggests that a good may become more desirable if its availability declines due to a cultural association between scarcity and quality; and
- risk seeking, which suggests that people who are risk seekers may become more attracted to a good if it is prohibited because its legal status may create an additional thrill associated with its use (for example, it may make the good seem mysterious or the thrill may be associated with avoiding detection).

Whether these factors produce a forbidden fruit effect in relation to illicit drugs in Australia is unknown. However, there are some studies that suggest it is a possibility. For example, there is evidence from the United States that when stronger enforcement measures were introduced to reduce underage smoking in a number of towns, the rate of teenage tobacco use increased (Rigotti *et al.* 1997). A number of studies have demonstrated that when warning labels are played before violent and sexually explicit television programs, interest in the programs increases suggesting viewers are lured rather than deterred by program warnings (Cantor 1998; Bushman and Stack 1996). It has also been claimed that a forbidden fruit effect may have operated during the period of alcohol prohibition in the United States in the 1920s and 1930s and offset the effects of alcohol laws on drinking behaviour and cirrhosis (Dills and Miron 2004).

While these studies suggest that drug laws could promote drug use amongst certain groups and individuals, it seems unlikely that the forbidden fruit effect is of a

sufficient magnitude to offset the suppressive effects that drug laws have on overall illicit drug consumption. Further evidence is required before any definitive conclusions can be reached on this issue.

Causing or perpetuating social disadvantage

Logic suggests that people who are convicted or arrested for drug crimes may suffer significant adverse economic and social consequences. This argument is supported by evidence from both Australia and overseas. For example, a study on the comparative effect of the CEN scheme in South Australia and the cannabis prohibition regime in Western Australia found that minor cannabis offenders apprehended under the prohibition regime were more likely to suffer adverse social and economic consequences than those served with a CEN (Lenton *et al.* 1999). On the basis of this research, Ali *et al.* (1999, p. ix) concluded that:

... negative employment consequences arising from a cannabis offence apprehension were more likely to be experienced by offenders in Western Australia compared to South Australia (eg. loss of job, missing out on a job opportunity). Those in the WA system were also more likely to report relationship problems, accommodation problems, and further involvement with the criminal justice system related to their first minor cannabis offence.

Socio-economic disadvantage, unemployment and relationship problems have all been identified as risk factors for problematic drug use (Victorian Drug Policy Expert Committee 2000; MacCoun and Reuter 2001; Loxley *et al.* 2004). Consequently, prohibition may actually increase the risk of illicit drug abuse (particularly amongst certain vulnerable groups) by causing or exacerbating socio-economic disadvantage and social isolation problems (MacCoun and Reuter 2001).

Socialising people with drug users and criminals

Two important risk factors affecting illicit drug use and abuse are the availability of illicit drugs and association with people who are involved in illicit drug markets (Blackwell and Erickson 1988; Victorian Drug Policy Expert Committee 2000; MacCoun and Reuter 2001; Loxley *et al.* 2004). Strict drug laws may promote illicit drug use and involvement in illicit drug markets by exposing people to social groups that have access to illicit drugs and that use or sell illicit drugs (O'Callaghan *et al.* 2004).

The increased risk of involvement in illicit drug markets could arise simply because drug users must interact with other drug users and drug traffickers. This can occur outside of the criminal justice system, as when a drug user interacts with a drug dealer in order to buy an illicit substance. As the drug user gets to know the dealer, the user may be drawn into a social group that has access to and uses a wide variety of illicit substances. The drug user may then be pressured or simply choose to try other drugs or to use illicit drugs more frequently and may also become involved in the supply of illicit drugs or other criminal activity because of the exposure to other dealers and criminals or to service a drug habit.

The exposure of drug users to illicit drug traffickers and criminal networks can also occur within the criminal justice system (O'Callaghan *et al.* 2004). The available

evidence suggests that the prevalence of illicit drug use in Australia's gaols is significantly higher than the rates in the general population (Butler and Milner 2003; Makkai and Payne 2003; Johnson 2004; Prichard and Payne 2005) – see Table 4.

Table 4 Illicit drug use amongst male (2001) and female (2003/04) prisoners (per cent) – lifetime, recent and current regular use

	Ever used		Used in six months prior to arrest		Current regular user	
	Female	Male	Female	Male	Female	Male
Cannabis	78	81	49	62	40	53
Meth/amphetamines	61	58	42	42	37	31
Heroin	46	45	29	27	27	21
Cocaine	42	32	14	16	6	7
Any illicit	80	82	66	69	62	62

Source: Makkai and Payne (2003); and Johnson (2004).

Once a drug offender is exposed to illicit drug and other criminal networks in gaol, there is a significant risk they will continue or intensify their involvement in illicit drug markets and be drawn into other criminal activity (Ministerial Council on Drug Strategy 2001b; O'Callaghan *et al.* 2004).

The problems associated with the exposure of drug offenders to criminal and drug-related social networks may also be a result of socio-economic factors and social isolation. That is, the apprehension and punishment of drug offenders may trigger a cycle whereby the offence leads to social isolation and other adverse socio-economic outcomes, which then lead offenders to associate with deviant groups involved in criminal activities and illicit drug use, which then leads to an involvement in illicit drug markets. As MacCoun and Reuter (2001, p. 91) describe:

... the argument is that the stigma associated with criminal sanctioning alienates the individual from conventional society, promoting contact with deviant referent groups and enhancing the likelihood of future deviance befitting the label – a self-fulfilling prophecy.

It is not clear whether these factors have a significant effect on the size and characteristics of illicit drug markets in Australia. However, there is little doubt that they should be given serious consideration in the development of drug policies.

Key points

- There is a risk that drug law enforcement could promote drug use amongst certain users. There are three mechanisms by which this could occur: the forbidden fruit effect, causing or perpetuating social and economic disadvantage and social isolation, and exposing people to social networks that are involved in illicit drug markets.

- The forbidden fruit effect suggests that prohibiting an activity like drug use may actually increase its attractiveness to certain people. Very little research has been carried out on this issue. There is sufficient evidence to suggest it is a possibility, although it is unlikely to be of a sufficient magnitude to offset the suppressive effects that drug laws have on illicit drug markets.
- People arrested and convicted for drug offences suffer adverse economic and social consequences. Social and economic disadvantage are risk factors for drug misuse. Consequently, there is a risk that drug laws and drug law enforcement may increase involvement in drug markets on the part of people who are arrested or convicted for drug offences.
- Strict drug laws may promote illicit drug use and involvement in illicit drug markets by exposing people to social groups that have access to illicit drugs and that use or sell drugs.

7. The alternatives to the current approach

The most common criticism of the current approach to illicit drug issues is not simply that it does not work but that it is not the most effective policy option and that more liberal drug laws combined with an alternative mix of non-legal policy mechanisms would realise greater gains at less cost to society (Cowdery 1999; Wodak 1999; Wodak and Moore 2002).

Three important points should be noted before analysing this argument. Firstly, drug laws do not operate in a vacuum. The legal strategies that are employed to address drug problems are accompanied by a wide variety of non-legal policy mechanisms intended to complement the efforts of the justice system. The critical issue is getting the balance between the legal and non-legal mechanisms right and ensuring that they operate in a cohesive manner.

Secondly, no single policy mechanism will solve Australia's drug woes, nor is there any perfect mix of policy initiatives that will eliminate harmful drug use. As other people have said, devising drug policy is an exercise in identifying the 'least worst' options (Kilgour 1999).

Thirdly, as discussed, it is unlikely that a uniform legal regime for illicit drugs is the most appropriate strategy to address drug issues. The differences in the nature and effects of different drugs suggest that the best results are likely to be achieved by using different legal and non-legal policy structures for different types of drugs (Kleiman 1992; McDonald *et al.* 1994).

In order to analyse the argument that a mix of more liberal drug laws and alternative non-legal policy mechanisms is likely to be more effective, it is necessary to answer four questions.

- What are the causes of drug misuse problems?
- What are the legal and non-legal options?
- How effective are these options likely to be?
- What is the current balance in the allocation of resources to the legal and non-legal policy mechanisms?

7.1 The causes of drug misuse problems

Effective drug strategies aim to address not only the consequences of drug misuse but also the causes. One major difficulty however is in identifying the root causes of drug abuse and drug dependency.

Research has identified a collection of broad cultural and socio-economic factors that appear to have an association with drug misuse. For example, as discussed in Section 6.1, there are significant differences in the prevalence of drug use between age groups, with younger people being far more likely than older people to use drugs. The

available evidence also indicates that drug use is more prevalent amongst males than females – see Table 3 above.⁴⁷

Similarly, research has established a correlation between drug problems and socio-economic factors such as poverty, unemployment, education levels, homelessness and poor housing (Loxley *et al.* 2004; Spooner and Hetherington 2004). Some have also argued that various aspects of western culture, such as consumerism, materialism, postmodernism, secularism, economic rationalism and individualism are contributing factors to the rise in drug use and drug-related problems (Eckersley 2001; Spooner and Hetherington 2004).

There is a perception in the community that certain ethnic groups and people from non-English speaking backgrounds have a disproportionately high rate of illicit drug use when compared to the general population. For example, Asian communities are often identified as being conspicuously affected by drug problems (Webber 2002; Beyer and Reid 2000; Beyer *et al.* 2001). In fact, the prevalence of illicit drug use amongst people from non-English speaking backgrounds appears to be significantly less than the rate amongst the general population (Miller and Draper 2001; Loxley *et al.* 2004; AIHW 2005c). As shown in Table 5, the most recent data on drug use suggests that people from households where English is not the main language have much lower rates of illicit drug use.

Table 5 Illicit drug use according to language spoken at home, persons aged 14 years and over, 2004

Main language spoken at home	Never used illicit drugs (per cent)	Ex-users (per cent)	Recent users (per cent)
English	60.3	24.0	15.7
Other	84.1	7.4	8.5

Source: AIHW 2005c.

Despite this, there is evidence that the prevalence of illicit drug use amongst certain ethnic groups (for example, Vietnamese, Cambodian, Greek, Romanian and Lebanese) is higher than the rate in the broader community and that these groups exhibit an above average rate of drug-related crime (Beyer and Reid 2000; Beyer *et al.* 2001; Beyer 2003; Loxley *et al.* 2004). However, it appears that these linkages are attributable to the age profiles of the communities, patterns of drug use behaviour (for example, Vietnamese drug use behaviour is often highly visible, which increases the risk of detection) and socio-economic disadvantage (Beyer and Reid 2000; Beyer *et al.* 2001; Beyer 2003).

The precise mechanisms by which these broad cultural and socio-economic factors contribute to drug use are unclear. Further, it appears the predictive power of some social determinants (for example, gender, class and ethnicity) is substantially reduced when they are adjusted to account for more proximate risk and protective factors, such

⁴⁷ The prevalence of drug use (lifetime and recent use) amongst females currently exceeds that of males only in the 14 to 19 years age group (AIHW 2005a). In all other groups, drug use is higher amongst males (AIHW 2005a).

as educational difficulties, genetic predisposition to behavioural problems and being raised in a broken family (Loxley *et al.* 2004).

Risk factors refer to issues that tend to predict drug abuse behaviour, while protective factors tend to reduce the influence of risk factors and provide ‘some armour against the development of later problems’ (Victorian Drug Policy Expert Committee 2000, p. 77). Table 6 provides some examples of the risk and protective factors that have been identified.

Table 6 Risk and protective factors for drug use

Level	Risk factors	Protective factors
Community	Poverty Availability of drugs Community disorganisation in adolescence Lack of exposure to, and activity with, adults during adolescence	Cooperative cultures Well-managed environment for drug use Exposure to, and activity with, adults during adolescence Strong community links and opportunities to make a contribution to society (e.g. social networks, fulfilling employment etc)
Education facilities	Educational difficulties and failure Lack of parental interest in education Anti-social behaviour	Positive feedback and achievements Fitting in at school Preschool attendance
Family	Being raised in a broken family or by a sole-parent Being raised in a family that suffers from severe economic deprivation Being neglected or abused as a child Conflict with parents as an adolescent Favourable parental attitudes to drug use as a child or adolescent Maternal drug use prior to birth	Attachment to family in adolescence Parental supervision and monitoring of child and adolescent behaviour Involvement in religion in adolescence Marriage in early adulthood Absence of family conflict as a child Absence of family breakdown/divorce during adolescence Sense of belonging or connection to family
Individual/peer	Mental illness Childhood behavioural problems Genetic disposition to drug use disorders Adventurous/sensation seeking personality in adolescence Involvement with drug users Early initiation of drug use Traumatic life events	Being born outside of Australia Easy temperament in early childhood Social and emotional competence in childhood Shy and cautious temperament in childhood

Source: adapted from Victorian Drug Policy Expert Committee (2000) using Loxley *et al.* (2004) and Spooner and Hetherington (2004).

The nature of the relationship between drug use and a number of the socio-economic risk factors (including poverty, unemployment and educational achievement) is complex. These factors can cause or contribute to substance abuse problems and *vice versa*. Further, a significant proportion of the risk factors for substance misuse disorders are also risk factors for other health and social problems, including mental illness and crime. It seems, therefore, more logical and more efficient to address drug misuse as part of broader health and social strategies rather than as a stand-alone legal problem.

Irrespective of whether drugs are viewed as a component of health and social programs, the objective of drug prevention strategies should be to reduce the incidence and severity of risk factors and, where possible, to promote the development of known protective factors, while working to minimise the adverse social and personal effects of drug use (Pollard *et al.* 1999; Victorian Drug Policy Expert Committee 2000). This can be achieved through legal and non-legal mechanisms either specifically targeting drug-related issues or aiming to address problems at the individual, family, educational and community levels (Victorian Drug Policy Expert Committee 2000; Grove 2002).

7.2 The legal options

What are the legal options?

As discussed, there are five main legal options where drug laws are concerned: total prohibition; prohibition with civil penalties; partial prohibition; regulation; and free availability. Details of the nature of these alternatives are provided in Section 2.5.

This section will not consider free availability regimes as there appears to be very little support for this approach within the drug literature and the broader community (AIHW 2005a), due most likely to the fear that free availability could lead to a significant increase in the prevalence of illicit drugs, drug use and drug-related harm.

How effective are they likely to be?

The success of the different drug law options hinges upon their impact on:

- the prevalence and frequency of drug use;
- drug-related harm; and
- the social costs attributable to the laws.

As discussed in Section 6.1, it is extremely difficult to gauge the impact of the various legal options on the prevalence and frequency of drug use and drug-related harm. In relation to cannabis, the evidence suggests that more liberal drug laws are unlikely to lead to a significant increase in cannabis use or cannabis-related harm. Unlike the other options, regulated access offers the advantage of providing the state with the capacity to influence cannabis prices through the use of taxes. Regulatory options may also give the state an enhanced capacity to control suppliers. For example, prohibitions could be placed on the supply of cannabis to minors and to people who are intoxicated and restrictions could be placed on the potency of the drug. Doubtless,

these restrictions would be violated by a proportion of legal suppliers as are similar restrictions that apply to the supply of alcohol and tobacco. However, by placing the trade in the hands of legitimate businesses and introducing the risk of losing the right to trade, there is a greater potential for the state to exercise some control over the behaviour of distributors and retailers.

One possible drawback to the liberalisation of cannabis laws is that while it may not result in a marked increase in overall use, it could lead to an increase in the frequency of use amongst existing users (Weatherburn and Jones 2001). However, the evidence from Australian civil penalty schemes and similar approaches adopted abroad suggests the risk of this occurring on a large scale is low. Other policy mechanisms could also be introduced to minimise the risks associated with this issue, including an expansion of treatment facilities and prevention programs.

The situation in relation to harder drugs (for example, heroin, meth/amphetamines, ecstasy etc.) is more problematic. There is very little evidence on the likely impact of the introduction of more liberal drug laws on hard drug markets. The trends in the Netherlands, however, do suggest that alternative approaches to hard drug control are unlikely to trigger a pronounced spike in drug use or drug-related harm.

The Dutch approach to hard drugs is somewhat similar to the strategy they apply to cannabis (Boekhout van Solinge 1999; Spruit 1999). By law, the '[p]ossession, commercial distribution, production, import and export, and advertising the sale or distribution' of hard drugs is a criminal offence (Spruit 1999, p. 665). As with all drugs in the Netherlands, hard drug use is not prohibited, but users are vulnerable to prosecution for possession. However, a distinction is made between possession for personal use and possession for other than personal use. Possession of a hard drug in a quantity that is below the level prescribed in guidelines issued by the Prosecuting Counsel is defined as a petty offence and given a low priority for prosecution (Spruit 1999; Boekhout van Solinge 1999). In practice, this means that hard drug users are not prosecuted for possessing small quantities of prohibited substances or for merely being intoxicated, unless they are causing a public nuisance.

The prosecution guidelines require that users found in possession of small quantities of hard drugs be given care and assistance as a matter of priority and 'calls for early contact with treatment facilities in order for users to obtain needed assistance' (Spruit 1999, p. 668). These guidelines have been criticised as being overly restrictive, yet the attitude toward hard drug users has generally remained 'non-punitive, with particular emphasis on care and treatment' (Boekhout van Solinge 1999, p. 2).⁴⁸ A central element of harm reduction in the Dutch strategy has been broad access to methadone treatment for heroin addicts and syringe exchange programs. Their 'customised care' approach to treatment and harm reduction has also seen the trialling of a heroin prescription program for treatment-refractory, severely dependent heroin users.⁴⁹

⁴⁸ The Netherlands has introduced compulsory and coerced treatment programs for criminals with drug dependency problems, a move that has been viewed as a 'hardening of the Netherlands' policy' (de Kort and Cramer 1999).

⁴⁹ Concerns have been expressed about the failure of the Dutch Government to implement broader heroin prescription programs for severely dependent users and it has been suggested that this failure may reflect the threat that the rise in conservative politics in the Netherlands could pose to the country's pragmatic approach to drug issues (Lemmens 2003).

This more lenient, harm reduction-orientated position on hard drugs does not appear to have caused an elevated level of hard drug use or drug-related harm. In fact, the evidence is consistent with the hypothesis that more liberal drug laws, when combined with appropriate prevention and treatment programs, can reduce the social costs of drug markets. Table 7 outlines the statistics compiled by the United Nations Office on Drugs and Crime (2005) on the prevalence of use of selected drugs in the Netherlands.

Table 7 Annual prevalence of use of selected drugs in the Netherlands as percentage of population aged 15 – 64 (2001), compared to prevalence in other western and central European countries

Drug	Prevalence (per cent)	Western and central Europe Ranking according to UN Office on Drugs and Crime
Cannabis	6.1	14 th highest out of 30
Opiates	0.3	22 nd highest out of 28
Cocaine	1.1	4 th highest out of 30
Amphetamines	0.6	15 th highest out of 28
Ecstasy	1.5	3 rd highest out of 29

Source: United Nations Office on Drugs and Crime (2005).

As shown in Table 7, the annual prevalence of opiate use in the Netherlands amongst people aged 15 to 64 is 0.3 per cent, a level that places it in the bottom quarter of western and central European countries according to heroin use (United Nations Office on Drugs and Crime 2005). The annual prevalence of amphetamine use is very much in the mid-range for European countries, while cocaine and ecstasy use are relatively high in comparison to neighbouring countries.

The fact that the annual rate of hard drug use in the Netherlands is not consistently higher than other western and central European countries and that it varies between substances supports the conclusion that the more liberal approach taken by the Dutch Government has not significantly increased drug use or drug-related harm. The Netherlands still has drug problems, but they are similar to those experienced by neighbouring countries with more stringent drug laws and in many respects they are notably better (Boekhout van Solinge 1999; de Kort and Cramer 1999; Spruit 1999; Ketelaars *et al.* 2002; Ministerie van Volksgezondheid, Welzijn en Sport 2002). For example, while other European countries have witnessed increasing rates of heroin use, in the Netherlands it has remained stable and relatively low with the user profile ‘aging markedly’ as existing users mature and fewer younger people take up the drug (de Kort and Cramer 1999, p. 483; Ketelaars *et al.* 2002; International Narcotics

Control Board 2005).⁵⁰ Similarly, as the Dutch Government has pointed out, while hard drug use may be quite extensive:

[t]he number of problem users of hard drugs in the Netherlands is the lowest in the EU (Ministerie van Volksgezondheid, Welzijn en Sport 2002, p. 5).⁵¹

Moreover, the evidence indicates that harm reduction initiatives (for example, pill testing, improvements in conditions at dance parties and broad access to treatment services) have been reasonably successful in reducing the negative social effects associated with hard drug use and have ensured that the Netherlands has been spared some of the adverse impacts associated with repressive drug regimes (Spruit 1999; de Kort and Cramer 1999; Ministerie van Volksgezondheid, Welzijn en Sport 2002; International Narcotics Control Board 2004).⁵²

While the laws and policies adopted by the Dutch Government have resulted in a number of positive outcomes in terms of hard drug use and drug-related harm, it must be emphasised that this regime is, nevertheless, based on prohibition and it takes a restrictive approach to many hard drug issues. The question of whether more liberal regimes would generate significant spikes in the incidence of hard drug abuse and drug-related harm remains to be answered. Yet, the experience in the Netherlands indicates that showing leniency towards users within a prohibition framework is unlikely to lead to adverse drug-related outcomes and it can have important benefits.

In some respects, the National Drug Diversion Initiative and associated diversion programs that have been introduced in Australia are a move towards a Dutch-style approach to hard drugs. Like the initiatives in the Netherlands, these programs attempt to soften some of the more repressive aspects of prohibition. However, they suffer from two main flaws. Firstly, because of their limited reach, many drug users (as well as low-level dealers who are motivated by a desire to finance a drug habit) will still face criminal prosecution for what is essentially a health disorder requiring treatment. Secondly, in the majority of cases, these programs involve one or more forms of compulsory or coerced treatment which, as discussed in Section 6, suffer from a number of weaknesses, amongst the more compelling being the fact that they do not appear to be cost-effective when compared to voluntary treatment programs. Diversion programs are an admission of the deficiencies of prohibition, yet they do not go far enough to mitigate its flaws.

Given the lack of evidence on the likely impact of drug law reforms and the complexity associated with drug use and drug-related harms, advocates for more liberal drug regimes are often forced to rely heavily on the capacity of those regimes to reduce the social costs caused by drug laws and drug law enforcement. The two main potential cost savings comprise reduced negative effects of drug laws on users and reduced enforcement, prosecution and punishment costs.

⁵⁰ A number of other western European countries have also seen declining rates of heroin abuse in recent years (International Narcotics Control Board 2005).

⁵¹ See also Ketelaars *et al.* (2002, p. 28).

⁵² The Netherlands is often criticised as being a source of illicit drugs, particularly amphetamine-type substances (including ecstasy). However, it appears amphetamine and ecstasy producers have shifted in recent times from the Netherlands to central and eastern European countries, particularly Belgium, Poland and Estonia (International Narcotics Control Board 2005).

Reduced negative effects of drug laws on users

A number of the harms that drug laws impose on users are outlined in Section 5. Several could be significantly reduced if a more liberal approach to the control and regulation of drug markets were adopted.

The capacity for prohibition and drug law enforcement to stigmatise drug users and link them with isolated and deviant subcultures can have adverse effects on users' relationships, employment prospects and the risk of developing further drug and criminal problems (Lenton *et al.* 1999; Spooner *et al.* 2004; O'Callaghan *et al.* 2004). In many cases, prosecution for a drug offence can set off a chain of events that causes a disproportionate degree of harm to both the individual and society. More liberal drug regimes can reduce the danger of this occurring by minimising the contact that drug users (and possibly also minor drug suppliers whose offences are motivated by a desire to service a drug habit) have with the criminal justice system and, where contact is unavoidable, decreasing the associated risks.

Alternative drug control regimes can also reduce some of the health risks associated with drug use which strict drug laws tend to exacerbate. These include needle sharing, unsafe disposal of injecting equipment, reluctance to seek medical assistance, binge consumption, drug switching and taking drugs in isolated locations. By removing the threat of criminal prosecution for matters such as drug use, intoxication and possession of drug paraphernalia or small quantities of illicit substances, liberal drug regimes could greatly improve the safety of drug users and responses to adverse drug events. Some liberal drug regimes offer the added benefit of being able to exercise a greater degree of control over drug supply and drug content. Regulated access regimes are best placed to achieve improvements in the reliability and safety of drugs. However, even in the more conservative options, there is scope for improvement. Pill testing, where the state provides, or allows others to provide, users with facilities to evaluate the content of illicit drugs without the fear of being apprehended is one example. These services can reduce the risk of contaminated substances causing mortality and morbidity amongst drug users.

An additional advantage offered by more liberal drug control regimes is their capacity to result in greater stability of drug markets. Strict prohibition can destabilise drug markets (for example, by forcing them further underground or by exacerbating 'turf wars'), which can result in higher levels of violence, corruption, public nuisance and health problems. Liberal drug law regimes can lessen the severity of these consequences by helping to maintain greater order in drug markets and encouraging strong ties between users, user-dealers and public authorities (de Kort and Cramer 1999).

A move away from prohibition could also serve to diminish the problems that drug laws and their enforcement impose on sufferers of mental illness. At the very least, they could reduce the number of people inflicted with mental health and substance misuse disorders who are incarcerated or given other punishments for small-scale drug offences. Further, more liberal approaches to drug issues would help relieve some of the pressures associated with obtaining drugs and drug treatment currently magnified by prohibition and strict drug law enforcement.

In summary, a significant proportion of the harms associated with drug markets are the result of strict drug laws and their enforcement. A more tolerant approach to drug issues would go a long way towards reducing the harms suffered by drug users, their friends and families and the broader society.

Reduced enforcement, prosecution and punishment costs

The potential administrative savings to be gained from more liberal drug regimes come in the form of reductions in enforcement effort and decreases in prosecution and punishment costs. These savings can be due to fewer drug apprehensions and prosecutions and expedited punishment processes. They can also arise as a result of improved outcomes leading to lower drug misuse, drug-related crime and recidivism.

A number of the alternative legal regimes can also lessen the burden on government finances by enhancing the state's capacity to recoup drug-related expenses through taxes and fines. For example, in regulated access regimes, drug taxes such as those that apply to alcohol and tobacco provide the state with a source of revenue with which to fund prevention and treatment programs. Drug fines in civil penalty regimes can also provide a source of revenue, although fines also apply under strict prohibition approaches.

The evidence on civil penalty regimes and modified prohibition regimes supports the conclusion that more liberal drug laws can reduce the social costs related to drug law enforcement.⁵³ For example, research on the CEN scheme in South Australia found that it decreased enforcement, prosecution and punishment costs and increased government revenues (Lenton *et al.* 1999; Ali *et al.* 1999). Similar findings have been made in relation to moves to reduce penalties for cannabis offences in the United States. According to Single *et al.* (1999, pp. 28 - 29):

[i]n the United States, decriminalisation resulted in substantial savings to drug enforcement due to lower numbers of cannabis possession cases and increases in fine revenues. ... It cannot be claimed that decriminalisation laws eliminated the social costs and adverse individual consequences associated with cannabis prohibition, but it would appear that decriminalisation succeeded in reducing enforcement costs without increasing the health and safety hazards associated with use.

The evidence that has emerged from the Australian pre-arrest and pre-trial diversion programs also supports these conclusions (Baker and Goh 2004; Hales *et al.* 2004). For example, the three-year evaluation of the New South Wales Cannabis Cautioning Scheme concluded that:

[t]he Scheme appears to have produced substantial time and cost efficiencies for both the police and the Local Courts, in terms of the time saved at the time of drug detection and the time saved in not having to deal with the matters in court. Over the three years of the Scheme it is estimated that police have saved over 18,000 hours, or over \$400,000, and the Local Courts have saved at least \$800,000 and probably more than \$1,000,000 (Baker and Goh 2004, p. viii).

⁵³ Lenton *et al.* (1999); Ali *et al.* (1999); Single *et al.* (1999); Baker and Goh (2004); and Hales *et al.* (2004).

There have even been suggestions that these programs may assist in lowering drug-use and crime (Hales *et al.* 2004).

Liberal drug regimes that are more tolerant than those trialled are likely to offer even greater administrative savings. Any reduction in the imprisonment of drug users and low-level drug dealers would realise considerable financial benefits. There are approximately 25,000 people now in Australian gaols, of which ten per cent are serving a most serious offence involving illicit drugs (ABS 2005). Over the last decade, the prison population has grown by 45 per cent and the rate of imprisonment has increased from around 130 to 163 prisoners per 100,000 adults (ABS 2005). In 2003/04, total expenditure on corrective services in Australia topped \$1.8 billion, broken down into \$1.6 billion for prisons, \$198 million for community corrections and \$67 million for transport and escort services (SCRGSP 2005). Both real and unadjusted expenditure on prisons and corrective services has increased significantly since the mid to late 1990s (SCRGSP 2005) with the punishment of those involved in drug markets making a significant contribution to the increases in prison populations and the cost of corrective services. The liberalisation of drug laws is likely to ease the financial burden associated with drug markets.

This is not to suggest that the introduction of liberal drug laws will eliminate enforcement, prosecution and punishment costs. Under all reasonable alternatives, the criminal and civil justice systems will play a major role. For example, should a regulated access regime be introduced for cannabis, law enforcement agencies will continue to monitor and enforce the restrictions that are placed on the market. Authorised cannabis dealers would also rely on the civil justice system to enforce contracts and ensure government agencies exercise their powers according to the law. Similarly, under all of the more tolerant options, the state will have to engage in some level of supply-side law enforcement. However, notwithstanding these imperatives, in most cases it is likely that the adoption of more liberal drug regimes will result in a significant reduction in enforcement, prosecution and punishment costs.

The assumption that more liberal drug programs will always result in reductions in the costs associated with drug law enforcement should be approached with caution. In some instances, the number of people who are apprehended for drug offences may increase through a process commonly known as 'net-widening'. This was witnessed after the introduction of the CEN scheme in South Australia (Ali *et al.* 1999), as well as the Cannabis Cautioning Scheme in New South Wales (Baker and Goh 2004). In South Australia, there was also evidence that a significant proportion of people who were served with CEN were subsequently prosecuted after failing to pay the required fine (Ali *et al.* 1999). Obviously, the disadvantages associated with net-widening and the non-payment of fines would be far less of an issue in a regulated access or partial prohibition regime.

A net decrease in social costs can result even in those situations where the direct costs associated with more liberal drug regimes remain commensurate with those under prohibition. The evidence concerning the CEN in South Australia illustrates this point. Notwithstanding the fact that there was net-widening, the official research on the scheme concluded that it has been 'more cost-effective for dealing with minor cannabis offences than a prohibition approach' and that it reduced the social and economic impacts associated with these offences (Ali *et al.* 1999, p. ix - x).

Both logic and the available evidence suggest that the adoption of more liberal drug laws and law enforcement strategies could realise substantial cost savings and reduce the health, economic, social and legal harms suffered by drug users. The prevalence of drug use may rise by a small margin although the evidence on this issue is equivocal and there is a possibility it could actually decline. The weight of evidence suggests that drug dependency problems are unlikely to increase and that drug-related health costs are likely to fall.

7.3 The non-legal options

What are the non-legal options?

Drug strategies are often divided into three parts: drug law enforcement, drug prevention and drug treatment (Boekhout van Solinge 1997; Victorian Drug Policy Expert Committee 2000). As the names suggest, both prevention and treatment concern non-legal options for reducing the demand for drugs and drug-related harm.

Drug prevention

Drug prevention programs are non-legal initiatives (other than treatment) that aim to reduce, or have the effect of reducing, the demand for illicit substances and drug-related harm. The Victorian Drug Policy Expert Committee (2000) has suggested that prevention programs can be placed into three groups.

- Primary prevention, which encourages abstinence from drug use.
- Secondary prevention, which attempts to reduce drug abuse and drug dependency.
- Tertiary prevention, which aims to reduce drug-related harm amongst problem users.

Education and the provision of information play a key role in most prevention strategies leading many to equate prevention with school drug education programs and anti-drug social marketing campaigns (Victorian Drug Policy Expert Committee 2000). However, prevention programs now encompass a wide range of initiatives that not only increase awareness of the dangers associated with drug use, but also promote community cohesion, ensure supportive learning and working environments, provide positive alternatives to drug use and enhance the ability of communities, families and individuals to respond to drug problems.

Because of the breadth of drug prevention strategies, it is unusual to limit the mechanisms that are used in prevention to those that exclusively target drug problems. For this reason, an alternative method of categorising prevention programs divides them into two main groups: drug-specific and non-drug specific (or generic). Examples of drug-specific and non-drug specific programs are provided in Table 8.

Table 8 Drug and Non-Drug Specific Prevention Programs

Drug-specific prevention programs	Non-drug specific prevention programs
School drug education and substance use prevention programs Peer drug education programs Anti-drug social marketing campaigns (i.e. mass media campaigns) Workplace drug education programs Welfare and family support services for drug users and carers of drug users Drug injecting rooms or drug consumption rooms	Health promoting school programs* Programs involving the provision of recreational and social opportunities The welfare system (for example, unemployment benefits, public housing, family support services) Employment assistance and apprenticeship programs The child care system Occupational, health and safety programs

* 'Health promoting school programs' aim to enhance the capacity of schools to provide a 'healthy setting for living, learning and working'. The focus is on ensuring there is a safe learning environment, developing students' life skills, providing access to a variety of activities (for example, sport, drama etc) and support services (for example, nurses, councillors etc), and promoting links and cooperation between schools and the broader community (Grove 2002).

In many non-drug specific programs, the nexus between the program and drug problems may be quite remote and the program itself may not explicitly list addressing drug problems as one of its objectives. However, these programs and services often play a critical role in reducing risk factors and promoting protective factors. For example, the public education system contributes significantly to reducing poverty and social disadvantage while promoting connectivity between students and their community, conditions that can assist in reducing the risk factors and promoting the protective factors that are associated with drug misuse.

The success of prevention mechanisms in reducing drug use and drug-related harms varies considerably. Evidence concerning the efficacy of some of the more well-known drug-specific prevention programs is discussed below.

School drug prevention programs

The available data suggests that, when appropriately designed and implemented, school substance use prevention programs can make an important contribution in addressing drug problems (Dusenbury and Falco 1995; White and Pitts 1998; Lowden and Powney 2000; Midford *et al.* 2000; Ballard *et al.* 2002; Hawks *et al.* 2002). The difficulty is ensuring they are appropriately designed and delivered.

Early school drug education programs concentrated on the provision of information about drugs and teaching life-skills (for example, self-esteem and decision-making and communication skills) (Midford *et al.* 2000; Grove 2002). The assumption was that providing information about the dangers of drug use and promoting personal development skills would change attitudes and drug-use behaviour. However, when research into these programs was carried out, they were found to be ineffective in

preventing or stopping illicit drug use (Wragg 1992; Coggans and Watson 1995; Midford *et al.* 2000; Victorian Drug Policy Expert Committee 2000; Ballard *et al.* 2002; Hawks *et al.* 2002). An important criticism found that the assumed links between information, life skills and drug use were simplistic (Lowden and Powney 2000). As Lowden and Powney (2000) note:

[e]valuations have shown that ‘there is no simple relationship between knowledge gained about drugs, attitudes to drug use and drug-related behaviour’.

The failure of the early programs, together with a recognition of the complexity of the relationship between education and outcomes, has resulted in the creation of a wide range of approaches to school substance use prevention programs (Lowden and Powney 2000; Midford *et al.* 2000; Ballard *et al.* 2002; Grove 2002; Hawks *et al.* 2002). These are often placed into five broad groups (Coggans and Watson 1995; Lowden and Powney 2000).

- Information-based approaches that focus on providing information on drugs and their effects on users and society.
- Life-skills and values-deficit approaches that aim to give people a range of skills to help them make well-informed decisions on drug use (for example, self-esteem, ability to cope with social anxiety and decision-making and communication skills).
- Resistance training and normative education that seek to provide people with the skills and values to assist them in resisting drug use or drug abuse and external ‘pressures which promote health-compromising behaviours’ (Lowden and Powney 2000).
- Alternatives-based approaches directed at promoting alternatives to drug use and changing social environments that may be conducive to drug taking and drug abuse, usually by involving vulnerable people in community-based activities.
- Peer education approaches that ‘aim to use the interactions between peers, and the associated socialisation and influence, to promote health-related behaviours and reduce drug-use’ (Lowden and Powney 2000).

The results from these various approaches to school drug prevent have been mixed – see Table 9 below. Not surprisingly, the evidence indicates that design and implementation are critical to the success of any program (Coggans and Watson 1995; Lowden and Powney 2000; Midford *et al.* 2000; Hawks *et al.* 2002). Some of the more important elements include: realistic objectives, an appropriate fit between the program and the target audience (for example, any information provided is relevant and of immediate use), open exchange of information and ideas between teachers and students, and the provision of coherent and consistent messages (Coggans and Watson

1995; Lowden and Powney 2000; Victorian Drug Policy Expert Committee 2000; Midford *et al.* 2000; Hawks *et al.* 2002).⁵⁴

There is a considerable amount of support for comprehensive programs that combine classroom activities with parental interventions, social marketing and other broad community-based support activities (Victorian Drug Policy Expert Committee 2000; Lowden and Powney 2000; Grove 2002; Hawks *et al.* 2002). As the Victorian Drug Policy Expert Committee (2000, p. 84) explains:

[r]esearch indicates that strategies that are comprehensive (involving school, community, parents, community organisations and social policy) are more likely to be effective generally than single channel programs (for example, school educational programs for substance use or mass media advertising) on their own.

Similarly, Hawks *et al.* (2002, p. 43) state that:

... there are conceptually sound arguments for providing comprehensive school substance use education programmes, as messages are then more likely to be reinforced by many sources in which young people are exposed.

Comprehensive programs generally aim to promote student wellbeing and their sense of connectedness to their school, family and peers, while also helping to build appropriate support structures (Lowden and Powney 2000; Victorian Drug Policy Expert Committee 2000; Grove 2002). In this way, they are able to target a collection of risk and protective factors and ensure students receive mutually reinforcing messages. Nevertheless, despite the ‘conceptually sound arguments’ supporting comprehensive approaches, there is currently relatively little evidence supporting their effectiveness (Hawks *et al.* 2002).

A research result that is worthy of note is the apparent ineffectiveness of school programs that focus on abstinence. According to Hawks *et al.* (2002, p. x):

... there is evidence that programmes having [abstinence as their goal] consistently fail to produce behavioural effects suggesting that there is a need to develop programmes with outcomes other than abstinence as their goal.

In summary, although there are difficulties with school initiatives, they appear to have the capacity to make an important contribution to reducing the personal and social costs of illicit drugs (White and Pitts 1998; Victorian Drug Policy Expert Committee 2000; Midford *et al.* 2000; Grove 2002; Hawks *et al.* 2002). Care must be taken in designing and implementing these programs, but their problems are not insurmountable and there is sufficient evidence of their benefits to warrant their continued support. Progress in promoting school drug education has been made in recent times by all Australian jurisdictions; however, it appears there are still deficiencies and problems associated with under-investment (Department of Education Science and Training 2004).

⁵⁴ Several studies have suggested that interactive programs are between two and four times more effective than non-interactive programs (Hawks *et al.* 2002).

Table 9 Efficacy of drug education

Approach	Results and critique
Information-based	Little or no impact on reducing the prevalence of drug use (Wragg 1992; Lowden and Powney 2000; Hawks <i>et al.</i> 2002), but appropriately designed information programs may assist in reducing drug-related harm and the provision of information can play an important part in other types of school drug prevention programs (Coggans and Watson 1995; Lowden and Powney 2000; Hawks <i>et al.</i> 2002).
Life-skills	Limited impact on reducing the prevalence of drug use (Lowden and Powney 2000), but may help to reduce frequency of use and the number of users graduating to harder drugs (Coggans and Watson 1995; Lowden and Powney 2000; Hawks <i>et al.</i> 2002). Criticised for being based on the assumption that drug use and drug abuse are caused by a lack of social skills (Lowden and Powney 2000).
Resistance training and normative education	Mixed evidence. Some research suggests this approach is effective, particularly the normative education component (Lowden and Powney 2000; Hawks <i>et al.</i> 2002). Others argue there is little evidence to support resistance training and normative education initiatives and that the theory on which the approach is based is flawed (Coggans and Watson 1995; Lowden and Powney 2000).
Alternative-based	Insufficient evidence on which to evaluate these programs accurately (Coggans and Watson 1995; Lowden and Powney 2000). There is some evidence suggesting alternative-based approaches can have positive outcomes if they are integrated with broader community-based support activities (Lowden and Powney 2000).
Peer education	The 'evidence for effectiveness of this approach is inconclusive' and the outcomes are likely to be highly dependent on the structure of the program (Lowden and Powney 2000; Hawks <i>et al.</i> 2002). It appears that peer interaction is important to success, supporting other findings on interactive programs that encourage the exchange of ideas and experiences (Hawks <i>et al.</i> 2002).

Mass media and social marketing

Social marketing is a phrase that describes the use of commercial marketing techniques to influence the voluntary and involuntary behaviour of individuals in a way that is likely to benefit society (O'Connor and Parker 1995; Victorian Drug Policy Expert Committee 2000; Donovan and Henley 2003; Goren 2005). It can involve the use of the mass media, as well as more limited methods of delivering information, for example information brochures and targeted internet campaigns.

Over the last 20 years, mass media has played an increasingly prominent role in the social marketing of drug-related issues in Australia. A large number of government funded television, radio and newspaper advertisements have been run in an attempt to raise drug awareness, encourage abstinence and alter drug use behaviour. These have included the National Tobacco Campaign, numerous drink-driving campaigns, responsible drinking advertisements and, more recently, the National Illicit Drug Campaign, which was launched in 2001. Between 1996 and 2004, the Federal Government alone spent \$17.5 million on anti-smoking advertising campaigns, \$5.5 million on alcohol abuse campaigns and \$7.7 million on illicit drug campaigns (Department of the Prime Minister and Cabinet 2004).

Despite the increasing popularity of drug-related mass media marketing campaigns, there is very little evidence that they are capable of altering problematic drug-use behaviour unless they are integrated with other prevention programs (Carroll 1996; Hawks *et al.* 2002; Australasian Centre for Policing Research 2002; Bertram *et al.* 2003; Hornik *et al.* 2003; Loxley *et al.* 2004; Goren 2005). Studies have demonstrated their ability to raise awareness and understanding of drug issues, promote debate and assist in the introduction of new drug policy measures (Hawks *et al.* 2002; Australasian Centre for Policing Research 2002; Bertram *et al.* 2003; Hornik *et al.* 2003; Goren 2005). Yet, if they are not combined with other initiatives, media campaigns seem to be incapable of making notable inroads into drug misuse. Hawks *et al.* (2002, p. x) accurately summarised the evidence when they concluded that:

[t]he use of the mass media on its own, particularly in the presence of other countervailing influences, has not been found to be an effective way of reducing different types of psychoactive substance use. It has however been found to raise information levels and to lend support to policy initiatives. Combined with reciprocal and complementary action, particularly environmental changes, media campaigns have proved more successful in influencing attitudes towards psychoactive substance use and use itself.

The results of drug-related media campaigns appear to mirror those found in relation to information-based school prevention programs and reinforce the findings concerning the complex nature of the relationship between information, attitudes and behaviour.

Although they have their limitations, drug-related mass media marketing campaigns can play an important role in drug prevention strategies. Their ability to increase knowledge and raise awareness can be useful in facilitating improved prevention and treatment outcomes and increasing support for new policy initiatives (Hawks *et al.* 2002). When combined with other measures, social marketing can also reduce drug-related harm. This has been demonstrated by drink-driving campaigns, which have proven to be a cost-effective way of reducing alcohol-impaired driving and alcohol-related vehicle accidents when operated in conjunction with other law enforcement and prevention programs (Elder *et al.* 2004; Delaney *et al.* 2004). At the very least, media campaigns can provide people with the opportunity to make more informed decisions about illicit drug use and drug policies.

Drug consumption rooms (DCRs)

DCRs are legally sanctioned drug consumption facilities that allow drug users to consume pre-obtained drugs in a hygienic and professionally supervised environment (Kimber *et al.* 2003; Freeman *et al.* 2005).⁵⁵ In Australia, they are most commonly associated with the controversial Sydney Medically Supervised Injecting Centre (MSIC) in Kings Cross.

There is a considerable amount of evidence that DCRs are effective in reducing drug-related harm (MSIC Evaluation Committee 2003; Kimber *et al.* 2003; Kimber *et al.* 2005; Hall and Kimber 2005), their main health benefits being their capacity to decrease overdoses, drug-related deaths and blood borne-virus risk behaviour (MSIC Evaluation Committee 2003; Kimber *et al.* 2003; Kimber *et al.* 2005; Hall and Kimber 2005). They can also link drug users with health services and help facilitate the movement of people with substance misuse disorders into treatment (Malkin 2001; MSIC Evaluation Committee 2003).

One of the fears associated with DCRs is that they could create social problems (Mitchell 2005), but the available evidence suggests that drug-related crime and public nuisance problems do not increase around these centres (MSIC Evaluation Committee 2003; Freeman *et al.* 2005; Hall and Kimber 2005) and, in some cases, they have declined (Kimber *et al.* 2003).

The apparent benefits and minimal downside associated with DCRs has led a wide range of people to support their trialling in Australia, including the Victorian Drug Policy Expert Committee, Australian Drug Foundation, Alcohol and Other Drugs Council of Australia and the Victorian AIDS Council (Malkin 2001; Australian Drug Foundation 2001). Some have even argued that international law requires Australia to trial DCRs (Malkin 2001). Despite the evidence of their virtues and support from a number of prominent groups and individuals, Australia currently has only one DCR, the Sydney MSIC.

There have been proposals to trial DCRs in other Australian jurisdictions, but community and political opposition have thwarted these plans (Hall 1999; Malkin 2001). Moreover, there is a significant risk that the Sydney MSIC will be closed. Claims have been made that it is acting as a 'honey pot for drug dealers' and New South Wales Opposition Leader, Peter Debnam, has vowed to close the centre if the Liberal-National Party Coalition wins office (Mitchell 2005).

The degree of community opposition to DCRs is regrettable, as is the tendency of political parties to attempt to manipulate DCR trials for political purposes. Not only have these factors stifled the adoption of DCRs, but when they have been trialled, the anxiety about their social effects has led to conditions being placed on their operation that have hindered their ability to generate measurable benefits. As Hall and Kimber (2005, p. 272) have noted:

... the conditions under which trials in supervised injecting facilities have been established make it unlikely that they will have a large effect on the harms

⁵⁵ DCRs are a legal and non-legal policy mechanism because they rely on either changes to the law or its non-application to work effectively.

caused by injecting drug use. Governments typically impose age limits on clients of supervised injecting facilities, exclude intoxicated and pregnant injectors, and restrict the number of facilities ... all of which limit the reach and hence the effect that the facilities might have on population-level measures of drug-related harm.

These obstacles set up a cycle whereby governments and members of the community refuse to support DCRs due to a lack of evidence about their benefits, while blocking trials that are likely to produce measurable outcomes. Despite these limitations, overseas trials and the results of the evaluation of the Sydney MSIC provide sufficient evidence of the benefits of DCRs to support their wider introduction in Australia.

Drug treatment

Drug treatment has been defined as:

... interventions that aim to eliminate dependence and/or reduce substance use to safer levels in a context of the overall amelioration of the harms associated with ongoing drug use (Victorian Drug Policy Expert Committee 2000, p. 104).

There are a number of different forms of drug treatment and several different ways in which treatment is delivered to drug users. Treatment programs range from brief interventions, short-term treatment episodes of minimal contact primarily involving the provision of education and information, through to long-term community and residential-based programs. The services offered in treatment programs include case assessment, withdrawal management (or detoxification), counselling, rehabilitation, peer support, the provision of information and education, and pharmacotherapy (i.e. the prescription and provision of drugs such as methadone) (Victorian Drug Policy Expert Committee 2000; AIHW 2005e).

In addition to specialist drug treatment, drug-related health care services are sourced by drug users from the broader health care system which serves as an initial point of contact for many acute and chronic drug problems. General practitioners assist in the diagnosis of drug problems, prescribe treatment and can refer drug users to specialist treatment facilities. Drug users also rely heavily on the emergency departments of hospitals for the provision of acute care, particularly overdoses and drug-related trauma injuries (Victorian Drug Policy Expert Committee 2000; Cretikos and Parr 2003). For example, research from the intensive care unit at Liverpool Hospital in Sydney found that six per cent of presentations over the study period were non-alcohol drug-related; 80 per cent of these concerned overdoses and 16 per cent were trauma cases involving drugs (Cretikos and Parr 2003). Other health services that play an important role in drug treatment include ambulances, mental health facilities and child and family health centres (Victorian Drug Policy Expert Committee 2000; Mental Health Council of Australia and Brain and Mind Research Institute 2005).

Studies from around the world have consistently shown that drug treatment can substantially reduce drug abuse and dependency problems.⁵⁶ According to the United States National Institute on Drug Abuse:

... treatment of addiction is as successful as treatment of other chronic diseases, such as diabetes, hypertension, and asthma (National Institute on Drug Abuse 1999, p. 15).

Research has shown some variance in the success of different treatment programs with respect to certain drugs and between treatment types.⁵⁷ However, the results provide strong support for the central role of treatment in reducing drug misuse problems, particularly pharmacological maintenance treatments. For example, research undertaken on heroin treatment as part of the Australian Treatment Outcomes Study found that 'last month' heroin use amongst users in treatment declined from 95.7 per cent to 55.7 per cent after three months and 32.9 per cent after 12 months (Bament *et al.* 2004). The study also found marked decreases in heroin dependence, the use of other drugs, injecting drug use and overdoses (Bament *et al.* 2004).⁵⁸ The majority of the participants in the study were undergoing maintenance pharmacotherapy.

Not only does treatment reduce substance misuse, but it has also been shown to reduce associated health and social problems. For example, the evidence demonstrates that drug treatment can substantially reduce drug-related crime and mental illness.⁵⁹ Research from the United Kingdom found:

... an estimated fall in crime costs of £16.1 million in the first year after index treatment compared to the year before treatment ... and a fall of £11.3 million in the second year after treatment compared to the year before intake (Godfrey *et al.* 2004, p. 703).

Similarly, the Australian Ministerial Council on Drug Strategy (2001b, p. 33) stated succinctly that:

[t]reatment is one of the most effective strategies for preventing drug use, crime and the next generation of problems.

The combined effect of treatment on patient outcomes and drug-related health care and criminal costs make it an extremely cost-effective method of addressing drug

⁵⁶ See Mattick and Hall (1993); Hubbard *et al.* (1997); Metrebian *et al.* (1998); Ward *et al.* (1999); National Institute on Drug Abuse (1999); Metrebian *et al.* (2001); Ministerial Council on Drug Strategy (2001b); Franey and Ashton (2002); Gossop *et al.* (2002); Gossop *et al.* (2003); Mattick *et al.* (2003); Godfrey *et al.* (2004); Meara and Frank (2005); and Belenko *et al.* (2005).

⁵⁷ See, for example, Best *et al.* (2001b); Ministerial Council on Drug Strategy (2001b); and Lind *et al.* (2004).

⁵⁸ For similar findings on the efficacy of methadone treatment, see Metrebian *et al.* (1998); Ward *et al.* (1999); Metrebian *et al.* (2001); Gossop *et al.* (2003); Mattick *et al.* (2003); Lind *et al.* (2004) and Amato *et al.* (2005). There is also evidence that other opiate treatments like buprenorphine maintenance can be effective in addressing opiate dependence and related-health problems (Ward *et al.* 1999; Barnett *et al.* 2001; Amato *et al.* 2005).

⁵⁹ See National Institute on Drug Abuse (1999); Ministerial Council on Drug Strategy (2001b); Gossop *et al.* (2002); Gossop *et al.* (2003); Flynn *et al.* (2003); Lind *et al.* (2004); Bament *et al.* (2004); and Belenko *et al.* (2005).

problems (National Institute on Drug Abuse 1999; Ministerial Council on Drug Strategy 2001b; Godfrey *et al.* 2004; Belenko *et al.* 2005). The United States National Institute on Drug Abuse has stated that:

[a]ccording to several conservative estimates, every \$1 invested in addiction treatment programs yields a return of between \$4 and \$7 in reduced drug-related crime, criminal justice costs, and theft alone. When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1 (National Institute on Drug Abuse 1999, p. 21).⁶⁰

In summary, drug treatment works. It can reduce substance misuse disorders, problematic drug use behaviour, drug-related mental health problems and crime, and it can do so in a cost-effective manner. Substance misuse disorders are a health problem and the effectiveness of treatment reinforces the notion that they should primarily be dealt with through the health system. This does not mean that drug treatment is a complete solution to drug problems. Not all treatment is successful and there are limits to the quantum of resources that should be invested in treatment services (Meara and Frank 2005).⁶¹ However, at present, drug treatment in Australia is grossly under-resourced and there are gaping holes in the available services.⁶²

As in the case of DCRs, political influences have played an influential role in restricting the reach of treatment services. The Howard Government's refusal to allow a heroin trial in the Australian Capital Territory and the reluctance of state governments to undertake their own trials is one example of politics hindering medical practice. Compared to other opiate treatments, few detailed studies have been conducted on the effectiveness of heroin prescription in reducing opiate dependence and other related health issues. However, the available evidence indicates that it is safe and reasonably effective in reducing illicit drug use, drug-related health problems and crime, particularly amongst severely dependent opiate users (Wodak 2005). The fact that heroin prescription appears to provide a treatment option for highly dependent opiate users is of importance, as this small group of users accounts for a disproportionate amount of the social costs of illicit drug use, including crime, adverse health effects and recruitment of new illicit drug users (Wodak 2004). Despite the promise shown by heroin prescription, governments continue to refuse to establish an Australian trial on its effectiveness, thereby denying users and society its potential benefits.

⁶⁰ Similar results have been found in the United Kingdom (Godfrey *et al.* 2004). See also Mears *et al.* (2002).

⁶¹ The treatment of meth/amphetamine dependence and abuse problems is especially difficult. There is currently limited evidence that the available treatments generate positive results (Srisurapanont *et al.* 2001).

⁶² See Wodak (1999); Victorian Drug Policy Expert Committee (2000); Wodak and Moore (2002); House of Representatives Standing Committee on Family and Community Affairs (2003); McKetin *et al.* (2005); and Mental Health Council of Australia and Brain and Mind Research Institute (2005).

7.4 The balance between legal and non-legal policy mechanisms

There are four important questions to consider in this context.

- How much money is spent on drug law enforcement?
- How is the drug law enforcement budget divided between demand- and supply-side issues, and between the so-called ‘soft’ and ‘hard’ drugs?
- How much money is spent on non-legal policy mechanisms?
- How is the non-legal policy mechanism budget divided between the relevant programs and services?

Expenditure on drug law enforcement

As discussed, the estimated police, court and prison costs attributable to illicit drugs in 1998/99 was \$1.427 billion (Collins and Lapsley 2002). The major part of these costs was associated with policing activities (\$1.105 billion), followed by the operation of prisons (\$227.9 million), then the criminal courts (\$94 million). The current cost of policing, prosecuting and punishing drug offenders is not known (Wodak 2004). Since 1998/99, additional resources, for example from the National Illicit Drug Strategy, have been allocated to law enforcement agencies for the purpose of drug law enforcement. The Commonwealth claims to have committed over \$1 billion to this strategy since its launch in November 1997, ‘with a further \$439.6 million over four years announced in 2004’ (Commonwealth Department of Health and Aging 2005a). A significant proportion of these funds have been directed to law enforcement programs, including \$159.6 million to the AFP over seven years to the end of 2004/05 (AFP 2001) and \$325 million to the Illicit Drug Diversion Initiative over the period 1999 to 2007 (Howard 2002).⁶³ It is unclear how these changes have affected the total allocation of resources to drug law enforcement.

The split of law enforcement resources between supply and consumption of illicit drugs is also difficult to determine. One proxy for this division is provided by the data on arrests, which suggest consumption offences devour the largest share of police budgets – see Appendix C.

Between 1996/97 and 2003/04, the number of drug-related arrests fell by seven per cent, from 85,046 to 79,026 (AIHW 2005b).⁶⁴ Over the same period, the number of consumption arrests increased from around 60,380 to 63,220 and the proportion of illicit drug arrests that concerned consumption offences rose from 71 per cent to approximately 80 per cent (ACC 2001; ACC 2003; ACC 2005; AIHW 2005b).⁶⁵

⁶³ Part of this funding is used to pay for assessment, education and treatment services that are linked to diversion initiatives.

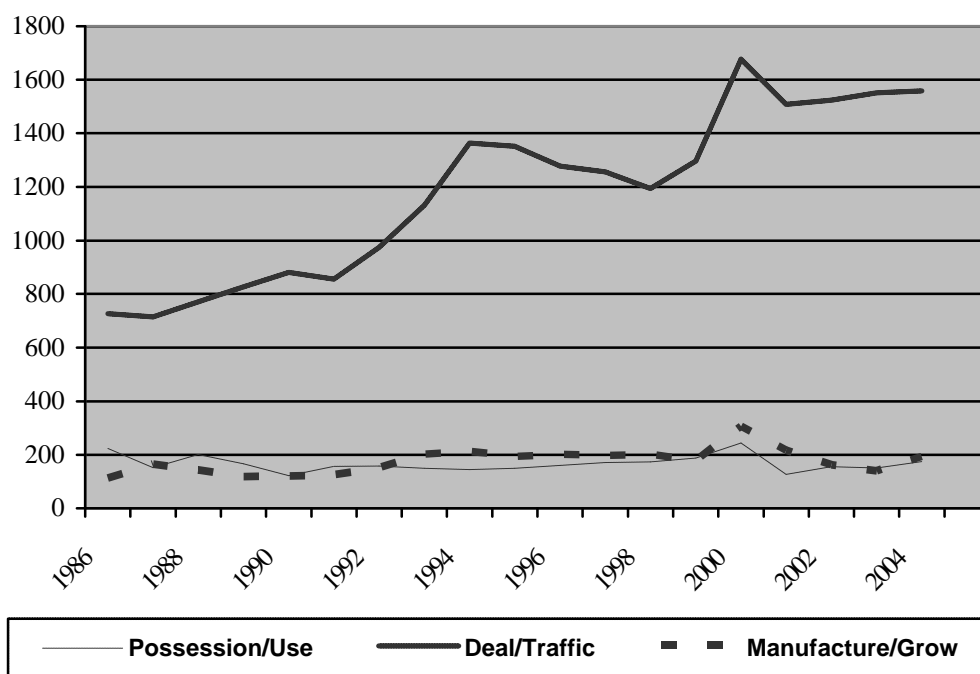
⁶⁴ Arrests for this purpose include the issuing of Cannabis Expiation Notices (South Australia), Simple Cannabis Offence Notices (Australian Capital Territory) and Drug Infringement Notices (Northern Territory) in relation to minor cannabis offences (ACC 2005).

⁶⁵ The increase in the number of consumption offences cannot be explained by ‘net-widening’ in jurisdictions that have civil penalty regimes for minor cannabis offences. Between 1997/98 and 2003/04, the total number of civil penalty notices issued for cannabis offences in South Australia, the Australian Capital Territory and the Northern Territory fell from 11,406 to 5,761, a decrease of almost 50 per cent (ACC 2005).

Drawing precise conclusions about the allocation of law enforcement resources on the basis of arrest statistics is impossible. However, these figures do indicate that a large proportion of police resources are being directed to demand-side drug law enforcement.⁶⁶

Further insight into the division of resources within the drug law enforcement budget is provided by imprisonment statistics. In 2004, 1,925 prisoners in Australia (or ten per cent of all prisoners) were serving sentences for a most serious offence involving illicit drugs (AIHW 2005b). Of these, approximately 174 were imprisoned for drug possession or use offences, 1,558 for trafficking offences, and 193 for production or manufacturing offences (AIHW 2005b). These figures have changed dramatically over the past 18 years, as there has been a significant increase in the number of people serving prison sentences for drug trafficking offences - see Figure 5.

Figure 5 Sentenced prisoners by type of drug offence, Australia – 1986 to 2004



Source: AIC 2005

These statistics suggest that the majority of illicit drug-related prison costs are attributable to drug trafficking and drug production (or supply-side issues). This may also be the case for court costs, although the proportional differences in expenditure are likely to be significantly less due to the greater probability of receiving a custodial sentence for a trafficking as opposed to a consumption/possession offence.

Similar difficulties are encountered when attempting to evaluate what proportion of law enforcement resources are currently directed to particular illicit drugs. A study published in 1995 found that regulation of the illicit cannabis market accounted for approximately 73 per cent of the total costs of illegal drug law enforcement in Australia in 1991/92 (Atkinson and McDonald 1995). The data on drug arrests

⁶⁶ See also Sutton and James (1996) and Green and Purnell (1996).

suggest this figure may still be a reasonable approximation of the proportion of police resources (if not total law enforcement resources) that are directed towards the cannabis market – see Appendix C.

In 2003/04, 72 per cent of all drug-related arrests were for the consumption or supply of cannabis, down from 81 per cent in 1996/97 (ACC 2005; AIHW 2005b).⁶⁷ Eighty-four per cent of cannabis arrests and 59 per cent of all drug arrests were for cannabis consumption (ACC 2005; AIHW 2005b). These figures suggest that while changes have occurred over the last decade, a significant proportion of police resources are still being directed to the regulation of the cannabis market. This is a conclusion that the Australian Crime Commission clearly agrees with.

High demand and the trend toward hydroponic production ensure that cannabis will continue to require the greatest allocation of law enforcement resources (ACC 2003, p. 18).

The other types of drugs that the arrest statistics suggest demand a large proportion of police budgets are opiates and meth/amphetamines. At the height of the heroin boom in the late 1990s, between 12 and 17 per cent of illicit drug arrests pertained to opiates and 74 per cent of these were consumption-related (AIHW 2005b). Since then, the proportion of illicit drug arrests involving opiates has fallen to around five per cent (AIHW 2005b). Over the same period, there has been a dramatic rise in the number of meth/amphetamine arrests. Between 1996/97 and 2003/04, meth/amphetamine arrests rose from 3,907 to 9,593 and around 12 per cent of illicit drug arrests now concern meth/amphetamines (AIHW 2005b). As these statistics indicate, the allocation of law enforcement resources between the various drugs appears to be highly influenced by the prevailing trends in the illicit drug markets.

Expenditure on non-legal mechanisms

It is currently impossible to determine the exact sum of money allocated to non-legal drug policy mechanisms, or even the amount allocated to drug health. The Collins and Lapsley (2002) study estimates that government expenditure on illicit drug-related health care in 1998/99 was \$68 million,⁶⁸ comprised of \$27.6 million on hospitals, \$30.8 million on medical, \$4 million on pharmaceuticals and \$5.5 million on ambulances. It is not clear how these amounts have changed since the late 1990s.

Further, there is very little data available on the amounts of money allocated to prevention programs like social marketing and drug education. In relation to social marketing, the Federal Government claims to have spent \$7.7 million on advertising campaigns aimed at illicit drugs between 1996 and 2004 (Department of the Prime Minister and Cabinet 2004). The 2005/06 Federal Budget also included an additional \$850,000 for the National Illicit Drugs Campaign, which budget papers suggest ‘will bring the total campaign budget to \$13.1 million over 2004-05 and 2005-06’

⁶⁷ The total number of cannabis arrests also decreased, falling from 69,136 in 1996/97 to 56,747 in 2003/04. The reduction is largely attributable to notable decreases in the number of cannabis arrests in Western Australia, New South Wales, Victoria and South Australia. Over the same period, there were significant increases in cannabis arrests in Queensland and the Australian Capital Territory. In Queensland, cannabis arrests rose from 13,021 in 1997/98 to 22,065 in 2003/04 (ACC 2005).

⁶⁸ This figure has not been adjusted to account for the savings in nursing home costs that arise due to premature deaths.

(Commonwealth Department of Health and Aging 2005b, p. 2). There is not enough information to estimate the amounts spent on equivalent advertising by the states and territories, nor the amounts invested in drug education, community programs and other prevention initiatives.

Funding distributed under the National Drug Strategy in its early years tended to be weighted in favour of health programs over law enforcement. As Single and Rohl (1997, p. 58) explain:

[t]he preponderance of NDS activities have been orientated towards health rather than law enforcement. ... The distinct emphasis on health programming under the NDS redresses a prior imbalance in Australia's national response, which was towards law enforcement approaches to illicit drugs.

Since 1992, there has been a more even distribution of funding between the various legal and non-legal options, although some have claimed that the financial support has been unjustifiably skewed towards law enforcement (Parliament of Australia Parliamentary Library 1998). Irrespective of whether this is correct, it is undeniable that the National Drug Strategy has resulted in some additional money being invested in prevention and treatment programs since the late 1990s. This has included 'more than \$124 million' between 1997 and May 2005 for the Non-Government Organisation Treatment Grants Program, \$31 million over the same time frame for the Community Partnerships Initiative, and the \$13.1 million noted above over two years for the National Illicit Drugs Campaign (Commonwealth Department of Health and Aging 2005a; 2005b).

Whether the amounts invested in treatment and prevention programs over the past decade have 'redressed the prior imbalance' is another question. The estimates compiled by Collins and Lapsley (1996; 2002) suggest that over 80 per cent of federal and state illicit drug resources are directed to law enforcement rather than non-punitive prevention and treatment measures. Further, there is little doubt that Australia's prevention and drug treatment services are still deficient, both in terms of resourcing and the services available.⁶⁹

Key points

- In order to be effective, drug strategies need to address the causes and consequences of drug misuse.
- There is a range of risk factors and protective factors that influence drug misuse. Risk factors include poverty, access to drugs, community disorganisation, educational difficulties, child neglect, being raised in a broken family and mental illness. Protective factors include strong community links, fitting in at school, positive reinforcement, attachment to family during adolescence, absence of family conflict as a child, parental supervision as a child and adolescent, and social competence in childhood.

⁶⁹ Wodak (1999); Victorian Drug Policy Expert Committee (2000); Wodak and Moore (2002); House of Representatives Standing Committee on Family and Community Affairs (2003); Department of Education Science and Training (2004); McKetin *et al.* (2005); Mental Health Council of Australia and Brain and Mind Research Institute (2005).

- There is a two-way relationship between a number of the socio-economic risk factors and drug misuse disorders. The risk and protective factors for drug use also overlap those for a number of other health and social problems, including mental illness and crime.
- Drug strategies can be divided into three parts: prevention, treatment and law enforcement.
- The available evidence strongly suggests that more liberal drug regimes can reduce the social costs of illicit drug markets. Liberalising existing drug regimes is likely to decrease drug-related harms, as well as those associated with drug law enforcement.
- The most important benefit offered by liberal drug regimes is the potential to reduce the economic, social and health risks to drug users, dependent petty dealers and their families and friends. Alternative drug regimes are also likely to result in a substantial reduction of the burden that drug markets place on government budgets. In most cases, enforcement, prosecution and punishment costs will be cut considerably and, in some instances, the state will be provided with a greater capacity to recoup the costs associated with drug consumption (for example, by imposing taxes on use or by increasing fines). In addition, more liberal drug regimes can reduce many of the adverse effects that drug markets and drug laws impose on the broader society, including drug-related violence, property crime and restrictions on civil liberties.
- There is a possibility that more liberal drug regimes may result in an increase in the prevalence of drug use (although in most cases this risk appears to be slight and manageable), but it is unlikely that there will be an increase in substance use disorders and other drug-related harms.
- Drug prevention programs are non-legal initiatives (other than treatment) that aim to reduce, or have the effect of reducing, the demand for illicit drugs and drug-related harm. They include drug-specific programs like school drug prevention initiatives, social marketing and drug consumption rooms (DCRs), as well as non-drug specific programs like the welfare system, employment assistance programs and the child care system.
- Neither school drug prevention programs nor social marketing campaigns are likely to make large inroads into illicit drug problems. They can however, play an important role in reinforcing attitudes against drug misuse, raising awareness about drug problems, linking users and prospective users with support services and creating public support for new drug policy initiatives.
- Drug consumption rooms (DCRs) have been proven to be effective in reducing drug-related harm (including overdoses, overdose deaths and the transmission of disease). The evidence suggests that DCRs have few adverse side effects and that they do not increase drug-related crime or public nuisance problems as is often claimed by critics.
- Non-drug specific prevention programs (particularly the welfare, public education, public health and child care systems) play an important role in

preventing drug problems and they require ongoing political and social support. Drug problems need to be viewed as part of broader social and health strategies rather than as a stand-alone legal issue.

- Drug treatment aims to eliminate drug dependence and reduce substance use to safer levels in order to alleviate drug-related harms. The evidence shows that treatment can substantially reduce drug abuse and dependency problems, problematic drug use behaviour (for example, injecting drug use and needle sharing), mental health problems and drug-related crime. Studies have proven that treatment is extremely cost-effective, possibly yielding savings of up to \$12 for every one dollar invested. There is little doubt that treatment is the most cost-effective option available to address drug issues.
- Pharmacological maintenance treatments are the most effective in reducing the health and criminal costs associated with substance misuse disorders.
- The evidence indicates that Australia's treatment services are grossly underfunded and that they provide an inadequate range of services. The fault for this deficiency lies primarily with politicians and policy-makers rather than those providing the services.
- There is a striking imbalance in the investment of resources under Australian drug strategies. Law enforcement receives approximately 80 per cent of federal and state illicit drug resources. It also appears that a large proportion of enforcement resources are directed towards drug consumption offences, particularly those involving cannabis. In 2003/04, consumption offences comprised 80 per cent of illicit drug arrests with 72 per cent involving cannabis.

8. The inequity of current drug laws and drug law enforcement

Four principal arguments can be advanced with respect to the inequity of Australia's current drug laws and drug law enforcement policies.

- They result in an illogical and inconsistent treatment of different drugs and other dangerous behaviour.
- They punish victims and people who have a diminished capacity to control their behaviour.
- The drug laws are not uniformly enforced, meaning only certain drug offenders are arrested, charged, prosecuted and punished.
- They are inconsistent with values that are supposed to underpin our society.

8.1 Inconsistencies

There is no doubt that significant costs are associated with illicit drug use and that a large proportion of these costs are borne by society. But, there are many other activities that generate negative externalities and threaten the welfare of individuals that are not outlawed, such as sun-baking, mountain climbing, gambling, overeating and smoking. What makes illicit drugs different from other behaviours that have an adverse effect on human health and society?

Domestic and international political factors explain a great deal of the difference in the way drug issues are treated. Drug policy is highly emotive and politicians have proven adept at manipulating community fears and misunderstandings for electoral purposes. The influence of international factors should also not be underestimated. As discussed in Section 3, pressure from the United States and the United Kingdom was critical in the introduction of strict drug laws in Australia and elsewhere and there is no doubt that the international drug control regime and the support it attracts from countries such as the United States has stymied the trialling of more liberal alternatives.

From a rational, utilitarian-based policy perspective, there is no simple answer to the question of why drugs have been singled out for special treatment. Some illicit drugs, like heroin and crack cocaine, are highly addictive and have a high incidence of abuse. Given this, it is arguable that the personal and social risks associated with these drugs are of sufficient magnitude to warrant their tight regulation. However, this is not the case with all illicit drugs. When used appropriately, certain illicit drugs are unlikely to be significantly more dangerous than licit drugs or other dangerous activities. Further, even when the risks associated with hard drugs are taken into account, the evidence suggests that the harms associated with strict prohibition outweigh the benefits.

A number of arguments could be used to try to justify the different treatment of the specific drugs.

- Caffeine, tobacco and alcohol have been widely used and accepted drugs in western societies for hundreds of years and there is neither the political nor social will to change their legal status.
- Illicit drugs are prohibited by international law and it is important for Australia's foreign relations to continue to be a party to the relevant international treaties and conventions, and to adhere to their terms, irrespective of whether our drug laws lack a consistent philosophical and evidentiary basis.
- Licit drugs are less dangerous than illicit drugs.
- Illicit drugs pose a greater threat to young people and other vulnerable groups than licit drugs.

It is beyond the scope of this paper to review the counter arguments to the first two assertions, other than to note that there is considerable scope within international drug conventions for alternative, harm reduction strategies to be implemented. There is also no legal reason why Australia could not withdraw from the international drug conventions (Wodak and Moore 2002).⁷⁰ The third and fourth arguments deserve some comment.

Are licit drugs less dangerous than illicit drugs?

The available information suggests that licit drugs currently impose a far greater cost on society in terms of money, mortality and morbidity than illicit drugs. For example, Collins and Lapsley (2002) estimated that approximately 80 per cent of the total health care costs associated with drug abuse in 1998/99 were attributable to tobacco, while 16 per cent were attributable to alcohol. By comparison, only five per cent were attributable to illicit drug use (Collins and Lapsley 2002).

Similarly, it has been estimated that in 1998, a little over 19,000 deaths in Australia were caused by tobacco, 3,271 were attributable to alcohol, while only 1,023 people died as a result of illicit drug use (Ridolfo and Stevenson 2001).⁷¹ Arguably a more informative statistic than the raw number of drug-related deaths is the potential years of life lost, which 'provides a measure of the time lost because of premature mortality' (Ridolfo and Stevenson 2001, p. 4). The potential years of life lost approach allows the mortality figures to be adjusted to account for the fact that many illicit drugs tend to kill a larger proportion of young people than alcohol and tobacco. Yet, even when this measure is used, it appears licit drugs still impose a far greater cost on society than illicit drugs. According to Ridolfo and Stevenson (2001), in 1998 an estimated 184,579 years of life were lost due to tobacco, compared to 25,375 and

⁷⁰ For information on international law concerning drugs, see Fox and Mathews (1992); Manderson (1993); Norberry (1997); Dupras (1998); Sinha (2001) and Carstairs (2005).

⁷¹ The data on alcohol-related mortality and morbidity is complicated due to the so-called 'protective effects' associated with light and moderate alcohol consumption (Ridolfo and Stevenson 2001; Chikritzhs *et al.* 2003). When the lives saved due to these protective effects were accounted for, Ridolfo and Stevenson (2001) estimated that alcohol consumption actually decreased mortality by approximately 2,371 lives. Yet, the benefits of these protective effects are concentrated in the older age groups, while the adverse effects of alcohol consumption are spread more evenly across the population. Consequently, Ridolfo and Stevenson (2001) ultimately concluded that 21,147 years of life were lost as a result of alcohol consumption in 1998. Chikritzhs *et al.* (2003) reached similar conclusions.

21,147 years lost in relation to illicit drugs and alcohol respectively (Ridolfo and Stevenson 2001).

The fact that illicit drugs result in a greater number of potential years of life lost than alcohol may lead some to conclude that alcohol is less dangerous than illicit drugs. The figures concerning alcohol, however, are adjusted to account for the fact that light to moderate alcohol consumption can have a positive impact on health and life expectancy (Ridolfo and Stevenson 2001; Chikritzhs *et al.* 2003). These positive or protective effects are estimated to have saved approximately 26,739 years of life in the 65 years and over age group in 1998 (Ridolfo and Stevenson 2001). Yet, in the under 65 years age group, alcohol is still a greater cause of lost lives than illicit drugs. Ridolfo and Stevenson (2001) estimate that in 1998, 47,887 years of life were lost in the under 65 years age group as a result of alcohol consumption compared to 25,093 years lost in this age group due to illicit drugs.

The data on hospital admissions show a similar weighting towards tobacco and alcohol as that found in relation to mortality and potential years of life lost. In 1997/98, tobacco consumption accounted for 71 per cent of drug-related hospital patient days (Ridolfo and Stevenson 2001). The remaining 29 per cent were attributable to alcohol (22 per cent) and illicit drugs (seven per cent).

Although the available evidence concerning social costs, mortality and morbidity suggests that licit drugs impose greater costs on society than illicit drugs, this does not necessarily mean that illicit drugs are less dangerous. Two important points should be kept in mind.

- Current drug laws are supposed to suppress the supply of, and demand for, illicit drugs and therefore may reduce the harm caused by these drugs, both to individuals and the broader community. Accordingly, if drug laws were to be liberalised, there is a risk that both consumption and drug-related harm could increase. As discussed in Sections 6 and 7, the risk of this occurring is low (especially in relation to drug-related harm) and could be reduced further if changes to drug laws are made in the context of an appropriate prevention and treatment strategy aimed at reducing the demand for illicit drugs and mitigating drug-related harms.
- Whether a drug has an adverse impact on an individual will depend on a range of factors, including the chemical composition of the drug, the quantity that is consumed, its purity, whether it is taken in combination with other drugs, and the physiological and psychological characteristics of the user. Given the range of factors contributing to the health effects of a drug, it is often difficult to determine whether one drug is more dangerous than another.

Appendix B lists some of the adverse health affects that have been linked to some licit and illicit drugs and demonstrates that none of the major licit and illicit drugs is immune from health risks. Clearly, some drugs are more dangerous than others. For example, it appears a large proportion of the adverse health effects associated with illicit drugs are related to the use of opiates. Ridolfo and Stevenson (2001) estimated that in 1998, 77 per cent of illicit drug-related deaths were due to opiate dependence and abuse and opiate poisoning. They also found that conduct of this nature was responsible for approximately 31 per cent of hospital patient days attributable to illicit

drug use (Ridolfo and Stevenson 2001).⁷² Placing opiates in the same category as some other illicit drugs such as cannabis provides a distorted picture of the relative safety of licit and illicit drugs. Yet even cannabis can have adverse effects. Similarly, both alcohol and tobacco may be less dangerous than heroin, but they currently have a far greater impact on society.

Given the available evidence, there does not appear to be any compelling reason for the favourable treatment of alcohol and tobacco on health grounds. The case against tobacco is particularly strong. Not only is it responsible for the overwhelming majority of drug-related health costs, but a significant proportion of the adverse health effects associated with tobacco are also borne by non-users. Collins and Lapsley (2002) estimated that in 1998/99, 224 deaths, 77,950 hospital bed-days and \$47.6 million in hospital costs were caused by passive (or involuntary) smoking. Further, unlike alcohol and some illicit substances, there is no safe level of tobacco consumption (Collins and Lapsley 2002; Bjartveit and Tverdal 2005), with even light and moderate smokers likely to suffer adverse health affects. Tobacco (or more accurately nicotine), like many of the demonised illicit drugs, is also highly addictive (Tobacco Advisory Group of the Royal College of Physicians 2000).

One possible response is that tobacco and alcohol taxes largely offset the revenues expended by government in dealing with their adverse effects (Collins and Lapsley 2002). But this surely is a reason to liberalise the laws applying to illicit drugs like cannabis rather than prohibiting either alcohol or tobacco – an argument that is only made stronger when consideration is given to the magnitude of the costs associated with prohibition.

Do illicit drugs pose a greater threat to young people and other vulnerable groups than licit drugs?

The argument that illicit drugs pose a greater threat to young people and other vulnerable groups than licit drugs is complex. The available information suggests the following.

- A significant number of young people use both licit and illicit drugs. A survey undertaken in 2004 found that the lifetime prevalence of illicit drug use amongst people aged 14 to 19 years was 29 per cent and that 21 per cent of respondents in this age group had used illicit substances in the previous 12 months (AIHW 2005a). For those aged between 20 and 29, lifetime use of illicit drugs was 58.1 per cent and recent use (last 12 months) was 31.5 per cent. In the general population, lifetime use was 38.1 per cent and recent use was 15.3 per cent (AIHW 2005a). While the prevalence of illicit drug use among the young people is relatively high, so too is the use of alcohol and tobacco - see Table 10.

⁷² These figures are now likely to be noticeably different due to the decline in heroin use and rising popularity of methamphetamines. Since 2000, the number of opiate-related deaths and illnesses have decreased significantly, while methamphetamines-related health costs are undoubtedly on the rise, particularly in relation to mental illnesses (McKetin and McLaren 2004; McKetin *et al.* 2005).

Table 10 Proportion of young people using tobacco and alcohol (2004)

	Age Group		
	14-19	20-29	Aged 14+
Tobacco			
Daily	10.7	23.5	17.4
Weekly	1.6	3.2	1.6
Alcohol			
Daily	0.6	2.9	8.9
Weekly	24.4	47.6	41.2

Source: AIHW 2005a.

- Illicit drug-related mortality and morbidity is concentrated in the younger age groups. For example, 64 per cent of the 1,023 people who are estimated to have died in 1998 due to illicit drug use were under 35 years of age (Ridolfo and Stevenson 2001). Similarly, approximately 75 per cent of hospital separations caused by illicit drug use in 1998 involved people under 35 (Ridolfo and Stevenson 2001).
- A large proportion of the adverse health effects associated with illicit drug use in all age groups (including the young) are caused by opiates and methamphetamines. For example, Ridolfo and Stevenson (2001) estimate that in 1998, 79 per cent of illicit drug-related deaths in the under 35 age group (or 520 out of 658) were attributable to opiate poisoning, dependence and abuse (Ridolfo and Stevenson 2001). Similarly, approximately 46 per cent of the illicit drug-related hospital separations of people under 35 during that year were caused by opiate poisoning, dependence and abuse (Ridolfo and Stevenson 2001). In more recent times, the social costs of opiates have declined, but those associated with methamphetamines have increased dramatically (McKetin and McLaren 2004; McKetin *et al.* 2005).
- The adverse health effects of tobacco consumption are concentrated in the older age groups. For example, according to Ridolfo and Stevenson's (2001) analysis, only one per cent of the estimated 19,019 people who died as a result of tobacco consumption in 1998 were less than 35 years old and only 22 per cent were under 65. Yet, these adverse health effects are often a product of a sustained period of tobacco consumption that starts in younger age groups.
- Alcohol-related mortality and morbidity is more evenly distributed across the population. For example, approximately 835 people under the age of 35 years died as a result of alcohol use in 1998, approximately 25 per cent of the total number of alcohol-related deaths in that year (Ridolfo and Stevenson 2001). Similarly, Chikritzhs *et al.* (2003) found that people under 30 accounted for 28 per cent of the total number of acute deaths that were attributable to high risk drinking between 1992 and 2001.
- On raw numbers, tobacco and alcohol have a greater impact on young people than illicit drugs. In 1998, an estimated 1,014 people under the age of 34 years

died as a result of alcohol and tobacco use, compared to 658 deaths caused by illicit drugs in the same age group (Ridolfo and Stevenson 2001).⁷³ Similarly, Ridolfo and Stevenson (2001) found that in 1998, 171,053 hospital patient days concerning people under 35 were attributable to tobacco and alcohol (83,317 to tobacco and 87,736 to alcohol), which far exceeded the 72,543 linked to illicit drugs. However, a far greater number of young people use alcohol and tobacco than they do most illicit substances, particularly on a regular basis (AIHW 2000; Chikritzhs *et al.* 2003; Chikritzhs and Pascal 2004; AIHW 2005a).⁷⁴

It is difficult to draw definitive conclusions as to whether illicit drugs pose a greater risk to young people than licit drugs. There is little doubt that the adverse health effects associated with illicit drugs are concentrated in the younger age groups; however, tobacco and alcohol continue to have a greater impact on young people than illicit drugs. Further, any attempt to determine whether all illicit drugs are more or less dangerous than licit drugs glosses over the significant differences between different drugs, particularly between the various illicit drugs. The fact that a large proportion of mortality and morbidity associated with illicit drug use is attributable to opiates and methamphetamines is particularly problematic as it tends to distort the data concerning the health effects of illicit drugs.

In addition, the concentration of illicit drug use and drug-related harms in younger age groups also means that young people are often victims of the adverse effects of strict drug law enforcement. The recent cases of Schapelle Corby, Van Nguyen and the so-called Bali Nine vividly illustrate how young adults can get caught in the net of prohibition and suffer grossly disproportionate punishments for their actions. Australian drug laws are less repressive than those in Indonesia and Singapore, but they still result in young adults being drawn into the criminal justice system and deviant social networks. This leads to stigmatisation and increases the risk of developing further drug and criminal problems. As discussed, strict drug laws also magnify the health risks associated with drug markets and work against attempts to minimise the human cost of drug consumption. In effect, prohibition has dealt young people a double blow: it has failed to protect them from substance abuse disorders and magnified the risks associated with drug markets.

⁷³ When older age brackets are included, the estimated number of deaths that are attributable to licit drug use far outstrips those that are caused by illicit drug use. For example, an estimated 6,286 people under the age of 65 died as a result of alcohol and tobacco in 1998, compared with 990 deaths in this age group that were attributed to illicit drug use (Ridolfo and Stevenson 2001).

⁷⁴ In 1998, approximately 32 per cent of people aged between 14 and 29 years described themselves as regular (daily or most days) or occasional tobacco smokers (AIHW 2000). Similarly, almost 79 per cent of people aged between 14 and 29 years reported using alcohol on a regular (daily or most days) or occasional basis at that time (AIHW 2000). Cannabis is by far the most widely used illicit drug in Australia (AIHW 2005a; 2005c). Over 39 per cent of the population reported having used cannabis at least once in their life in 1998 (AIHW 2000). Reported lifetime use amongst young people is even higher (AIHW 2000; AIHW 2005). In 1998, approximately 36 per cent of people aged between 14 and 29 years reported having used cannabis in the previous 12 months, but only 40 per cent of these people used the drug once a week or more (AIHW 2000). The proportion of young people using other illicit drugs is significantly less than that reported for cannabis. In the 1998 survey, no other major category of illicit drug reported a recent use rate (i.e. use in the last 12 months) amongst people aged between 14 and 29 years that was above ten per cent (AIHW 2000).

The argument that illicit drugs pose a greater threat to other vulnerable groups in society than licit drugs is also difficult to sustain. The available evidence suggests there is a strong correlation between licit drug abuse and socio-economic disadvantage (Loxley *et al.* 2004). As Loxley *et al.* (2004, p. 66) state in relation to tobacco:

[t]he relationship between deprivation and health behaviour has been consistently demonstrated for cigarette smoking, which is more frequent among lower SES [Socio-economic Status] groups, people living in rented dwellings, those without private transport, the unemployed and those living in crowded accommodation.

Although there is similar link between illicit drug abuse and socio-economic disadvantage, there is no evidence that illicit drugs pose a greater threat to vulnerable socio-economic groups than licit drugs.

8.2 Punishing victims and those with diminished capacity

The risk and protective factors described in Section 7 illustrate that drug use is a product of a collection of interrelated issues, many of which are beyond the direct control of the individual. Once users become drug dependent, they often lose the ability to control their behaviour effectively and many resort to supplying drugs to support their drug use. Further, many drug users and dealers suffer from mental illnesses (Teesson and Proudfoot 2003; McKetin *et al.* 2005), which lessen their culpability for drug offences and other criminal behaviour.

With the exception of mental illness, it is arguable that these factors do not absolve those involved in drug markets from responsibility for their behaviour. However, at the very least, it is a consideration that should be taken into account when devising and implementing drug policies and punishing minor drug users and suppliers.

8.3 Who is punished for drug offences?

Drug laws are not uniformly enforced by police, nor is there consistency in the way in which drug offences are prosecuted and punished. This is a product of the discretion given to police, prosecutors and judges to handle offences in a manner that they believe will result in the best outcomes. Sometimes, the exercise of discretion is influenced by formal guidelines or policies that are supposed to guarantee that the outcomes of the criminal justice system are fair, as well as welfare-maximising. But this is not always the case.

In the United States, the evidence strongly suggests that African-Americans have borne the brunt of the government's 'War on Drugs' (Schiraldi *et al.* 2000; Beyer and Reid 2000). In a study of 37 states, it was found that the rate of incarceration for African-Americans for drug offences in 1996 was approximately 279 people per 100,000, compared to 20 per 100,000 amongst white offenders (Schiraldi *et al.* 2000). Similarly, between 1986 and 1996, the rate of drug-related incarcerations for African-Americans increased by approximately 465 per cent, *versus* a 115 per cent increase for white offenders (Schiraldi *et al.* 2000).

The situation in Australia does not appear to be as bleak as that in the United States. However, there are a number of facts that give rise to concerns about the manner in which drug laws are being enforced and the equity of the outcomes of the criminal justice system.

Firstly, as discussed, a significant proportion of the burden of existing drug laws falls on drug users – see Appendix C (Sutton and James 1996; Green and Purnell 1996). Secondly, when drug traffickers are apprehended and punished, they tend to be lower-level offenders, not the ‘Mr Bigs’ of the drug industry (Sutton and James 1996; Green and Purnell 1996). Thirdly, the majority of drug-related arrests are for the consumption or supply of cannabis. Finally, there is evidence that certain types of people tend to suffer greater criminal consequences as a result of their involvement in illicit drug markets than others (Beyer and Reid 2000). As Beyer and Reid (2000, p. 101), state:

[i]n Australia there is evidence of discrimination at every level of the criminal justice system, including police attention on the streets, police processing, courts, sentencing and in prison.

There are a number of possible explanations for the discrimination that occurs in the enforcement of drug laws including the tendency for certain communities to engage in more visible forms of drug-related behaviour, conscious and unconscious racial profiling by police, and language and cultural differences that influence outcomes (for example, body language) (Beyer and Reid 2000). There is also anecdotal evidence that police tend to ignore certain drug use behaviour amongst social and professional elites (Shand 2005).

8.4 Consistency with liberal values

In the vast majority of cases, the only direct harm caused by drug use is the adverse health effects suffered by the users. This is why drug use is often referred to as a ‘victimless crime’ (Dale 1999). Even with heavy users, the direct drug-related harms will usually be confined to the health effects suffered by the person consuming the drugs. In some cases, direct harm can be suffered by other non-users, as in the case of passive smoking, health effects on unborn children due to maternal drug use and needle stick injuries. However, on the whole, most of the direct harm associated with illicit drug use is confined to users and their families and friends.⁷⁵

Given the nature of the harm associated with drug use, it is arguable that laws that punish drug users are inconsistent with liberal values. As discussed in Section 4, the essence of liberalism is that the individual is best placed to determine what is in their best interests and society should only intervene when the actions of one person cause harm to another. In fact, John Stuart Mill made it clear that under his conception of liberalism, the state should only apply legal restrictions on drug use in extreme circumstances, for example when a person had demonstrated a propensity to injure others when intoxicated. According to Mill (1959, Chapter 5, para. 5):

... when there is not a certainty, but only a danger of mischief, no one but the person himself can judge of the sufficiency of the motive which may prompt

⁷⁵ Many of the direct adverse health effects of illicit drug use are outlined in Appendix B.

him to incur the risk: in this case, therefore, (unless he is a child, or delirious, or in some state of excitement or absorption incompatible with the full use of the reflecting faculty) he ought, I conceive, to be only warned of the danger; not forcibly prevented from exposing himself to it.

These ideals are arguably supposed to underpin our political system and, in this case, at the very least legislators should err on the side of caution when seeking to outlaw behaviour that imposes little or no direct harm on other people. Indeed, by punishing drug users, drug laws can cause greater direct harm to those most likely to be affected by the relevant behaviour - the users and their families and friends.

Key points

- Australia's drug laws are arguably unfair because they treat similar substances in an illogical and inconsistent manner, they often punish victims and others who have a diminished capacity to control drug-related behaviour, and the way in which they are enforced is often discriminatory.
- The inconsistency in the treatment of licit and illicit drugs cannot be justified on the grounds that tobacco and alcohol are necessarily less dangerous than other drugs. Certain illicit drugs like heroin and crack cocaine are more dangerous than licit drugs, but that may not be the case with 'softer' drugs like cannabis.
- Tobacco and alcohol are a far greater cause of mortality and morbidity in Australia than illicit drugs. While the adverse health effects associated with illicit drugs tend to be more concentrated in younger age groups than those associated with licit drugs, tobacco and alcohol are the cause of greater mortality and morbidity in young people.
- The fact that illicit drug-related harms are concentrated in younger age groups also means that young people are often victims of the adverse effects of strict drug law enforcement. Prohibition has dealt young people a double blow: it has failed to protect them from substance abuse disorders and magnified the risks associated with drug markets.
- In many cases, the only direct harm caused by illicit drug use is the adverse health effects suffered by users and the emotional distress suffered by their families and friends – hence the claim that drug use is a 'victimless crime'. Strict drug laws are, therefore, arguably inconsistent with liberal values that suggest that the state should only intervene when the actions of one person will cause harm to another.

9. Conclusion

History demonstrates that drug use is unavoidable in liberal societies and that prohibition is incapable of substantially reducing illicit drug consumption or drug-related harm. Given this reality, harm minimisation is the best objective for drug strategies. Any program that accords greater priority to reducing drug use than drug-related harm will cause more damage to society than it prevents.

The success of the harm reduction strategies that have been adopted as part of the National Drug Strategy illustrates this point (Single and Rohl 1997). Probably the most significant of these achievements has been the role played by needle and syringe exchange programs in reducing the spread of HIV/AIDS and other blood-borne diseases. An evaluation of these programs conducted on behalf of the Federal Government found that between 1991 and 2000, they prevented an estimated 25,000 cases of HIV and 21,000 cases of hepatitis C and saved between \$2.4 billion and \$7.7 billion (Health Outcomes International Pty Ltd *et al.* 2002). Few other programs can boast such statistics with respect to saving lives and money. Several other harm reduction initiatives have also helped prevent the loss of lives and lower the harms associated with illicit drug markets. Pharmacological maintenance treatments are an example. The evidence shows that methadone and buprenorphine treatment has been extremely successful in addressing substance misuse disorders and health and criminal problems associated with illicit drugs. Similarly, the tentative steps towards more liberal cannabis laws have proven to be reasonably successful and have shown what can be accomplished when the most repressive aspects of drug control regimes are ameliorated.

Despite these achievements, the National Drug Strategy has failed to realise the objective of minimising the harms associated with illicit drug markets. This is attributable to two main factors: the lack of appropriate prevention and treatment services particularly; and prohibition and drug law enforcement.

At present, drug prevention and treatment programs are grossly under-resourced and constrained in their reach with the evidence indicating that this shortfall in services is leading to a loss of lives and illness that could easily be avoided. The lack of drug consumption rooms and prescription heroin trials are the most visible signs of the deficiency in these services, but are merely indicative of a broader policy failure.

Governments should expand and improve the range of treatment services offered to drug users. In recent times, the Howard Government and others have advocated abstinence-based treatment, but the evidence shows that it is often the pharmacological maintenance programs that are the most effective in reducing drug-related harm and crime. Existing methadone, buprenorphine and other pharmacological maintenance services should be made more readily available to opiate users and further research should be undertaken on ways to treat meth/amphetamine-related disorders.

While the shortfall in treatment and prevention services is problematic, the greatest obstruction to the achievement of the harm minimisation objective of the National Drug Strategy appears to have been prohibition. Research clearly shows that more tolerant, practical approaches to drug control can reduce the harms associated with

illicit drug markets and drug laws. There may be a slight increase in the prevalence of drug use (although, if this occurs, it is likely to be temporary), but it is unlikely that more liberal drug laws will cause a rise in substance misuse disorders and other drug-related health risks. In fact, the evidence points in the other direction – more liberal drug regimes are likely to reduce drug-related harm. Even if there is a rise in drug use, where liberal drug regimes are appropriately designed and implemented, the evidence indicates that they will almost certainly reduce the net effect that drug markets and drug laws have on society. A small increase in drug use may be the price that society must pay for a decline in substance misuse disorders, corruption, crime, mental illness and the other economic, social and political costs that arise because of strict drug laws.

For around half a century, drug issues have been seen primarily as a legal issue that could be resolved by strict drug laws and rigid enforcement. This strategy has been an abysmal failure. Prohibition failed to prevent illicit drug use emerging as a major social issue in the 1960s and 1970s and it has been unable to stop the escalation of these problems in the later part of the 20th century and early 21st century. On the basis of the available evidence, it appears that the best thing that can be said of prohibition is that it may have resulted in a slightly lower incidence of drug use than might otherwise have been. The price paid for this underwhelming achievement has been enormous.

The evidence shows that prohibition has cost taxpayers billions of dollars, caused extensive corruption and fuelled employment, social and criminal problems. It has also ruined the lives of many otherwise law abiding individuals (often teenagers and young adults) and has caused substantial damage to the families and friends of drug users. Paradoxically, research indicates that prohibition may also have increased the health costs associated with illicit drug use by prompting unsafe drug consumption behaviour, deterring users from seeking medical treatment, increasing the risk of disease transmission and exacerbating the causes of substance misuse disorders.

The data suggest that the most glaring flaw in the current approach to drug market control concerns cannabis. Experience both in Australia and overseas indicates that lessening penalties for demand-side cannabis offences, or simply not enforcing them, does not result in a sustained increase in cannabis consumption or any notable increase in cannabis-related harm. In addition, liberal cannabis regimes usually cost less to enforce and generate fewer adverse impacts for users and society. The only major deficiency in the liberal approaches to cannabis that have been tried thus far is that they have not gone far enough and, as a result, have prevented the state from exercising an effective level of control over suppliers and diluted the benefits of the changes. The evidence indicates that if the objective is to minimise drug-related harm and the costs associated with drug law enforcement, serious consideration should be given to introducing a tightly regulated access regime for cannabis.

The case for drug law reform in relation to harder drugs is also compelling, yet governments have been less willing to trial alternatives which has resulted in a lack of evidence on the likely outcomes of more liberal regimes. However, what evidence is available indicates that liberal reforms are likely to produce significant benefits, including reductions in drug-related harm and the economic, social and personal costs associated with drug law enforcement. At the very least, governments should stop enforcing demand-side hard drug offences and establish broad diversion programs for

low-level supply offences, particularly where the offences are motivated by a desire to finance a drug habit. Every effort should be made to ensure that drug users and low-level suppliers are not incarcerated solely for drug offences. As the Ministerial Council on Drug Strategy (2001b, p. 28) has stated:

[a]s a general principle, detention is to be avoided whenever possible; it is expensive and can prove counter-productive for individuals and the community alike. Where the seriousness of an offence or other circumstances make detention unavoidable, there is a need to make better use of evidence-based therapeutic interventions within the detention system.

These changes, as well as those associated with cannabis, should be accompanied by an increase in prevention and treatment programs to reduce the risk of the reforms producing unwanted side-effects.

These pragmatic and evidence-based reforms are unlikely to appeal to the Howard Government. To date, its approach to drug issues has been characterised by a marked inconsistency between public rhetoric and public policy. In public, the Howard Government has wanted to be seen as reigning over a strict prohibition regime where no tolerance is shown towards those involved in illicit drug markets. The most visible sign of this political marketing is the current federal illicit drugs policy, called 'Tough on Drugs'. Many within the Howard Government have also advocated a switch in the focus of the National Drug Strategy from harm minimisation to harm prevention. However, until recently, this strict public stance on illicit drugs seemed to be more about posturing and politics than the substance of policy for while the Howard Government stood in the way of liberal drug law reforms and many innovative prevention and treatment programs, it tolerated a number of important harm reduction initiatives, including needle and syringe exchange programs and methadone treatment. This inconsistent approach has resulted in society having to endure unnecessary costs and harms associated with illicit drug markets, but it has ensured that Australia has avoided some of the more troubling aspects of a US-style 'War on Drugs'.

This dichotomy between rhetoric and policy is not confined to the Federal Government or the Liberal/National Coalition. State and territory Labor governments have also been keen to talk tough on illicit drugs and reluctant to adopt harm reduction initiatives and liberal drug reform. The best description of the state of play in relation to harm minimisation and harm reduction in Australia is an unstable truce. Governments talk tough and block controversial harm minimisation strategies, while supporting less contentious harm reduction initiatives.

Unfortunately, there is now evidence that this truce is unravelling. The Howard Government has recently passed laws enabling the Commonwealth to encroach into drug-related areas that have traditionally been the exclusive domain of the states and territories. It has also explicitly stated its desire to use these laws and associated processes to end civil penalty regimes that operate in relation to cannabis in four jurisdictions. Similarly, in early February 2006, the new Labor Premier of New South Wales, the Hon Morris Iemma MP, announced plans to introduce 'hardline' cannabis laws that would see people found cultivating as few as five hydroponically-grown cannabis plants facing up to ten years imprisonment. The leader of the opposition in New South Wales, the Hon Peter Debnam MP, has not ruled out toughening up the existing cannabis cautioning scheme and has indicated that he would shut down the

MSIC in Kings Cross if the Liberal/National Party Coalition is elected to government. If that is not sufficient evidence of a shift in sentiment, over a one month period between late October and late November 2005, *The Australian*, one of Australia's most conservative newspapers, published approximately 25 articles or opinions that were supportive of stricter drug laws.⁷⁶

The apparent move towards a stricter form of prohibition is not being justified on the basis of new evidence relating to the perils of harm minimisation or more liberal drug laws. Data and analysis have consistently demonstrated the virtues of harm minimisation, the pitfalls of prohibition and the benefits associated with more liberal drug regimes. The main justification being provided for the change appears to be that illicit drugs are harmful, particularly cannabis. Yet, most advocates of liberal drug reforms do not question the fact that there are hazards associated with drug use and that drug use should be discouraged. The key question is whether prohibition produces better net outcomes than the alternatives, and the evidence suggests that it does not.

Strict drug laws adversely affect drug users and society. In terms of drug users, the evidence indicates that prohibition causes unemployment and social difficulties, magnifies the health risks associated with drug use, and exacerbates the problems that contribute to substance misuse disorders. Importantly, drug law enforcement exposes users to criminal networks, harder drug users and drug traffickers, which can contribute to later involvement in the criminal justice system and lead to longer and more problematic drug use. In many cases, those apprehended, prosecuted and punished for drug offences also suffer mental illnesses that are related to their drug use. The arrest and punishment of these offenders can worsen the mental health problems they suffer and reduce the prospects of recovery.

The damage prohibition does to society is no less severe. Countless inquiries, both in Australia and abroad, have identified illicit drug markets as a major cause of government corruption. The social dislocation associated with illicit drug markets weakens government institutions and the trust that the community places in them. The financial burden of prohibition is also immense and, worst of all, the data show that money is often applied in ways that are counterproductive or ineffective.

The available information indicates that more liberal drug laws and law enforcement policies can decrease the harmful effects of drug laws and reduce the fiscal burden that drug law enforcement imposes on society. The weight of evidence suggests that these benefits can be obtained without increasing, and possibly decreasing, the net health costs associated with drug use. Outright prohibition also does not sit comfortably with Australian democratic values, being inconsistent with the way we treat other dangerous activities and with widely held liberal ideals.

While the evidence points towards the need for radical reform, the trend is in the opposition direction; strict drug laws and law enforcement, tempered by diversion programs aimed primarily at users. While diversion programs are an improvement on previous policies, they are no solution to the flaws in prohibition. They are costly, can be counterproductive and, in so far as they include compulsory or coerced treatment, are generally unproven. The entrenchment of Australia's drug policy in this

⁷⁶ This figure was derived from a search of Factiva, a media database (2 December 2005).

prohibition-based mould is harmful to society and sacrifices the gains offered by liberal drug laws and other harm reduction initiatives. Substance misuse disorders are a health problem, not a legal one. Governments need to admit the deficiencies of prohibition and pursue the changes that the evidence shows will produce better outcomes rather than trying to manipulate drug issues for political purposes.

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Appendix A Pre-arrest diversion programs for minor cannabis offences committed by adults

Jurisdiction	Relevant conditions	Penalty	Legislation
Total prohibition with formal cautioning systems			
New South Wales ¹	<p>Possession or use of not more than 15 grams of dried cannabis (leaf, stalk, seed or head – does not apply to plants, freshly cut cannabis, hashish or hash oil) and/or possession of equipment for use of cannabis.</p> <p>Must be for personal use, not trafficking.</p> <p>Person can only receive two cautions.</p> <p>Offender must have no prior convictions for drug, violent or sexual offences.</p> <p>Offender must admit offence, consent to caution and sign caution notice.</p> <p>Not be involved in another criminal offence at the time of arrest, for which a brief of evidence would be submitted.</p> <p>Caution must be appropriate.</p>	<p>First caution - Issued with a notice that contains education and treatment information.</p> <p>Second caution – offender required to participate in telephone health education session.</p>	Guidelines only, no legislative base.
Victoria ²	<p>Possession or use of not more than 50 grams of dried cannabis (leaf, stem, stalk, or seed – does not apply to plants, freshly cut cannabis, hashish or hash oil).</p> <p>Must be for personal use, not trafficking.</p> <p>Person can only receive two cautions.</p> <p>Offender must admit offence and consent to caution.</p> <p>Not be involved in another criminal offence at the time of arrest.</p> <p>Caution must be appropriate.</p>	Issued with a notice and information brochure, which includes details of a voluntary two-hour education program and referral service.	Guidelines only, no legislative base.
Queensland ³	<p>Arrested or questioned about a minor drug offence, which involves possession or use of not more than 50 grams of cannabis and/or possession of equipment for use of cannabis.</p> <p>Must be for personal use, not trafficking.</p> <p>Not be involved in another indictable offence in circumstances related to the minor drug</p>	Mandatory attendance to a Drug Diversion Assessment Program that consists of a combined assessment, education and counselling session with a health worker that takes	Guidelines and <i>Police Powers and Responsibilities Act 2000</i> (Qld).

	<p>offence.</p> <p>Offender must have no prior convictions for offence involving violence against another person.</p> <p>Offender must admit offence during an electronically recorded interview.</p> <p>Person can only receive one caution.</p> <p>Person must sign form acknowledging they accept the offer of the diversion program and agree to attend the Drug Diversion Assessment Program.</p>	approximately two hours	
Tasmania ⁴	<p>Possession or use of not more than 50 grams of cannabis and up to two cannabis plants (although the police have the discretion to divert people in circumstances where these limits are breached).</p> <p>Must be for personal use, not trafficking.</p> <p>Offender must admit offence.</p> <p>There must be sufficient admissible evidence of the drug offence.</p> <p>Not be involved in another offence involving violence and certain other issues (such as driving under the influence) at time of arrest.</p> <p>Person can have prior convictions and can be involved in certain other offences at time of arrest (for example, if a person is arrested for attempting to steal a car and is found to be in possession of a small quantity of cannabis, they can be charged and convicted of larceny, while receiving a diversion notice or caution in relation to the drug offence).</p> <p>There are three levels in the diversion program.</p> <ul style="list-style-type: none"> • First cannabis offence – person can receive a Cannabis Caution. • Second cannabis offence – person can receive a Drug Diversion Notice. • Third cannabis offence – person can receive a Drug Diversion Notice. <p>Person must agree to sign a Drug Diversion Notice before it will be issued.</p>	<p>First offence – issues with a Cannabis Caution, which contains education and treatment information.</p> <p>Second offence – issued with Drug Diversion Notice and required to attend brief counselling session.</p> <p>Third offence – issued with Drug Diversion Notice and required to attend assessment and follow-up treatment and education sessions.</p>	Guidelines only, no legislative base.

Infringement notice systems			
South Australia ⁵	<p>Not discretionary (i.e. relevant offenders must be given expiation notice, otherwise they cannot be prosecuted – although offender can elect to be prosecuted for offence, rather than having to comply with the expiation notice).</p> <p>Expiation notice must be issued for:</p> <ul style="list-style-type: none"> • possession of less than 100 grams of cannabis (which includes any part of a cannabis plant, but does not include cannabis resin or cannabis oil) or less than 20 grams of cannabis resin; • consumption of cannabis or cannabis resin, except where the offence is committed in a public place; • cultivation of not more than one cannabis plant, provided the cultivation is not artificially enhanced (for example, the plant is not grown hydroponically); and • possession of equipment for use in connection with consumption or preparation of cannabis or cannabis resin. 	Fines ranging from \$50 to \$150.	<i>Controlled Substances Act 1984 (SA)</i> and <i>Expiation of Offences Act 1996 (SA)</i> .
Western Australia ⁶	<p>Discretionary.</p> <p>Cannabis Infringement Notices (CIN) can be issued for:</p> <ul style="list-style-type: none"> • possession or use of not more than 30 grams of cannabis provided it does not involve cannabis resin or any other cannabis derivative; • cultivation of not more than two cannabis plants, provided the plants are located at the offender’s principal place of residence, no other cannabis plants are being grown on the premises by any other person, and the plants are not being hydroponically grown; and • possession of any pipes or other utensils for use in connection with the consumption of cannabis. <p>Offender can elect to be prosecuted for offence in court, rather than having to comply with the terms of a CIN.</p>	<p>If no CIN previously issued, offender can either pay a fine of up to \$200 or attend a Cannabis Education Session.</p> <p>If two or more CINs issued on separate occasions in past three years, offender must attend Cannabis Education Session.</p>	<i>Cannabis Control Act 2003 (WA)</i> and <i>Misuse of Drugs Act 1981</i> .

Australian Capital Territory ⁷	Discretionary. Simple Cannabis Offence Notices (SCON) can be issued for: <ul style="list-style-type: none"> • possessing not more than 25 grams of cannabis; • consuming cannabis; and • cultivation of not more than 2 cannabis plants, except for artificial cultivation. 	Fine of \$100.	<i>Drugs of Dependence Act 1989 (ACT).</i>
Northern Territory ⁸	Discretionary. Drug Infringement Notices (DINs) may be issued for: <ul style="list-style-type: none"> • Possession of less than 50 grams of cannabis plant material, 10 grams of cannabis seed, 10 grams of cannabis resin or 1 gram of cannabis oil; and • cultivation of not more than 2 cannabis plants. 	Fine of \$200.	<i>Misuse of Drugs Act (NT).</i>

¹ Information obtained from Baker and Goh (2004) and Johns (2004).

² Information obtained from NIDSDI – Victorian State Reference Group (2002).

³ Information obtained from Queensland Police (undated).

⁴ Information obtained from Biggs, S., Tasmanian Police Service (pers comms 6 September 2005); and Tasmanian Department of Health and Human Services (2005).

⁵ Information obtained from *Controlled Substances Act 1984 (SA)* and *Expiation of Offences Act 1996 (SA)*.

⁶ Information obtained from *Cannabis Control Act 2003 (WA)*, *Misuse of Drugs Act 1981*, WA Drug and Alcohol Office (2003); and WA Drug and Alcohol Office and WA Police Service (2004).

⁷ Information obtained from *Drugs of Dependence Act 1989 (ACT)*.

⁸ Information obtained from *Misuse of Drugs Act (NT)*.

Appendix B Health effects of licit and illicit drugs

Drug	Health effect
Alcohol	<p>Various forms of cancer, including gastrointestinal, oropharyngeal, liver and breast cancers (Chase <i>et al.</i> 2005; Collins and Lapsley 2002).</p> <p>Liver disorders, including cirrhosis, alcoholic hepatitis, and fatty liver (Chase <i>et al.</i> 2005; Collins and Lapsley 2002).</p> <p>Gastrointestinal disorders, including gastro-oesophageal reflux disease, gastritis, pancreatitis and haemorrhoids (Chase <i>et al.</i> 2005).</p> <p>Cardiovascular disorders, including stroke, coronary artery disease, hypertension, cirrhotic cardiomyopathy, alcoholic cardiomyopathy and heart failure (Chase <i>et al.</i> 2005; Collins and Lapsley 2002).</p> <p>Renal and metabolic disorders, including acute renal failure, hepatorenal syndrome and electrolyte disorders (Chase <i>et al.</i> 2005).</p> <p>Respiratory disorders, including atelectasis and an increased risk of pneumonia (Chase <i>et al.</i> 2005).</p> <p>Neurological disorders, including alcohol myopathy, withdrawal epilepsy, withdrawal seizures and impairment of memory, attention and cognitive function amongst heavy users (Chase <i>et al.</i> 2005; Collins and Lapsley 2002; Hall and Solowij 1998).</p> <p>Possible risk of causing depression and anxiety (Alati <i>et al.</i> 2005; Degenhardt <i>et al.</i> 2001).</p> <p>Trauma (for example, road injuries and falls), drowning and suicide (Collins and Lapsley 2002).</p> <p>Alcohol dependence (Collins and Lapsley 2002).</p> <p>Alcohol poisoning (Collins and Lapsley 2002).</p> <p>Assault and child abuse (Collins and Lapsley 2002).</p> <p>Possible modest negative impacts on educational attainment (Paschall and Freisthler 2003; Wood <i>et al.</i> 2000).</p> <p>Negative effects on unborn children, including Foetal Alcohol Syndrome and Alcohol Related Neurodevelopmental Disorder, which are characterised by growth retardation, facial abnormalities and central nervous system anomalies (O'Leary 2002).</p>
Tobacco	<p>Various forms of cancer, including anal, bladder, cervical, endometrial, lung, laryngeal, oesophageal, oropharyngeal, penile, stomach, colorectal, vulvar, pancreas and kidney cancers (Collins and Lapsley 2002; US Surgeon-General 2001).</p> <p>Cardiovascular disorders, including stroke, coronary artery disease, subarachnoid haemorrhage, cardiomyopathy, transmural myocardial infarction and heart failure (Collins and Lapsley 2002; US Surgeon-General 2001; Hartz <i>et al.</i> 1984).</p> <p>Respiratory disorders, including chronic obstructive pulmonary disease, pulmonary circulation disease and pneumonia (Collins and</p>

	<p>Lapsley 2002; US Surgeon-General 2001).</p> <p>Low bone density (US Surgeon-General 2001).</p> <p>Eye disorders, including increased risk of cataracts and macular degeneration (US Surgeon-General 2001).</p> <p>Gastrointestinal disorders, including peptic ulcers, Crohn's disease and ulcerative colitis (Collins and Lapsley 2002; US Surgeon-General 2001).</p> <p>Increased risk of Parkinson's disease (Collins and Lapsley 2002; US Surgeon-General 2001).</p> <p>There is a correlation between smoking and mental illness (including depression, anxiety and schizophrenia), but the reasons for the link are unclear (Degenhardt <i>et al.</i> 2001; US Surgeon-General 2001; Goodman and Capitman 2000).</p> <p>Negative effects on unborn children and infants, including increased risk of low birth-weight, reduced lung function, foetal and infant mortality and sudden infant death syndrome (SIDS) (Collins and Lapsley 2002; US Surgeon-General 2001).</p> <p>Fertility and reproduction disorders, including spontaneous abortions, menstrual abnormalities and infertility (Collins and Lapsley 2002; US Surgeon-General 2001).</p>
Cannabis	<p>Risk of acute psychotic episodes (particularly among heavy users and susceptible individuals) (Arseneault <i>et al.</i> 2004; Johns 2001; Hall <i>et al.</i> 2001; Hall 1998a), which can lead to the development of long-term psychotic conditions (Arendt <i>et al.</i> 2005).</p> <p>Risk of acute non-psychotic psychological reactions such as anxiety, panic and depression, particularly among inexperienced users (Hall <i>et al.</i> 2001).</p> <p>Possible risk of precipitating psychotic disorders in people who are vulnerable to mental illnesses, particularly amongst younger people (Hall <i>et al.</i> 2004a; Arseneault <i>et al.</i> 2004; Degenhardt <i>et al.</i> 2003b; Fergusson <i>et al.</i> 2003; Hall <i>et al.</i> 2001).</p> <p>Possible risk of causing psychotic disorders that would not have otherwise occurred, particularly amongst younger people (Arendt <i>et al.</i> 2005; Hall <i>et al.</i> 2004a; Arseneault <i>et al.</i> 2004; Degenhardt <i>et al.</i> 2003b; Fergusson <i>et al.</i> 2003; Hall <i>et al.</i> 2001).</p> <p>Possible risk of exacerbating the symptoms of a pre-existing psychosis (Hall <i>et al.</i> 2004a; Degenhardt <i>et al.</i> 2003b; Hall <i>et al.</i> 2001).</p> <p>Possible low risk of causing depression amongst frequent and dependent users (Degenhardt <i>et al.</i> 2003c).</p> <p>Respiratory illnesses (for example, bronchitis) (Hall <i>et al.</i> 2001; Weatherburn and Jones 2001; Lenton <i>et al.</i> 2000; Hall 1998b; Hall and Solowij 1998).</p> <p>Probable increase in the risk of certain cancers if cannabis is smoked (particularly of the aerodigestive tract) (Hall <i>et al.</i> 2001; Lenton <i>et al.</i> 2000; Hall and Solowij 1998).</p> <p>Cannabis dependence (Coffey <i>et al.</i> 2002; Jones and Weatherburn 2001; Lenton <i>et al.</i> 2000).</p>

	<p>Increase in the risk of using other illicit drugs and developing drug abuse and dependence problems, particularly amongst younger frequent users (Hall and Lynskey 2005; Ellickson <i>et al.</i> 2005; Lynskey <i>et al.</i> 2003; Hall <i>et al.</i> 2001; Hall <i>et al.</i> 1994).</p> <p>Increase in the risks of traffic and machinery accidents (Lenné <i>et al.</i> 2004; Kelly <i>et al.</i> 2004).</p> <p>Impairment of memory, attention and cognitive function amongst heavy users, although the effects are not as severe as those suffered by heavy alcohol users (Hall and Solowij 1998; Hall <i>et al.</i> 1994).</p> <p>Possible increase in the risk of birth defects if used during pregnancy, including lower than average birth-weight and length (Hall <i>et al.</i> 2001; Lenton <i>et al.</i> 2000).</p> <p>Possible low risks of impairing educational attainment (Degenhardt <i>et al.</i> 2003c; Lenton <i>et al.</i> 2000; Lynskey and Hall 2000; Hall and Solowij 1998).</p>
Opiates	<p>Fatal and non-fatal overdoses (i.e. opiate poisoning).</p> <p>Collapsed lungs.</p> <p>Pneumonia.</p> <p>Risk of contracting hepatitis B and C and HIV/AIDS from shared injecting equipment.</p> <p>Vein damage.</p> <p>Infertility and impotence.</p> <p>Opiate dependence.</p> <p>Chronic constipation.</p> <p>Road injuries.</p> <p>Antepartum haemorrhage.</p> <p>Low birth-weight.</p>
Meth/amphetamines	<p>Acute adverse effects including hypertension, sleeping difficulties, stomach upsets, headaches, dizziness, anxiety, depression, insomnia, and under-eating (Dyer and Cruickshank 2005; Comer <i>et al.</i> 2001; Vincent <i>et al.</i> 1998; Hando <i>et al.</i> 1997).</p> <p>Adverse neurological effects that may include depletion of presynaptic neurotransmitter stores, down-regulation of neurotransmitter transporters and receptors, neurotoxicity and decreased dopamine levels in certain brain regions (Dyer and Cruickshank 2005).</p> <p>Possible cause of mental illness, including mood swings, depression, anxiety and psychosis (Baker <i>et al.</i> 2004; Zweben <i>et al.</i> 2004; Vincent <i>et al.</i> 1998; Hando <i>et al.</i> 1997; Hall <i>et al.</i> 1996).</p>

	<p>Meth/amphetamine dependence (Dyer and Cruickshank 2005).</p> <p>Adverse withdrawal affects including drug craving, agitation, decreased energy, anxiety, loss of interest and pleasure, and sleep difficulties (Dyer and Cruickshank 2005).</p> <p>Risk of contracting hepatitis B and C and HIV/AIDS from shared injecting equipment.</p> <p>Possible negative effects on educational attainment (Vincent <i>et al.</i> 1998).</p>
Ecstasy (MDMA)	<p>Low risk of loss of normal control of body temperature leading to hyperthermia or hypothermia, which can cause death, seizures, rhabdomyolysis, renal and liver impairment, and disseminated intravascular coagulation (Gowing <i>et al.</i> 2002; Spruit 1999).</p> <p>Low risk of hyponatraemia (low concentration of sodium in the blood), which can lead to death and seizures (Gowing <i>et al.</i> 2002).</p> <p>Possible low risk of liver damage and hepatitis unrelated to hyperthermia (Gowing <i>et al.</i> 2002).</p> <p>Possible low risk of adverse effects on the central nervous system that can lead to fits and seizures (although the evidence suggests central nervous system effects are most likely due to impurities in ecstasy tablets) (Gowing <i>et al.</i> 2002).</p> <p>Risk of acute transient psychological effects, including paranoia, anxiety and depression (Gowing <i>et al.</i> 2002; Spruit 1999).</p> <p>Risk of sleeping difficulties (Gowing <i>et al.</i> 2002).</p> <p>Possible but unproven low risk of ecstasy dependence (Gowing <i>et al.</i> 2002).</p> <p>Possible adverse neurological effects and increased risk of psychiatric disorders, including impairment of short-term memory function, depression, and panic disorders (Gowing <i>et al.</i> 2002; Spruit 1999). The risk of psychiatric disorders appears to be greater amongst frequent users, people with a predisposition to psychiatric disorders, and polydrug users (particularly ecstasy-cannabis users) (Gowing <i>et al.</i> 2002).</p> <p>Possible low risk of acute adverse cardiovascular effects, including heart attack, ruptured blood vessels and cerebral haemorrhaging, particularly among people with pre-existing cardiovascular disorders (Gowing <i>et al.</i> 2002).</p> <p>Trauma (including road injuries and falls – although the evidence relating to vehicle accidents is not conclusive) (Gowing <i>et al.</i> 2002; Kelly <i>et al.</i> 2004).</p> <p>Tooth wear due to jaw-clenching and tooth-grinding (Gowing <i>et al.</i> 2002).</p> <p>Possible increased risk in birth defects (Gowing <i>et al.</i> 2002).</p>

Appendix C Illicit drug arrests in Australia, by drug type and consumer/provider status 1996/97 to 2003/04

Drug	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04
Number and proportion of total illicit drug arrests (in brackets)								
Cannabis*	69136 (81)	64861 (77)	58145 (70)	55268 (67)	54044 (70)	55585 (75)	55689 (74)	56747 (72)
Opiates	7140 (8)	10366 (12)	14341 (17)	11223 (14)	7391 (10)	3259 (4)	3824 (5)	3691 (5)
Meth/amphetamines	3907 (5)	4766 (6)	6584 (8)	8083 (10)	8846 (11)	7953 (11)	8313 (11)	9593 (12)
Cocaine	609 (1)	524 (1)	571 (1)	433 (1)	651 (1)	612 (1)	250 (0.3)	328 (0.4)
Hallucinogens	460 (1)	460 (1)	618 (1)	290 (0.3)	199 (0.3)	131 (0.2)	124 (0.2)	124 (0.2)
Steroids	71 (0.1)	71 (0.1)	87 (0.1)	74 (0.1)	90 (0.1)	112 (0.2)	113 (0.2)	99 (0.1)
Other	3723 (4)	3276 (4)	3201 (4)	6812 (8)	6400 (8)	6307 (9)	6660 (9)	8444 (11)
Total	85046	84324	83547	82183	77621	73959	74973	79026
Consumer arrests - as a proportion of arrests for each substance								
Cannabis	71	73	81	85	85	83	83	84
Opiates	70	70	74	74	70	62	66	65
Meth/amphetamines	69	70	76	77	76	73	72	93
Cocaine	43	61	58	76	70	82	70	66
Hallucinogens	67	72	81	58	62	62	58	47
Steroids	90	86	97	92	90	85	89	87
Other	82	77	76	80	80	76	73	78
Total	71	72	79	82	82	80	80	80

* Cannabis arrests include the issuing of Cannabis Expiation Notices (South Australia), Simple Cannabis Offence Notices (Australian Capital Territory) and Drug Infringement Notices (Northern Territory) (ACC 2005).

Source: AIHW 2005b; ACC 2005.



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Philosophy

The Institute was established in 1994 by a number of individuals from various sections of the community. They share a deep concern about the impact on Australian society of the priority given to a narrow definition of economic efficiency over community, environmental and ethical considerations in public and private decision-making. A better balance is urgently needed.

The Directors, while sharing a broad set of values, do not have a fixed view of the policies that the Institute should advocate. Unconstrained by ideologies of the past, the purpose of the Institute is to help create a vision of a more just, sustainable and peaceful Australian society and to develop and promote that vision in a pragmatic and effective way.

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