Regulator of Medicinal Cannabis Bill 2014
Submission 3 - Attachment 1

# DRUG LAW REFORM

NOVEMBER 2014

## DISCUSSION PAPER

Criminal Law Committee


NEW SOUTH WALES
BAR ASSOCIATION

## Contents



*Criminal lawyers, who see the human face of those caught up in the law concerning illegal drug use, have an obligation to bring what they see to the notice of their fellow citizens who may have more confidence than is warranted in the capacity of criminal law and punishment to deliver results.*

Kirby, M. 'The Future of Criminal Law' (1999) 23 *Criminal Law Journal* 273.

## Executive summary

The Criminal Law Committee of the New South Wales Bar Association is composed of barristers who both prosecute and defend those caught up in the criminal justice system as a result of the current policy of drug prohibition. Based on the available research here and overseas and our own professional experience we have reached the following conclusions:

- Illicit drug use undoubtedly results in both primary and secondary harm, particularly for dependent users.
- However, the total social costs arising from the frequent use of tobacco substantially outweigh those resulting from the frequent use of illicit drugs; the total social costs resulting from the frequent use of alcohol and frequent use of illicit drugs are comparable; and while the harms of cannabis use are not trivial they are modest compared to those associated with tobacco and alcohol.

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# Executive summary

- The current prohibitionist approach to illicit drugs has substantially failed in that it has had limited effectiveness in reducing drug availability or drug use, and that position is unlikely to change as the law struggles to adapt to synthetic drugs, the internet drug trade and the illicit use of pharmaceutical drugs.
- The harms resulting from the prohibitionist approach, for drug users and for the wider community, are considerable (these include: an unregulated black market; drug overdoses; resort by drug users to crime to pay for drugs; the growth of criminal networks; corruption of public servants and reduced respect for the law).

The Committee has concluded that the goals of drug policy should be to reduce levels of drug-related harm, increase the number of drug dependent users seeking treatment and implement effective demand reduction strategies. The Committee has reached the preliminary conclusion, which is subject to further research and consultation, that the only way to achieve these goals is to replace the black market for drugs with a form of legal availability under a highly regulated system. This might involve:

- Licensing controls surrounding production and supply of drugs.
- Different levels of control depending on the drug and its potential to cause harm (for example, higher risk drugs would be subject to stringent controls and might only be supplied to registered dependent users who would be required to use the drug in controlled environments).
- The establishment of a specialist advisory committee (including health professionals) that would review all drugs and provide advice to regulators regarding potential harm and treatment options, as well as suitable forms of control.
- Prohibition on private production and trafficking.
- Prohibition of supply to children.
- The taxation of drugs in a way that ensures that the price is sufficiently high to discourage excessive use while being sufficiently low to prevent users from sourcing drugs on the black market.
- The promotion of a public health oriented approach to drug use (including: ensuring the quality and concentration of drugs; prohibition on advertising and the rampant commercialisation that has traditionally characterised the markets in tobacco and alcohol; availability of appropriate and comprehensive treatment services for drug dependence in the community and in prisons).

This regulatory model has many benefits, but the primary advantage is that drugs, users and suppliers will no longer be beyond legal control. While it may result in an increase in drug usage, at least in the short term, the extent of any increase would largely depend on the nature of the regulation applied to particular drugs. Furthermore, the risk of increased use needs to be weighed against the potential to:

- improve access to treatment
- reduce the risk of mortality
- reduce the costs to society
- encourage less harmful patterns of use
- reduce the incidence of drug-related crime
- address stigma and discrimination
- restrict the activities of criminal networks.

It is time to implement a public health oriented approach that is evidence-based and guided by expert advice. It is time for governments to take control of the problem, rather than allowing the black market to control drug use in this country.

# Acknowledgements

On behalf of the NSW Bar Association, I would like to acknowledge the contribution made by all members of the Criminal Law Committee of the Bar Association during the three years over which the research and writing of this paper has proceeded.

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Stephen Odgers SC

Chair, Criminal Law Committee

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## Introduction

Many areas of the practice of the law are concerned with the consequences of the use of prohibited drugs. This is particularly the case for lawyers who work in the field of criminal law. Barristers who regularly prosecute and defend those caught up in the criminal justice system as a result of that prohibition have had an extensive opportunity to assess the current system.

We have seen the harm that can be caused by the use of illicit drugs, particularly for dependent users. Drug use can damage not only the health and well-being of the user, it also damages social cohesion and places a heavy burden on health care providers, law enforcement and the justice system. It affects the productivity of our nation.

Yet we have also seen the harm that is caused by the current prohibitionist model with its heavy reliance on the criminal law to deter drug use. We know addicts who have obtained drugs from the black market and then died from overdoses or contaminants. We have seen young drug users who become small-time dealers to meet their drug needs and then end up in prison for drug dealing. We have seen young women who prostitute themselves, and young men who commit armed robberies, in order to pay for drugs from those drug dealers. We have seen the scale of the black market, the huge profits to be made by drug importers and drug manufacturers, the violence committed by those determined to share in those profits, the risks of corruption of public servants that are the consequences.

We also see the massive amounts of public money spent on law enforcement, the courts and prisons in the attempt to deal with the problem of drugs, but to limited effect. The law, which has been largely ineffective at preventing the availability of prohibited drugs or in decreasing levels of use, is now struggling to keep pace with synthetic drugs, the internet drug trade and the illicit use of pharmaceutical drugs. When a teenager in Sydney's Northern Beaches can order cocaine online and have it posted to his front door, it is a sign that law enforcement can do little to reduce the market in illicit drugs.

There is increasing awareness around the world that things must change. The United Nations Conventions governing illicit drug use require member states to criminalise the illicit possession, cultivation and purchase of drugs. Yet the most powerful force behind the global drug prohibition, the United States, has a number of its own States that are actively breaching Convention provisions in relation to prohibition of cannabis. Portugal has decriminalised personal possession and use of all drugs. New Zealand has moved to allow the licensed sale of 'party pills'. A number of South American countries, having experienced the terrible consequences of the 'war on drugs', have decided that a new approach must be tried.

We have a responsibility as citizens to speak out if we conclude that the system needs reform. That point has been reached. This paper is the result of extensive research, reflection and discussion over several years. It is apparent to us, based on the available research here and overseas, and our own professional experience, that the time has come for the current prohibitionist approach to drugs to be abandoned.

## The current prohibitionist approach

The *Drugs Misuse and Trafficking Act 1985* (NSW) applies to 'prohibited drugs' which are set out in Schedule 1 to the Act. The Schedule lists over 240 drugs including cannabis, ecstasy, heroin, cocaine, and a range of synthetic narcotics. The Act makes it an offence, punishable by imprisonment, to possess, use, manufacture or supply such prohibited drugs. The maximum penalties vary from two years imprisonment all the way up to imprisonment for life for the most serious drug supply offences. The Commonwealth Criminal Code also creates similar offences with similar maximum penalties for 'controlled drugs', as well as import/export offences for 'border controlled drugs'.

The approach to illicit drugs is set out in the current National Drug Strategy 2010–15, and has three elements:[1]

- supply reduction
- demand reduction
- harm reduction.

The aim of supply reduction is to reduce the availability of illicit drugs by interfering with the activities of the supplier, thereby increasing the financial cost to the consumer and deterring them from using drugs.[2]

Extraordinary legal steps have been taken to facilitate drug prosecutions. For example, possession of certain threshold quantities of particular illicit drugs creates a presumption that the drugs are intended to be supplied.[3] The presumption of innocence is thereby diluted and the burden of proof reversed, with the defendant having to prove that the drugs were not intended to be supplied.

Measures to reduce demand primarily take the form of prevention and education programs.

Harm reduction measures are designed to minimise or reduce the harms suffered by drug users, without reducing drug use per se.[4] Harm reduction measures include, but are not limited to: [5]

- supervised injection facilities
- methadone programs
- free needle exchange
- diversion
- drug content testing.

Diversion is one of the most widely implemented harm reduction measures, and a range of diversionary schemes operate in all Australian jurisdictions.[6] Diversion generally involves diverting drug users and drug-related offenders out of the criminal justice system and into some form of treatment.[7] Diversion has been divided into three types:[8]

- police diversion
- court diversion
- drug courts.

Most diversion takes place at the police level. Depending on the particular form of diversion, savings can be made in court and imprisonment costs, although the costs of running the scheme and providing education and/or treatment can offset any savings.[9]

Drug courts are another form of diversion. The Australian experience suggests that drug courts are more effective than conventional sanctions in reducing recidivism among drug-related offenders.[10]

Treatment is a component of many harm reduction schemes. It has been found to be more cost-effective than law enforcement with respect to reducing levels of use.[11] Users are also less likely to commit crimes while they are being treated for drug dependence. However, some treatments are more effective than others and success depends upon a number of factors, including: the resources available to the treatment provider; the design and co-ordination of the treatment service; the characteristics of the user; the period of dependence; the drug of dependence; and the level of family and community support for the user.

Research suggests that drug treatment services are under-funded, poorly coordinated and in some cases inconsistent with each other.[12]

There is no indication in the National Drug Strategy as to what the ideal balance among supply reduction, demand reduction and harm reduction should be. However, if you consider levels of government spending, almost two-thirds is devoted to law enforcement.[13]

## Why have we adopted the current prohibitionist approach?

The short answer to this question is that our society, through its elected representatives, concluded that the harms caused by certain drugs are so great as to require prohibition of the possession, use and supply of those drugs and the enforcement of that prohibition by means of the criminal law.

The harms caused by drugs may usefully be divided into primary harms and secondary harms. Primary harms fall into two general categories: toxicity and dependence.[14] Secondary harms generally focus on health-related harms (for example, blood borne viruses) and crime.

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There are a number of issues that complicate consideration of drug-related harms:

- Prevalence of use will have an effect upon the prevalence of harm.
- Levels of use are concentrated among younger age groups, so combining data for younger age groups with data for the general population will misrepresent prevalence of use.
- It can be very difficult to establish the causal connection between the use of a particular drug or drugs and certain consequences.
- The circumstances surrounding use will affect risk of harm.[15]
- The adulteration of illicit drugs will affect risk of harm.
- Not all drug use is abuse.
- Many drug dependent users use multiple drugs simultaneously, or over the course of time (poly-drug use).[16] Poly-drug use can substantially affect levels of harm.[17]
- Surveys gathering data on drug use and harms are generally voluntary and self-reported, with the result that levels of use and overdose are under-reported.[18]
- Drug use is not generally consistent over time.[19]
- Grouping all illicit drugs together is problematic as some are considerably more harmful than others.[20]

## Primary harms

Even though all drugs can be addictive,[21] only a minority of individuals who use illicit drugs become dependent upon them.[22] In 2005, the number of dependent and non-dependent users was estimated to be:[23]

### Cannabis

Cannabis was the most commonly used illicit drug in Australia in 2010, with about 1.9 million people reporting use of the drug in the preceding twelve months and 35.4% of the population aged over 14 years reporting the use of cannabis in their lifetime.[24]

Acute harms can include anxiety, dysphoria, panic, and paranoia. Chronic harms include damage done to lungs through smoking,[25] which is likely to be compounded by prevalent concomitant use of tobacco.[26] Cannabis use does not result in fatal overdose.[27] It has been estimated that the health care costs associated with cannabis use were $16.9 million in 2007.[28]

It has been argued that there are three conditions that are most strongly associated with cannabis use: schizophrenia/psychotic disorders; low birth weight babies born to cannabis-smoking mothers; and injuries sustained in road traffic accidents.[29] However, even strong associations do not necessarily demonstrate that the condition has been caused by cannabis use. Further, even among those who suggest a causal link, there appears to be some disagreement as to whether cannabis causes psychosis in its own right, or whether it merely exacerbates symptoms in those individuals already predisposed to such conditions.[30]

It has been suggested that the use of cannabis is a 'gateway' to the use of 'harder' illicit drugs. However, there are a number of studies that suggest that this proposition oversimplifies the connection between the use of cannabis and other illicit drugs.[31] There is no evidence that the use of cannabis itself increases the likelihood that a person will move on to use 'harder' drugs.[32] Only a very small percentage of cannabis users progress to the use of 'harder'

| | Cannabis | Cocaine | Opiates | Amphetamines |
|---|---|---|---|---|
| **Dependent users** | 247,500 | 13,892 | 41,401 | 73,257 |
| **Non-dependent users** | 1,662,575 | 162,454 | 107,898 | 495,500 |
| **Total users** | **1,910,075** | **176,346** | **149,299** | **568,757** |

drugs. It has been suggested that the 'gateway effect' may be no more than the:

> ...common temporal ordering of drug initiation – alcohol/tobacco, followed by cannabis use, and then other illicit drugs.[33]

In fact, patterns of drug initiation vary from one country and culture to the next, suggesting that the use of illicit drugs is more likely to be dependent upon social factors and drug availability, as well as characteristics of users that facilitate or deter use.[34]

What we do know is that there are a number of factors that can influence a person's decision to use 'harder' drugs and that these factors include the characteristics of the user, which can predispose them towards the use of other drugs.[35] Another relevant factor is the person's involvement with drug traffickers to obtain cannabis, as traffickers are more likely to offer a person another drug in lieu of cannabis with a view to expanding their own drug trade. The Netherlands, which has a system of 'coffee shops' that sell cannabis, has found that the separation of the cannabis market from the illicit drug market has reduced the number of people progressing from the use of cannabis to the use of 'harder' drugs.[36]

### Amphetamine-type stimulants

Amphetamine-type stimulants include methamphetamine and MDMA (commonly known as ecstasy).

In 2010 the rate of methamphetamine use among people aged 14 years or older in the previous twelve months was 2.1%.[37] In 2010 ecstasy was the second most commonly used illicit drug in Australia after cannabis, with 3.0% of people aged 14 years or older using ecstasy in the previous twelve months. Ecstasy use was highest among those aged 20–29 years, with about 1 in 4 (24.4%) using ecstasy in their lifetime and 1 in 10 (9.9%) using it in the past twelve months.[38]

Amphetamine-type stimulants can cause cardiovascular problems including rapid heart rate, high blood pressure and hypothermia, in addition to convulsions. Long-term use may result in aggressive/violent behaviour and psychosis.[39] Heavy users may 'binge' for a few days and then use opiates or benzodiazepines to 'come down'.[40] Such use can cause temporary psychosis,[41] even if the user has no predisposition to mental illness. Amphetamine use can severely exacerbate psychotic symptoms in those already experiencing a psychotic mental illness.[42]

In 2010–11 there were 12,563 treatment episodes for methamphetamine use.[43] In 2005 methamphetamine was considered to be the underlying cause of death in 26 of the 68 total methamphetamine-related deaths.[44] With respect to ecstasy, in the period 2000–2005 19 of the total of 82 ecstasy-related deaths were attributed to ecstasy toxicity alone. Ecstasy was considered a direct antecedent or cause in the remainder.[45]

### Opiates

The most widely used illicit opioid is heroin. In 2010, 1.4% of people in Australia aged 14 years or older had used heroin in their lifetime and 0.2% in the previous 12 months. Between 2007 and 2010 there was no change in the proportion of people using heroin in Australia.[46]

While the prevalence of heroin use is still relatively low, it is associated with a disproportionately large range of health and social harms.[47] Drug overdose and dependence are the two main primary harms associated with the use of heroin.[48]

It has been estimated that between one-fifth and one-third of people who ever use heroin become dependent on the drug.[49] Heroin dependence is a chronic condition, with periods of relative or total abstinence. It is unusual for a dependent user to sustain abstinence from heroin.[50]

The number of non-fatal overdoses is substantial, estimated to be between 10,500 and 20,500 annually.[51] It is also important to note the substantial contribution that drug injection makes to the high levels of HIV and HCV infections.[52] Hospital costs associated with heroin use amounted to $13 million/year in 2004–05.[53]

The following factors increase the risks associated with heroin overdose:

- poly-drug use[54]
- inconsistencies in patterns of use
- the adulteration of heroin with substances like talcum powder, starch, baking powder, quinine and strychnine.[55]

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In comparison to the rest of the world, the rate of drug-related deaths in Australia is high.[56] In 2009 there were 563 deaths attributable to opioids.[57] It has been estimated that among dependent users there is a 33.3% likelihood of death from its use.[58]

As with many illicit drugs, there is a link between the use of heroin and psychological problems, but it is difficult to establish a causal link as psychiatric symptoms often predate use of the drug.[59] There is also an elevated likelihood of suicide amongst heroin users which has been attributed to the following risk factors common to heroin dependent users: childhood sexual and physical abuse, psychiatric disorders and social isolation.[60] The result is that heroin users are 7–14 times more likely than a non-heroin user to commit suicide.[61]

### Cocaine

Prevalence of cocaine use in Australia remains relatively low, although there was an increase between 2007 and 2010 in the proportion of people who had used cocaine in the previous twelve months (from 1.6% to 2.1%).[62]

Cocaine use can cause high blood pressure, cardiac arrest and respiratory failure. Long term effects include mental illness and behavioural problems. Heavy and intravenous use has been associated with criminal activity,[63] unemployment, suicide,[64] mental health problems,[65] transmission of blood borne viruses,[66] poor health outcomes[67] and death. At any dosage, use of crack cocaine has the potential to cause serious and life-threatening effects on the user, including convulsions, depression and cardiovascular disorders.[68]

In 2009 there were 23 cocaine-related deaths. Cocaine use was the underlying cause of death in 5 of those instances.[69] In 2005 health costs associated with cocaine use amounted to $0.4 million.[70]

## Secondary harms

The distinction between dependent and non-dependent users in considering secondary harms is an important one, with dependent users suffering the highest levels of harm.[71]

Secondary harms include health-related harms. Unsafe injecting practices can result in the transmission of blood borne viruses. The risk posed by blood borne viruses is a serious one. Globally, approximately 1.7 million people, or 13.1% of the world's injecting drug users, are HIV positive.[72] The annual number of new HIV diagnoses per year in Australia has increased from 719 cases in 1999 to 1137 cases in 2011.[73] Injecting drug use was the exposure category in 64% of cases in 2007 and 60% of cases in 2012.[74] Hepatitis C infections decreased from 550 per annum in 2003 to 400 per annum in 2012.[75]

Secondary harms also include drug-related crime. A useful indication of the costs of drug-attributable crime has been prepared by the Drug Policy Modelling Program at the University of New South Wales (based on data from 2003–06, by $million):[76]

| | Cannabis | Cocaine | Opiates | Amphetamines | Other illicit drugs |
|---|---|---|---|---|---|
| *Income generating offences* | | | | | |
| **Dependent users** | $1,601 | $105 | $1,551 | $2,203 | $325 |
| **Non-dependent users** | $319 | $26.1 | $28.4 | $204 | $55.6 |
| **Total cost** | $1,919 | $131 | $1,579 | $2,407 | $380 |
| | | | | | |
| *Other Offences* | | | | | |
| **Dependent users** | $0 | $30.2 | $163 | $592 | $196 |
| **Non-dependent users** | $0 | $0.63 | $1.16 | $39.8 | $12.7 |
| **Total cost** | $0 | $30.8 | $164 | $632 | $209 |
| | | | | | |
| *All offences* | | | | | |
| **Dependent users** | $1,601 | $135.2 | $1,714 | $2,795 | $325 |
| **Non-dependent users** | $319 | $26.73 | $29.56 | $243.8 | $68.3 |
| **Total cost** | **$1,920** | **$161.93** | **$1,743.56** | **$3,038.8** | **$393.3** |

A significant proportion of drug-attributable crime derives from income generating offences. The illicit drug most associated with violent crime is amphetamine.[77] Cannabis, while accounting for the vast majority of seizures and arrests, is very rarely associated with violent crime.[78]

## How do the harms resulting from illicit drugs compare with those from alcohol and tobacco?

Given the current prohibitionist approach to drugs is based on the view that the harms caused by those drugs are so great as to require both prohibition, and the enforcement of that prohibition by means of the criminal law, it is reasonable to compare those harms with harms resulting from two lawful substances – alcohol and tobacco.

### Alcohol

Alcohol is the most widely used drug in Australia. In 2010, the proportion of people who reported drinking alcohol recently (80.5%) continued to decline from a peak in 2004, but was still higher than in 1993 (77.9%).[79] About 2 in 5 (39.7%) people aged 14 years or older drank in a pattern that placed them at risk of an alcohol-related injury from a single drinking occasion at least once in the preceding twelve months.[80]

Harm resulting from alcohol use depends substantially on its patterns of use. Between 1993–94 and 2004–05 alcohol-attributable hospitalisations increased in all Australian jurisdictions. The most common causes of hospitalisation were: dependence; falls; assaults; and alcohol abuse.[81] In 2011–12, 45.8% of all treatment episodes were alcohol-related.[82] Across all jurisdictions, the rate of alcohol-attributable death in 2005 was three deaths per 10,000 people and the main cause of death was alcoholic liver cirrhosis.[83]

Alcohol use has been estimated to cost the nation $15,318.2 million in tangible and intangible costs, such as lost productivity, health ($1,976.7 million per year), road accidents ($2,202 million per year),[84] loss of life, and pain and suffering.[85] Alcohol is also significantly associated with violent crime.[86] In the twelve months preceding June 2000, alcohol was involved in 23% of all reported assault incidents, 58% of offensive behaviour incidents and 6% of malicious damage incidents in NSW.[87]

### Tobacco

In 2010, 15.1% of people in Australia aged 14 years or older were daily smokers, declining from 16.6% in 2007 and from 24.3% in 1991. A quarter of the population were ex-smokers and more than half had never smoked.[88]

In 2003 tobacco was the single highest risk factor to mortality and morbidity, responsible for 7.8% of all years lost from Australian lives due to ill health, disability or early deaths.[89] It was attributable to 11.7% of all deaths in Australia.[90] Tobacco is also responsible for significant social costs, which include losses in productivity and intangible costs of $8,009 million per year and $19,459 million per year respectively.[91]

### Comparison

The table below sets out morbidity and mortality attributed to tobacco, alcohol and illicit drugs (based on available data from 2003).[92] The next table shows the tangible and intangible social costs of illicit drug use, as compared to alcohol and tobacco use.[93]

| | Mortality (2003) | | Morbidity (2003) | |
|---|---|---|---|---|
| | No. of Deaths | % of Total Deaths | No of DALYs | % of Total DALYs* |
| **Tobacco** | 15,511 | 11.7 | 204,788 | 7.8 |
| **Alcohol** | 1,084 | 0.8 | 61,091 | 2.3 |
| **Total illicit drugs** | **1,705** | **1.3** | **51,463** | **2.0** |

**DALYs:** Disability Adjusted Life Year. See note 92.

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| | Alcohol ($m) | Tobacco ($m) | Illicit drugs ($m) | Alcohol and illicits together ($m) | All drugs ($m) |
|---|---|---|---|---|---|
| **Tangible** | 10,829.5 | 12,026.2 | 6,915.4 | 1,057.8 | 30,828.9 |
| **Intangible** | 4,488.7 | 19,459.7 | 1,274.5 | | 25,222.9 |
| **Total** | 15,318.2 | 31,458.9 | 8,189.8 | 1,057.8 | 56,051.8 |
| **Prop. of unadjusted total** | 27.3% | 56.2% | 14.6% | 1.9% | 100% |

This comparison supports the following conclusion:

> ...[T]he greatest harm to global health from psychoactive substances comes from two substances, tobacco and alcohol, which are not included in the international drug conventions. Even comparing substances on the basis of the range of harms associated with heavy use or the most harmful form of the substance, alcohol and tobacco are among the most harmful.[94]

## How effective is the current prohibitionist approach to illicit drugs?

In assessing the effectiveness of the current prohibitionist approach, it is appropriate to separate out two issues: supply reduction and harm reduction.

### Supply reduction

It is difficult to demonstrate the effectiveness of law enforcement in respect of supply reduction, as it is subject to little in the way of meaningful assessment. Difficulties in assessment can in part be attributed to the clandestine nature of drug use and the black market. [95] Without accurate information as to consumption, prices, patterns of use and potency, it is difficult to know whether law enforcement is having any measurable impact on illicit drug use. [96] Similarly, it is difficult to establish causation in the analysis of data regarding drug trends:

> There is a natural tendency to equate periods of low prevalence with successful policy and to attribute spikes in the percentage of users with policy failings. Even if prevalence of use were the sole criterion by which to measure the success of drug policy, it would remain extremely difficult to attribute causation to specific policies given the myriad other social factors.[97]

Nevertheless, available data suggests that drug use is prevalent. In 2010 14.7% of the population aged over 14 had used illicit drugs in the preceding twelve months[95] and 39.8% of the population aged 14 years or older had used drugs in their lifetime.[98] Drugs appear to be readily available to those who want them. In a survey conducted in 2013, 86% of respondents described ecstasy as 'easy' or 'very easy' to obtain,[99] while 85% of respondents to a related study reported that heroin was similarly 'easy' or 'very easy' to obtain.[100]

The lower prevalence of illicit drug use compared with licit drug use has often been cited in support of the current law enforcement regime. There is undeniably a relationship between the criminalisation and prevalence of drug use. Having said that, studies show that 'legal reasons' are less relevant to the decision to use drugs, with 'a lack of interest' and 'health or addiction concerns' being the reasons most often cited for the decision not to use drugs.[101]

Another argument is that the function of law enforcement is not to eliminate drug use, but to increase the price of illicit drugs. The relationship between law enforcement and the price of illicit drugs is complex, although it is clear that there is some relationship. What is difficult to demonstrate is a measurable link between the efforts of law enforcement and changes in retail drug prices.[102]

Higher prices may deter new recreational users,[103] but to what exent depends upon how high the price is, the demographic, the user and the type of drug, among other things. There is little evidence that current prices are high enough to have any such impact. Indeed, the 2014 UN World Drug Report notes that Oceania is atypical in that both price and prevalence are relatively high.[104]

Price can affect an individual's decision to use drugs. This is referred to as 'price elasticity'. If the demand for a drug is not responsive to price (or price-inelastic), increasing price will not reduce consumption, and will only increase the profits to dealers, and also increase the levels of acquisitive crime committed to fund the drug habit.[105]

Dependence is relevant to price elasticity. Generally, non-dependent users are more responsive to price changes in the short term,[106] while dependent users will respond to long term price changes,[107] in some cases substituting other drugs for the desired drug,[108] although this may not universally be the case.[109]

The 2014 UN World Drug Report has noted that the 'heroin drought' experienced in Australia in 2001 resulted in lower levels of heroin use, although some users substituted prescription opioids, like Oxycodone.[110]

There is support for the hypothesis that involvement with the criminal justice system and police, can prompt users to enter treatment.[111] However, there is also research that suggests that dependent users seek treatment primarily for the following reasons:[112]

- toll on personal relationships, home and work lives
- the rewards for quitting/desire to change
- physical problems
- expense.

It is important to note that increased intensity of drug law enforcement will not necessarily increase the rate at which users enter treatment, and that 'involvement with the criminal justice system' does not necessarily mean arrest or imprisonment.[113]

While there is little meaningful assessment of the effectiveness of law enforcement, there are some conclusions that can be drawn: even though the price of drugs in Australia is relatively high compared with the rest of the world (although not relative to tobacco and alcohol), availability remains high and drug use is prevalent. It is plain that law enforcement has failed to eradicate the market in illicit drugs. An assessment of the situation offered by the Commonwealth Parliamentary Joint Committee on the National Crime Authority in 1989 remains apposite today:

> Despite 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 place 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.[114]

## Harm reduction

Harm reduction measures are designed to minimise or reduce the harms suffered by drug users, without reducing drug use per se.[115] Demand reduction measures are designed to reduce the demand for drugs, through educative programs and treatment.

Harm reduction encompasses a wide range of measures, including needle and syringe exchange programs and diversion schemes. A recent review has suggested that perhaps the most effective harm reduction measures are those that apply to injecting drug users, with more research to be done on the effectiveness of other measures.[116] It has been estimated that for every dollar spent on needle and syringe programs, $4 was saved in health care costs and $27 was saved in overall costs to the community.[117]

Diversion schemes are widespread, and involve re-directing users from the criminal justice system and into treatment. A key issue that has arisen with diversion schemes in Australia is 'net-widening'. For various reasons it seems that the introduction of diversionary schemes coincides with increased numbers of people being caught for drug offences and then diverted from the system.[118] This is problematic because there can be a great deal of harm caused merely from being caught up in the criminal justice system. It has been speculated that 'net-widening' may be intentional:

> 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.[119]

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Diverting drug users out of the criminal justice system and into treatment is appealing on a superficial level. However using the criminal justice system to coerce users into seeking treatment is ethically problematic. There are also issues surrounding the provision of such treatment. Inadequate funding and poor coordination of treatment services has already been noted. Further, treatment services often premise 'success' on the maintenance of total abstention. When opioid substitution therapy was first introduced, it aimed to achieve improved social functioning rather than abstinence,[120] which is a much better approach to the treatment of drug dependent users. Total abstinence is not only very difficult to achieve, it can be dangerous. Naltrexone implants promise the user total abstinence, but are very dangerous and have been implicated in recent deaths in New South Wales.[121] It must be accepted that there presently is no easy way to 'cure'[122] drug dependence.

There are enormous problems with the criminalisation of widespread conduct, then 'softening the blow' of that criminalisation by diverting users into inadequate forms of treatment, punishing failures to maintain total abstinence during treatment with incarceration, and expecting levels of drug use to diminish as a result.

Ultimately, conventional harm reduction measures, however effective, address in large part drug-related harms that result from the current prohibitionist regime. The encouragement of safe injecting practices would not be necessary if drugs did not have to be injected covertly and in dangerous environments. Diversion out of the criminal justice system would not be necessary if we did not criminalise drug taking in the first place. In effect, we are creating the circumstances that cause the harm and then developing harm reduction measures to remedy them.

## Why is the current approach of limited effectiveness?

There are a number of possible explanations for the apparent limited effectiveness of the current prohibitionist approach to illicit drugs.

### The reasons people use illicit drugs

If 'drugs' is understood to include such substances as alcohol, tobacco, caffeine and prescription medicines, then it is clear that almost everybody uses drugs. Such psychoactive substances have been consumed throughout history, in a variety of forms,[123] regardless of whether their use has been deemed licit or illicit.

Research has shown that the reasons for taking illicit drugs vary. A recent survey of drug users found that the most common reasons cited are: [124]

- relaxation
- enjoyment
- socialising with others
- to feel better or to cope with life issues
- dependency.

Many people who use drugs are rational consumers insofar as they make a deliberate choice to take a drug or drugs to achieve a desired effect.[125] Most drug users limit their levels of use to ensure minimal impact on education, employment and proper social functioning.[126]

Generally, there are a range of social and contextual factors that increase the likelihood that a person will use illicit drugs. These include: [127]

- availability
- use of tobacco and alcohol from an early age
- social norms that tolerate alcohol and other drug use
- socioeconomic background, with people from disadvantaged backgrounds more likely to use illicit drugs
- poverty
- social and cultural factors
- poor quality of parent-child relationships
- parental conflict
- parental and sibling drug use
- community disorganisation
- high level of neighbourhood transition and mobility
- family management problems.

The extent to which a factor will affect a particular individual depends largely upon the individual. However, social and cultural factors are very influential on an individual's decision to use illicit drugs.[128]

Research shows that illegality of a particular drug is rarely taken into consideration by individuals considering whether to use that drug.[129] A number of studies have shown that the reasons most often cited for the decision not to use a particular drug are: lack of interest (73.3%) and health or addiction concerns (47.0%). Legal reasons were cited by 28.6% of respondents.[130] For whatever reason, it appears that the normative force of the law is of comparatively little importance to illicit drug users.

## Price rises mean greater profits for the black market

Drug prices are a reflection of the risk involved in producing, trafficking and dealing drugs.[131] However, current levels of use would suggest that prices are not high enough to deter use. The result is that the risk involved in the black market serves to increase available profits. For example, a 2008 study showed the profits to be made from cocaine:[132]

| Product | Market Level | Effective Price per/kg |
|---|---|---|
| **Coca leaves** | Farmgate/ Colombia | $300 |
| **Coca base** | Farmgate/ Colombia | $900 |
| **Cocaine hydrochloride** | Export/Colombia | $1,500 |
| **Cocaine hydrochloride** | Import/US | $15,000 |
| **Cocaine (67% pure)** | Dealer/US | $40,000 |
| **Cocaine (67% pure)** | Retail/US | $150,000 |

The profits involved in the illicit drug trade are significant at a national level as well. In 2004, Afghan traders' opiate-related sales comprised over 60% of Afghanistan's GDP. This decreased to 16% in 2011 but it is important to note that depressions in one market cause accelerations in others, as levels of demand globally have remained stable.[133]

The profits involved in the trade of illicit drugs offer a substantial incentive to those willing to risk the consequences of arrest. Simply put, law enforcement cannot have a real impact on the operations of a black market which is covert, well-resourced and responds to a constant level of demand.[134]

## Improbability of detection and arrest

The prohibitionist approach endeavours to deter individuals from using drugs. The probability of detection and the likelihood of arrest is relevant to any consideration of law enforcement's effectiveness.

For someone who has used cannabis in the last month, the probability of arrest is 1 in 19.6. For people who have used cannabis in the past year, the probability is 1 in 34.8. The probability of arrest for use of heroin in the previous month is 1 in 14, and 1 in 35.6 for use in the previous twelve months. The likelihood of arrest is the lowest for methamphetamine, with the probability of arrest for use in the previous month being 1 in 34.5, and for use in the previous year, 1 in 86.4.[135]

## Marginalisation of illicit drug users

The prohibition of drug use has created an underclass of marginalised drug users. Drug use is viewed by some in the community as weakness or a lack of moral fortitude, although the truth of the matter is that the circumstances related to the use of drugs are complex, and dependence is often associated with an individual's exposure to personal trauma, and psychological or social factors.

The criminalisation of drug use serves to exacerbate what is already a severe social problem. The legacy of involvement in the criminal justice system can be far-reaching and long-lasting. It can affect a person's ability to obtain and maintain employment, housing and education. It exposes drug users to a different class of offender: professional offenders and violent offenders. It substantially increases the risk of mortality.

The criminalisation of drug use affects personal wellbeing and relationships. Social stigma and the activities of law enforcement also undermine the implementation of harm reduction measures and, in particular, programs designed to prevent the transmission of blood borne viruses like HIV.[136]

## Failure to meet the rationale for criminalisation

Criminal sanctions are justified on grounds that they will:

- secure the incapacitation of the offender
- exact retribution upon the offender for the harm that they have inflicted upon another and/or society

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- deter the offender (specific deterrence) and others (general deterrence) from engaging in criminal behaviour
- allow the offender to be rehabilitated.

However, given the nature of dependence, it is unlikely that temporary incapacitation will have any substantial long term effect on drug use, particularly given the availability of drugs in our prisons.

Retribution is difficult to justify in circumstances where the moral blameworthiness of the offender is questionable. The compulsive behaviour that characterises drug dependence and the reasons why people become dependent upon drugs make it difficult to consider drugs users morally blameworthy. One could argue that moral blameworthiness could be attributed to the user at the time of their initial decision to use an illicit drug. However, non-dependent use is not necessarily problematic. Where a drug-related offence is not associated with a violent crime, it is very difficult to justify the imposition of criminal sanctions on the grounds of retribution.

The 'compulsion' involved in drug dependence makes it unlikely that specific deterrence will be effective.[137] The efforts of law enforcement may prompt dependent users into entering treatment, although it has been suggested that other factors are generally responsible (for example, the toll on personal relationships).[138] Law enforcement may also be effective at deterring users who are not dependent, by increasing the price of illicit drugs. However, non-dependent users are not the demographic of greatest concern.[139] No one has demonstrated a link between heavier penalties and an increased deterrent effect.[140]

Insofar as rehabilitation is concerned, criminal sanctions alone do not serve to rehabilitate the offender, and in-prison drug treatment can be of limited success, particularly where there is insufficient follow-on care.[141] In fact, in many instances criminal sanctions exacerbate the causes of drug dependence.[142] The UN Office on Drugs and Crime has noted that imprisonment can be:

> […]counter-productive to recovery in vulnerable individuals who have already been 'punished' by the adverse experiences of their childhood and adolescence, who may already be neurologically and psychologically vulnerable.[143]

If general deterrence is the only ground upon which criminal sanctions can be justified, that goal could be better met without incarceration. It has been established that swift and certain sanction is more effective at deterring offenders than 'distant and uncertain punishments of greater severity':[144]

> The greater deterrence value of more immediately and likely sanctions seems especially important given the apparent risk and time preferences for drug users – individuals whose behaviour suggests a present-moment orientation and a heavy discounting of future burdens.[145]

## New challenges

There are new challenges facing law enforcement, many of which it is ill-equipped to address. Often, legislative responses to emerging challenges are many steps behind the market.

The proliferation of synthetic drugs is one of those challenges. There is an increasing number of new synthetic psychoactive substances that are chemically engineered to remain outside international and national controls.[146] Most notable in this category are methcathinone analogue 4-methyl-methcathinone (mephedrone) and methylenedioxypyrovalerone (MDPV). Mephedrone and MDPV are often marketed over the internet as 'plant food' or 'bath salts'. Many Australians would also be familiar with the marketing of synthetic cannabinoids (Kronic or Spice). The 2014 UN World Drug Report has noted that the number of new psychoactive substances on the global market more than doubled between 2009–13, totalling 348 new substances, only 234 of which are currently controlled under the UN Conventions.[147]

Increasingly, the internet is being used to advertise and distribute new synthetic drugs[148] as well as illicit pharmaceutical drugs.[149] There are well-established websites that sell drugs and provide information in relation to their use, referred to as 'dark net sites'.[150] One such popular site, 'Silk Road' was closed down by the FBI[151] in October 2013 but a number of alternate sites have since emerged. The NSW Drugs Squad Commander commented that '[w]e can't be in people's living rooms or next to a 16 year old with a smartphone… it's virtually unpoliceable'.[152]

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Recent efforts have been made to develop legislation banning the importation of synthetic drugs, and implementing a 'reverse onus of proof' scheme under which new drugs entering the market are presumed to be illegal until the authorities clear them as safe and legal.[153] While these government responses may be effective in overcoming the existing legal loopholes in relation to synthetic drugs, it remains to be seen whether they will have a significant impact on the supply and use of these drugs.

Another challenge is the increased misuse of pharmaceutical drugs.[154] It has been predicted that the misuse and trafficking of prescription pharmaceuticals will soon oustrip the misuse and trafficking of illicit drugs.[155] In Australia, the prevalence of non-medical use of pharmaceutical drugs is relatively low, but it increased significantly between 2007 and 2010 (0.2% to 0.4%).[156]

The most commonly misused pharmaceuticals include opioids, benzodiazepines, codeine, the stimulants methylphenidate (Ritalin) and dexamphetamine and performance-enhancing drugs such as steroids.[157] Heroin users frequently substitute opioid drugs, and in particular Oxycodone, for heroin. A recent study found that approximately 31% of injecting drug users injected Oxycodone in 2013, albeit sporadically.[158]

Pharmaceutical drugs also have the potential to attract people who would not otherwise use illicit drugs, due to a perception that they are reasonably 'safe'. Between 2001 and 2009 there were 465 Oxycodone-related deaths, of which 10% were due to Oxycodone toxicity alone.[159]

## What are the costs of the current prohibitionist approach?

Given the harms that can undoubtedly be caused by drug use, and the conclusion that the current prohibitionist approach does have some, albeit limited, effectiveness in reducing drug use, it might be argued that the current approach should be maintained (notwithstanding the very different approach currently taken to alcohol and tobacco). However, rational analysis requires consideration of the harms which actually result from the present approach and the availability of alternative strategies.[160]

It has been suggested that costs resulting from prohibition and criminalisation include:

- The stigmatisation of drug users,[161] which in turn affects the ability of the illicit drug user to seek treatment and/or rehabilitation[162] and perpetuates or exacerbates the social conditions that gave rise to drug abuse in the first place.[163]
- Socialisation with other drug users and criminals.[164]
- The creation of an unregulated black market for illicit drugs.[165]
- A rise in organised crime, due to the involvement of criminal organisations in national and international drug production and trade.[166]
- Encouragement to use more potent drugs that are more profitable to dealers and/or concealable.[167]
- Drug-related violence[168] and crime.[169]
- The criminalisation of politics and the politicisation of crime.[170]
- Corruption of public servants.[171]
- Encouragement of unsafe injecting practices.[172]
- Inability to control the quality of illicit drugs consumed by users.[173]
- Overdoses that occur as a result of the unknown purity and potency of illegally purchased drugs.[174]
- The health and social risks of imprisonment,[175] including lost income for the families of those incarcerated.[176]
- Increased risk of engagement in prostitution and other illegal activities.[177]
- Delays in the processing of criminal and civil matters by the courts as a result of the volume of drug-related matters.[178]
- Adverse impact on public amenity (public drug use, drug dealing and discarded drug injection equipment).[179]
- Decreased national productivity (absenteeism, workplace accidents, conflict in the workplace).
- Insufficient access to pain relief for medical purposes.
- Refusal to trial certain illicit drugs for licit medicinal use, for example the use of cannabis for treating cataracts.
- Government intrusion into citizens' lives.[180]

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- Geographical displacement, in which law enforcement 'crackdowns' in one area increase drug production or supply in another area[181] (also known as the 'balloon effect'). [182]
- Substance displacement, in which law enforcement 'crackdowns' targeting a particular drug cause users to move on to another drug or drugs. The UNODC has noted that while the markets for cannabis, cocaine and opiates appear to be shrinking globally, the market for synthetic stimulants appears to be increasing.[183]
- Policy displacement, in which expenditure is wasted on counter-productive law enforcement efforts at the expense of social and economic development.[184]
- Harms to public health.[185]
- Harms to community safety.[186]
- Harms to police-community relations.[187]
- Development interventions that remain influenced by drug war objectives, limiting their effectiveness.[188]
- The political and economic destabilisation experienced by source-countries as a result of the 'War on Drugs'.[189]
- Environmental destruction (for example the deforestation of Colombia as a result of aerial herbicide spraying and pollution from the illegal, unregulated processing of coca crops).[190]
- Funding conflict by providing income for insurgents, terror groups, militias and corrupt governments who profit from the illegal drug trade.[191]

A selection of these costs will be considered in greater detail.

## Government costs

Just as the majority of harms are suffered by drug dependent users, the majority of social costs are caused by drug dependent users, who generate between '50 and 100 times the average social costs of a non-dependent user.'[192] Government spending associated with illicit drugs is substantial. 'Reactive expenditure', being the costs associated with health, crime and other consequences of illicit drug use, totalled $1.875 billion nationally in the 2002–03 financial year.[193]

Reactive expenditure aside, the majority of government funds is spent on law enforcement. In 2009–10 this figure was estimated to be $1.031 billion, with the remaining government funds split between prevention and treatment, and a very small percentage devoted to harm reduction measures:[194]

| Policy Domain | Expentiture ($ million) | Percentage |
|---|---|---|
| Prevention | 156.8 | 9.7% |
| Treatment | 361.8 | 22.5% |
| Harm Reduction | 36.1 | 2.2% |
| Law Enforcement | 1031.8 | 64.1% |
| Other | 23.1 | 1.4% |
| **Total** | 1609.6 | 100% |

The costs of imprisonment should not be underestimated. The growth of the prison population over the last decade, and the burden resulting from repeated re-incarceration for drug offences is substantial.[195] The burden is not purely financial. Incarceration and re-incarceration also take a huge toll on the offender. Among other things, drug users who have been incarcerated experience serious difficulties securing and maintaining housing, employment, relationships and adequate health care. [196] Former prisoners also have a significantly higher risk of death compared to the general population. In NSW, the rate of death by drug overdose for ex-prisoners is a matter for concern. Male ex-prisoners are four times more likely to die of a drug overdose in the first two years following release than non-incarcerated individuals of the same age.[197] The likelihood of death by overdose is even higher for women, at eight times the rate of non-incarcerated individuals.[198]

## Drug-related crime

While there is a clear link between crime and drug use, what is less clear is the extent to which such crime is the result of intoxication; economic necessity (acquisitive crime); or being systemic in the black market. [19]

Causation between drug use and crime is difficult to establish. For example, a study of the link between heroin use and crime has suggested that heroin dependence intensifies criminal activity among existing offenders, rather than being the sole cause of criminal activity.[200]

During the 2011 financial year, an illicit drug offence was the most serious offence for 11% of the prison population.[201]

Data from the Drug Use Monitoring in Australia (DUMA) program assists our understanding of typical offenders and their levels/type of drug use. The program is based on urinalysis of police detainees, indicating drug use in the previous 48 hours. Of detainees tested between 2009 and 2010: [202]

- 66% tested positive to at least one drug type, most commonly cannabis (46%), followed by benzodiazepines (23%), opiates (22%) and amphetamines (16%).
- 47% consumed alcohol in the 48 hours prior to arrest and detention, and the average number of drinks consumed was 14.
- 45% confirmed that substance use had contributed to their current offences. Alcohol was more likely than other substances to be identified as a contributing factor in the case of violent offences or those associated with drink driving, disorder, breach or road and traffic matters. Other substances such as heroin and amphetamines were more likely to be implicated in property and drug offences.

It appears that the relationship between illicit drug use and crime is less attributable to the psychopharmacological properties of the drug itself than the nature of the market in which drugs are supplied.[203] The high prices of illicit drugs, and the nature of the black market, create an environment in which criminal networks flourish, and provide an incentive for drug dependent users to commit acquisitive crime.[204]

The illicit drug market is massive, complex and very profitable. Efforts to eradicate the market have not only failed, the market continues to grow. Indeed, the UN Office on Drugs and Crime now considers the reduction or elimination of drug use to be an 'aspirational goal akin to the elimination of war and poverty.'[205] Antonio Maria Costa, former Executive Director of the UN Office on Drugs and Crime has stated that:

> Without a doubt, the greatest single threat today to global development, democracy and peace is transnational organised crime and the drug trafficking monopoly that keeps this sinister enterprise rolling.[206]

It has been estimated that the illicit drug market generates between a fifth and a quarter of all income derived from organised crime.[207] The illicit drug market is characterised by low volume but high unit cost.[208] In 2003 it was estimated that the value of the illicit drug market at the production, wholesale and retail levels were US$13 billion, US$94 billion and US$322 billion, respectively. The wholesale market in illicit drugs dramatically overshadows the wholesale markets for wine, beer and coffee which are valued at $17.4 billion, $6.7 billion and $6 billion respectively. In 2003 the value of the wholesale market exceeded global exports of ores and other minerals, and the value of the retail market was higher than the GDP of 88% of the countries in the world.[209]

The incentive to produce, traffic and deal illicit drugs is enormous.[210] Law enforcement's efforts to increase the cost of illicit drugs mean that:

> [l]aw enforcement …imposes a value added tax on illicit drugs which is collected by criminals. The more severe the penalties and the greater the chance of detection, the more lucrative the trade and the higher the profits.[211]

Criminal networks involved in the drug market are flexible and dynamic, adapting to the drug, the market and the international and domestic efforts of law enforcement.[212] Most participants in a criminal network are low-level and earn very low incomes, in some cases less than minimum wage. Involvement in the criminal network is incentivised by the potential for progression to a role that involves higher levels of remuneration, an opportunity that may otherwise not be available in the licit job market.[213] While more centralised organisations operate at the higher end of certain markets, even these remain 'loose syndicates of independent entrepreneurs.'[214]

The amorphous nature of these criminal networks poses a major challenge for law enforcement. Law enforcement also faces challenges resulting from the involvement of corrupt law enforcement officers as key elements of these criminal networks.

## Blood borne viruses

Secondary harms arising from drug use include health-related harms. These include the transmission of blood borne viruses, including HIV and hepatitis, as a result of unsafe injecting practices. However, unsafe injecting

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practices are largely the consequence of the prohibition of drugs.[215] This is most evident in prisons. The harms suffered as a result of injecting drug use are amplified in the prison community. The prison community has a large percentage of injecting drug users,[216] with one study finding that 68.4% of inmates injected an illicit drug in prison.[217] Unsurprisingly, blood borne viruses are common amongst the prison population, and particularly hepatitis C.[218]

The failure to provide prisoners with access to the harm reduction services available to the wider community, and in particular needle and syringe exchange facilities, has contributed to this substantial burden of disease.[219] One study found that 81.9% of inmates who injected an illicit drug in prison shared a needle or syringe in doing so.[220]

### Reduced respect for the law

The law is intended to perform 'an important symbolic and ideological function in liberal democracies'.[221] Law enforcement agencies cannot arrest everyone who breaches the law, so the effectiveness of law enforcement is contingent upon general compliance. Respect for the law is an important factor in ensuring such compliance.

It is difficult to respect a law that has the potential to make criminals out of over 39.8% of the Australian population,[222] notwithstanding the fact that most of these people will never be prosecuted, let alone imprisoned. It is difficult to respect a law that exaggerates the dangers associated with some illicit drugs, [223] while making little effort to effectively regulate alcohol. It is difficult to respect a law that criminalises cannabis, which is less dangerous than widely available licit drugs. It is difficult to respect a law that still targets low-level users and fails to effectively rehabilitate offenders. The high percentage of the population who have used an illicit drug in their lifetime suggests that compliance with the law by virtue of its moral force alone is no longer a realistic goal.

Corruption resulting from prohibition has also had an undeniable impact on respect for the law. In 1997 the Royal Commission into the NSW Police Service investigated the links between drug law enforcement and corruption among NSW Police. In its report, the Commission noted:

> Much of the corruption identified in this inquiry was connected to drug law enforcement. The huge sums of cash associated with the drug trade, and the apparent inability of conventional policing to make any impact on the illegal market in narcotics creates cynicism among police working in the field. It also creates an environment in which corruption flourishes.[224]

The successful prosecution in 2011 of Mark Standen, former assistant director of the NSW Crime Commission, suggests that corruption within law enforcement remains a problem today.

## Possible alternatives to the current prohibitionist approach

If the current prohibitionist approach to drugs is of limited effectiveness (and is likely to remain so), and the costs of that approach are great, the question that plainly arises is whether the approach should be changed. Of course, before considering the arguments for and against change, it is necessary to focus attention on the options for change. There are many alternative models for the control of drug use which have been proposed. Broadly, alternative models can be divided into three categories: depenalisation; decriminalisation; and regulation.

### Depenalisation

In a depenalisation model, drug offences remain criminalised but criminal penalties for some or all offences are not imposed in practice.[225] This model effectively places the power to impose criminal penalties in the hands of law enforcement.[226]

Many countries implement some form of depenalisation for the personal use and possession of particular drugs. In 2000, California introduced Proposition 36, which applies to non-violent drug offenders and those who commit a drug-related parole violation, provided that they do not refuse treatment. Those subject to Proposition 36 are placed on probation and ordered into a community-based treatment program, followed by six months of treatment.[227] It does not apply to those convicted for offences involving the sale of drugs or property crime.

While the Californian scheme has been well-received, there are questions as to whether it is the most effective way of treating drug abuse. It has been noted:

> [A] treatment's effectiveness...is highly dependent on the quality of care and the patient's satisfaction. But many evaluations of public substance abuse treatment reflect the criminal justice framework and focus less on improving treatment and more on the contributory role of sanctions. This belief in the possible therapeutic value of penal deterrence has meant that increases in treatment capacity and access have tended to be accompanied by a deepening criminalisation and coercion of substance abusers.[228]

Therapeutic value aside, depenalisation schemes have the potential to produce substantial cost savings. In 1996 Arizona introduced Proposition 200, which required those convicted of drug possession offences to be granted probation with treatment for first and second offences. It has been estimated that the scheme saved the state more than $2.5 million in its first fiscal year.[229]

Western Australia introduced the Cannabis Infringement Notice Scheme in 2004. A study comparing data before and after the introduction of the scheme found that while levels of use decreased, this reflected national trends.[230] The authors of the study suggested that a reason why the scheme may have had little impact on levels of use was because the law has little impact on an individual's decision to use cannabis.[231] However, the scheme was somewhat successful in encouraging individuals to produce their own cannabis, thereby reducing the black market in cannabis.[232]

A major concern with the Western Australian scheme is the potential for confusion among members of the public in relation to the law.[233] Notwithstanding that Australia criminalises the use of all illicit drugs, a survey in relation to the scheme found that 45% of respondents believed that it was legal for adults to possess a small amount of cannabis for their personal use. This illustrates the difficulty in implementing a model that produces a conflict between the letter of the law and the practice of the law.

## Decriminalisation

Decriminalisation models involve the removal of criminal sanctions for some or all offences, with the option to use administrative sanctions instead.[234]

There are a number of countries that have decriminalised the personal use of some drugs but the most notable is Portugal, which is the only EU state to enact legislation explicitly decriminalising the purchase, possession and consumption of all drugs for personal use.[235] Portugal did not, however, legalise drug possession and use, and trafficking and dealing remain criminal offences.

Portugal treats personal drug offences as administrative violations[236] and has set up a panel system, the Commissions for Dissuasion of Drug Addiction. The Commissions adjudicate drug offences. Where there is evidence of dependence or repeated violations sanctions may be imposed, which can be suspended if the user seeks treatment. The Commissions can give warnings, impose fines, suspend professional licenses, place a ban on visiting high risk locales and/or associating with particular people, require regular reporting to the Commission, prohibit international travel and/or terminate public benefits.[237] The Commissions gather evidence from the user in relation to frequency of use, drugs used, the circumstances surrounding the offence and the individual's economic situation.[238] The 'overriding goal' of the system is to remove stigma and guilt, and promote health and treatment aspects of the process.[239]

On balance, the Portuguese experience has been successful.[240] The benefits of the model appear to outweigh slight increases in overall levels of drug use,[241] particularly in circumstances where those levels are lower than the EU average and on par with neighbouring countries.[242] Meanwhile, the levels of problematic use have declined.[243] While it is difficult to attribute particular statistics to decriminalisation, it worth noting that both crime committed while intoxicated, and acquisitive crime, have decreased substantially.[244] Perhaps not surprisingly, the court system has become more efficient.[245] Drug prices have dropped, although it is unclear whether this is due to lower levels of demand.[246] Dramatic improvements in the number of users seeking treatment and a reduction in levels of drug-related harm, including mortality, are perhaps the greatest successes of the Portuguese model.[247]

## Legalisation

Legalisation involves the removal of criminal and administrative sanctions, thereby dismantling prohibition.[248] Legalised supply can be regulated or unregulated. Few would suggest the unregulated supply of drugs. Depending on the nature of regulation, there is

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the potential to realise a substantial decrease in levels of drug-related harm through the provision of safer drugs, in safer environments, with sterile injection equipment and the availability of properly resourced treatment and rehabilitation services. Regulations may also be designed in such a way as to encourage users to use a less harmful but more readily available drug and/or less expensive substances.[249]

One of the key advantages of the regulatory model is that it allows restrictions on supply and use to be tailored to the particular substance and its associated harms. Drug regulation would reduce expenditure on law enforcement and incarceration while potentially bringing in new tax revenues to offset the costs of establishing the necessary regulations.[250] It would also allow law enforcement to focus their efforts on illicit drug production and trafficking, rather than the prosecution of drug users.

There are five basic types of regulation:

### Prescription

Prescription schemes exist in most countries for the supply of pharmaceutical drugs. In a regulatory model, prescription represents the most strictly controlled method of drug supply. The prescription model is controlled by legislation, regulatory structures and statutory bodies and can be costly to administer. The consumption of a drug without a prescription is prohibited. The prescription model has the benefit that drug supply can be closely controlled and monitored. It also ensures the purity and quality of the drugs and that accompanying paraphernalia is sterile and safe. Pharmacists can provide information and advice in relation to administration and dosage, as well as providing access to relevant treatment services.

### Pharmacy model

The pharmacy model combines some elements of the prescription model, without the requirement for a prescription. This model already applies in Australia with respect to the sale of some pharmaceuticals. It is less restrictive, with the additional benefit that oversight can be provided by pharmacists. This oversight can include the restriction of sales, the provision of information and advice in relation to administration, dosage and relevant treatment services.

### Licensed sales

The licensed sales model already applies in Australia with respect to alcohol and tobacco. Various statutory and regulatory controls apply to production and supply.

### Licensed premises

Similar to licensed sales, the licensing of premises for the sale of alcohol already applies in Australia. Statutory and regulatory controls apply to those circumstances surrounding supply including opening hours, qualification of the licensee, age restrictions, responsible service and so on.

### Unlicensed sales

The unlicensed sale model is the lowest form of regulation and at present it applies to drugs considered to be low-risk, such as caffeine. Regulatory requirements generally extend to testing for safety and appropriate labelling.

New Zealand has implemented a recommendation by the New Zealand Law Reform Commission to regulate the availability of psychoactive substances, subject to strict conditions. The *Psychoactive Substances Act 2013* regulates otherwise unregulated psychoactive substances such as 'party pills' and other 'legal highs'. The Act restricts all psychoactive substances by default, and only allows the sale of those approved by a regulatory authority (the 'licensed sale' model). The Act requires license holders to demonstrate that a product which is a psychoactive substance or that contains psychoactive substances, poses no more than a low risk to users before it can be legally sold. It provides for restrictions with respect to: age, places of sale; internet sales; free-of-charge distribution; advertising, labelling, and packaging; and health warnings, signage, display, storage, and record-keeping.

A number of American states have decriminalised cannabis use for medical purposes. At the end of 2012, Colorado and Washington went further and legalised personal cannabis possession and use, and established regulated cannabis cultivation and sale. However, at the Federal level, cannabis possession and use remains illegal which means that Federal agents can still arrest cannabis users, and cannabis cannot be used on Federal land.[251] The inconsistency between State and Federal law is troubling and puts the United States in an awkward position with respect to its compliance with the UN Conventions.

## What constraints do our international obligations impose?

There are three UN Conventions that prohibit the possession, use, cultivation and trafficking of certain drugs, other than for medical or scientific use. These Conventions are:

1. The Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol.
2. The Convention on Psychotropic Substances of 1971.
3. The UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.

The Single Convention is the foundation upon which the illicit drug control system has been built. The Single Convention requires signatories to:

> [L]imit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs; eradicate all unlicensed cultivation; suppress illicit manufacture and traffic and cooperate with each other in achieving the aims of the Convention.[252]

This language is strengthened in the 1988 Convention, which requires states to criminalise the illicit possession, cultivation and purchase of drugs. However, the UN Conventions do not require states to impose a penalty of any kind for drug consumption.[253] The Conventions also require member states to prohibit any domestic market in illicit drugs, other than for medical or scientific purposes.[254]

There is a crisis within the UN drug control system that is driving the reform debate. [255] The UN has failed to achieve its goal of a 'drug free world', settling instead for 'containment' of the drug problem although the available evidence suggests that the UN has failed to achieve even this. [256]

### Latitude in the Conventions

There is some latitude in the UN Conventions by virtue of the following:

- the failure to define 'medical and scientific' for the purposes of article 1 of the Single Convention on Narcotic Drugs[257]
- prosecutorial discretion with respect to small quantities of drugs[258]
- the possible inconsistency with the constitutional or basic legal precepts of the state, in which case the latter will prevail[259]
- the possibility of depenalisation provided that the offence remains criminalised.[260]

The Single Convention also stipulates that 'abusers shall undergo measures of treatment, education, after-care, rehabilitation and social reintegration'.[261] The International Narcotics Control Board (INCB), which monitors adherence with the Convention, has stated that such measures can be applied as 'complete alternatives' to conviction and punishment for offences involving possession, purchase or cultivation for personal use. [262]

Innovative reforms that operate within the UN Conventions' frameworks are possible. Depenalisation and decriminalisation may be consistent with the Conventions, provided that drug use remains prohibited (see Portugal).[263] Legalisation, however, is inconsistent with the Conventions.

### The International Narcotics Control Board

Compliance with the Conventions is generally secured by the exertion of diplomatic pressure, most notably by the United States.[264] Diplomatic pressure is augmented by the efforts of the INCB. The INCB does not have the power to force a signatory to implement the terms of the Conventions, or to punish a state that fails to comply with the Conventions.[265] The INCB can, however, recommend that signatories embargo the trade of licit pharmaceuticals from or to a non-complying country.[266]

The INCB has adopted a very conservative approach in monitoring compliance with the UN Conventions:

> Even when nations are careful to work within the limits of the conventions in implementing harm reduction measures, the INCB has been known to take a narrow view and claim that the actions are contrary to the spirit of the conventions.[267]

Among other things, the INCB has condemned safe injecting rooms on the basis that they 'promote social and legal tolerance of drug abuse and drug trafficking and therefore contravene the international drug control treaties'.[268]

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The stringency of the UN Conventions, and opposition from the INCB, has not prevented countries from attempting to achieve meaningful drug law reform within these confines,[269] although such moves have not been well-received:

> The growing global trend towards actual or de facto decriminalisation of personal possession/use of drugs, whilst nominally permitted within the treaties, like harm reduction, poses serious practical and intellectual challenges to the status quo in the longer term. Such reforms not only challenge the spirit of the conventions but are now pushing the 'room to manoeuvre' to its limits and arguably beyond.[270]

### Possible reforms

There are a number of available possibilities for reform. The first option is amendment of the Conventions, although such amendment would be difficult to implement and the amendment procedures are different for each Convention. It would be necessary to obtain a significant degree of consensus in order for a proposed amendment to the Conventions to be successfully implemented.[271]

Another option would be to remove a particular drug from the schedules to the Conventions. The process for doing so, however, is similar to the procedure for amendment and also requires a significant degree of consensus.[272] A more radical step would be to adopt an entirely new treaty, which would supersede the existing Conventions. The success of such an approach however, would depend on the number of member states prepared to accede to the new treaty. Parties to the new treaty would still be bound by the provisions of the old Conventions with respect to those member states who had not acceded to the new treaty.[273]

The remaining option is denunciation, with the possibility of re-acceding with reservations.[274] However, reservations may 'not be incompatible with the object and purpose of the treaty'.[275] Arguably, provided that the party undertakes to control the international trade in drugs, the overriding goals of the Conventions will still be met. This approach was taken by Switzerland and the Netherlands, which implemented reservations against the criminalisation of use and possession.[276] However, Bolivia's efforts to withdraw and re-accede with reservations regarding the traditional use of the coca leaf have been met with criticism from the INCB:

> [W]hile that course of action is technically permitted under the Convention, it is contrary to the fundamental object and spirit of the Convention. If the international community were to adopt an approach whereby States parties would use the mechanism of denunciation and re-accession with reservations to overcome problems with the implementation of certain treaty provisions, the integrity of the international drug control system would be undermined.[277]

The Committee suggests that the most appropriate approach would be the adoption of a new Single Convention, which would apply to all psychoactive substances, including alcohol and tobacco. Such action would of course require the support of a number of other countries [278] but it would provide member states with the ability to tackle the regulation of drugs in a rapidly changing world. It is time for an international regulatory regime that can deal with the drug problem effectively, and can adapt to deal with new challenges as they emerge.

## Some conclusions

The preceding discussion leads the Committee to the following conclusions:

- Illicit drug use undoubtedly results in both primary and secondary harm, particularly for dependent users.
- While the primary harms of cannabis use are not trivial, they are modest compared to those associated with other illicit drugs, as well as alcohol and tobacco.
- Insofar as total social costs are concerned, the frequent use of tobacco substantially outweighs the costs resulting from the frequent use of alcohol or illicit drugs, while the total social costs resulting from the frequent use of alcohol and the frequent use of illicit drugs are comparable.
- The current prohibitionist approach to illicit drugs has substantially failed. It has had very limited effectiveness in reducing drug availability or drug use, particularly among young people, and that is unlikely to change.

- The distinction between licit and illicit drugs is becoming increasingly arbitrary.
- The harms resulting from the current prohibitionist approach to illicit drugs for drug users, and for the wider community, are significant.
- Alternative strategies to deal with illicit drugs are available, and have been adopted in other countries with some success.

We have concluded that the goal of Australian drug policy should be to reduce levels of drug-related harm, increase the number of drug dependent users seeking treatment and implement effective demand reduction strategies. The focus should be on the alleviation of the secondary harms associated with drug use, as opposed to dubious assessments of prevalence of use.[279]

## Options for drug law reform

It is the view of the Committee that there are essentially three options for drug law reform:

1. Decriminalisation of cannabis
2. Decriminalisation of all illicit drugs
3. A regulatory model

### Option 1: Decriminalisation of cannabis

The view may be taken that it is not appropriate to implement a 'one size fits all' approach to drug use. Every drug is different in terms of its physical and psychological effects; its risk of dependence or abuse; its effect on the friends and family of the user; and its association with crime. Given that the health and dependence risks associated with cannabis, although real, are modest compared to those associated with other illicit drugs, alcohol and tobacco, one option would be to begin with a relaxation of the current prohibitionist model in respect of that particular illicit drug. This would involve decriminalising, for adult use, the cultivation, possession and use of small quantities of cannabis.

Decriminalisation of cannabis has the potential to have a dramatic effect in circumstances where the majority of drug possession and use offences, globally, relate to cannabis.[280] Given polls that show substantial support for changing how cannabis is regulated, this option would be politically feasible in the short to medium term. While it would not address the issues that this paper has raised with respect to other illicit drugs, such an incremental approach might build the confidence needed to encourage politicians to move to more radical options for reform. It would also provide useful information to assist in the assessment of the likely consequences of decriminalising other illicit drugs.

### Option 2: General decriminalisation

The conclusions that we have drawn above apply to all illicit drugs, not just cannabis. The view could be taken that the time has come for a new approach to be taken to all currently illicit drugs.

Decriminalisation models involve the removal of criminal sanctions for some or all offences, with the option of imposing administrative sanctions.[281] As we have noted, there are a number of countries that have decriminalised the personal use of some drugs but the most notable is Portugal, which has enacted legislation explicitly decriminalising the purchase, possession and consumption of all drugs for personal use.[282] A system of administrative sanctions has been adopted instead.

The Portuguese experience appears to have been largely successful, at least in terms of reducing levels of problematic use, reducing crime committed while intoxicated and reducing acquisitive crime. The court system has become more efficient, the number of users seeking treatment has increased and levels of drug-related harm and mortality have decreased – all without any significant increase in the overall levels of drug use. Because drugs have not been legalised, and administrative sanctions are applied to drug users, there is no significant risk of 'normalising' drug use or inadvertently encouraging a significant uptake in drug use.

However, the retention of the prohibitionist approach means that the benefits from decriminalisation are limited:

- An unregulated black market for illicit drugs remains.
- Organised crime continues to be involved in the black market.
- Socialisation with other drug users and criminals continues.
- Drug-related violence and crime continue (albeit at reduced rates).

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- There is an inability to control the quality of illicit drugs consumed by users.
- There is encouragement to use more potent drugs that are more profitable to dealers and/or concealable.
- There are corruption concerns.
- Unsafe injecting practices continue.
- Overdoses as a result of the unknown purity and potency of illegally purchased drugs continue.
- There is continued risk of engaging in prostitution and other illegal activities.
- There is an adverse impact on public amenity (public drug use, drug dealing and discarded drug injection equipment).
- There is arguably excessive Government intrusion into citizens' lives.

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

### Option 3: A regulatory model

The most radical option would be to strictly regulate the production, supply, possession and use of currently illicit drugs for personal purposes. This model has many benefits, which will be discussed below, but the primary advantage is that drugs, users and suppliers will no longer be beyond legal control.[283] The government has an obligation to protect its citizens from harm, including drug-related harm, and this is likely the most effective way to do so. The focus would be on treating drug addiction as a public health issue, on reducing drug consumption through education and rehabilitation programs, and on directing law enforcement to illicit drug production and trade.

The regulation of drugs in Australia might involve:

- The establishment of a specialist advisory committee (including medical and other health professionals) that would review all drugs and provide advice to regulators.
- Licensing controls surrounding production and supply of drugs.
- Different levels of control depending on the drug and its potential to cause harm (for example, higher risk drugs would be subject to stringent controls, and might only be supplied to registered dependent users who would be required to use the drug in controlled environments).
- Prohibition on private production and sale.
- Prohibition on advertising.
- Prohibition on supply to children.
- Criminal sanctions imposed for illegal production, trafficking and diversion of drugs from the legal system.
- The taxation of drugs in a way that ensures that the price is sufficiently high to inhibit excessive use while being sufficiently low to prevent users from sourcing drugs on the black market.
- Recognition of the distinction between drug use and abuse.
- The substitution of safer drugs for more dangerous or addictive drugs where possible (with more dangerous drugs available on a prescription only basis, with proof of dependence).
- The provision of training for those dispensing drugs to provide them with appropriate knowledge in relation to drug properties, administration, dosage, polydrug use and treatment options.
- The development and implementation of effective demand reduction measures.
- The promotion of a public health oriented approach to drug use.
- The availability of appropriate and comprehensive treatment services for drug dependence in the community and in prisons.

- The establishment of a body to licence importation, manufacture and sale of particular drugs and monitor compliance with the scheme.
- Regular review and assessment.

Of course, it must be conceded that drug markets are complex and there is no single suitable approach to regulation.[284] The proposal for varying levels of regulation for different drugs reflects their differing capacity to cause harm. The assessment of a drug's capacity to cause harm must take into account the differences between types of drugs, and different formulations of the same drug.[285] It would be necessary to consider both primary and secondary harms[286] resulting from use of a particular drug, in addition to that drug's patterns of use.[287] It is also relevant to consider the typical user of a particular drug, and the approach that would be most effective for that user.[288] The Transform Drug Policy Foundation has identified the following list of variables to be considered in developing such profiles:[289]

- acute and chronic toxicity
- propensity for dependence (both physiological and psychological)
- issues relating to dosage, potency, frequency of use, preparation of drug and mode of administration
- individual risk factors including physical and mental health, age and pharmacogenetics
- behavioural factors including setting of drug use, and polydrug use.

A regulatory model offers drug users the opportunity to make informed decisions regarding consumption. The strictly regulated production of drugs by government licensees would ensure that users have access to known drugs of reliable quality and purity.[290]

Regulating supply also has the potential to address a vast array of secondary harms associated with drug use. Health care costs associated with blood borne viruses and overdose could be reduced. Similarly, one would expect to see a decrease in the rate of drug-related offences[291] as involvement with the black market would diminish, personal drug offences would no longer exist and the price of drugs could be manipulated to reduce the incentive for acquisitive crime.

The most effective way to undermine the black market is to provide a legal source of supply.[292] Additionally, wresting the supply of drugs from the black market allows for strict enforcement of minimum age requirements, with the potential to reduce currently high levels of drug use among young people.[293]

The regulation of drugs would also shift the control over production and distribution from criminal networks to government.[294] The reduction in available opportunities for drug production and supply would have a substantial effect on organised crime and levels of drug-related violence generally.[295] While it is accepted that the black market in drugs would not disappear, it is reasonable to believe that it would be substantially reduced in size, which would have a subsequent effect on profit margins and diminish the financial incentive to engage in the black market.[296]

A regulatory model has the potential to reduce government expenditure on law enforcement and incarceration, while providing a source of revenue through taxation, some or all of which can be used to meet the costs of the scheme itself.[297] A regulatory regime would allow law enforcement to direct its efforts away from personal possession offences towards illegal drug production and trafficking. Regulating drug use also allows law enforcement to target areas where it can have the greatest benefit: the production, trafficking and supply of drugs on the black market. Alleviating some of the burden on law enforcement may improve the likelihood of breaches being detected, improve the swiftness and certainty of sanctioning, and otherwise deter potential offenders.[298]

In a regulatory scheme the government has direct control over prices, which can be adapted to reflect trends in drug use. The government can ensure that the price of drugs administered through the scheme is sufficiently high to discourage recreational users, without being so high as to incentivise users to buy drugs on the black market.

A regulatory model can effectively implement a public health oriented approach to drug dependence. In this way, what is normalised is not drug use, but the user.[299] It is of vital importance that commercialisation of supply is prohibited. The commercialisation of alcohol and tobacco demonstrates the harms of normalised use. The development and implementation of appropriate regulations can prevent use from becoming normalised,

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while addressing the stigma experienced by the drug dependent user.[300] In this way the classification of drug dependence as a public health issue may discourage drug use. A public health oriented approach could also address the social and cultural factors that contribute to drug dependence.[301]

The primary argument against this option, apart from the fact that it is unlikely to be politically feasible in this country in the short to medium term, is that it is likely to result in an increase in drug usage, with a consequent increase in the harm that drug use causes.

It must be conceded that it is likely that the legalisation and regulation of drugs will lead to an increase in use.[302] How much of an increase would largely depend on the nature of the regulation applied to particular drugs. A dramatic fall in price would undoubtedly lead to an increase in use, but regulation may be designed to prevent substantial price reductions.

Legalisation may also result in the 'socialisation' of drug use and/or experimentation with new drugs.[303] Some commentators cite levels of alcohol and tobacco use as evidence that legality increases levels of use. There is no denying that levels of alcohol and tobacco use are much higher than the levels of use for illicit drugs. However, the evidence suggests that it is social and cultural factors that primarily influence an individual's choice to use drugs, including licit drugs.[304] Any regulatory model applied to the sale of currently illicit drugs would take steps to avoid the rampant commercialisation that characterises today's markets in tobacco and alcohol.[305]

Similar arguments may be made in response to the proposition that moving away from prohibition would 'send the wrong message', thereby increasing levels of drug use. The evidence indicates that this argument largely misconstrues the reasons why people use drugs. As previously discussed, drugs are taken for a variety of social, environmental, recreational and personal reasons. The greatest levels of use and harm are associated with dependent users, who are less receptive to 'the message' than recreational users.[306] Insofar as the general community is concerned, the 'message' depends upon the audience and in some cases what they want to hear. A central component of many harm reduction measures is the provision of treatment and education. Rather than sending a message condoning drug use, such measures serve to emphasise the harms associated with use and treat drug dependence as the health concern that it is.

Further, it should not be assumed that an increase in drug use will necessarily result in increased harm. There is no denying that problematic drug use clearly harms the health of the user. However, not all drug use is necessarily harmful.[307] Any drug regulation scheme needs to differentiate between drug use and dependence. The former results in low levels of primary and secondary harm, while the latter can be very harmful and is responsible for the majority of drugs consumed.[308]

Potential increases in levels of use, health-related harms and intoxication-related crimes need to be weighed against the potential to:[309]

- improve access to treatment
- reduce the risk of mortality
- reduce the costs to society
- reduce the incidence of drug-related crime
- address stigma and discrimination
- restrict the activities of criminal networks.

The harms flowing from any increases in the level of use might be offset by the ability to encourage less harmful patterns of use.[310] A concomitant increase in the number of users seeking treatment may offset any increases in use that result from increased availability. Treatment should be accessible and available to all users regardless of where they live and for as long a period as necessary. Part of this will involve the development of broad social strategies to improve social cohesion and address the prevalence of those factors associated with the development of drug dependence.[311] Targeted demand reduction programs should provide accurate information about drugs and their use so that users are in a better position to make an informed decision in relation to those behaviours that are likely to result in drug dependence.[312]

## Our preliminary proposal

We introduced this paper by observing that we have a responsibility as citizens to speak out if we conclude that the system needs reform. We are convinced that it does. It is apparent to us, based on the available research here and overseas, and from our own professional experience, that the time has come for significant change to the current prohibitionist model in relation to illicit drugs.

We have concluded that the goals of drug policy should be to reduce levels of drug-related harm, treat drug addiction as a public health issue, increase the number of drug dependent users seeking treatment and implement effective demand reduction strategies. It is our preliminary view, which is subject to further research and consultation, that the only way to achieve these goals is to replace the black market for drugs with a form of legal availability under a highly regulated system – the third option for drug law reform discussed in the previous section.

The level of control placed on the production and supply of drugs will depend on the particular drug and its potential to cause harm. The serious risks of overdose, mislabelling, contamination and unsafe modes of consumption, which arise from the unregulated black market, will be substantially reduced. Drug-related crime will also be substantially reduced. Law enforcement activities will be focussed on illicit drug production and trade. Reduced government expenditure on law enforcement and incarceration, along with revenue derived from licensed supply, will provide funds to meet the costs of the regulatory scheme. The risks of increased drug use can be managed and will be outweighed by the benefits of such a scheme, reducing harm both to drug users and to our community as a whole.

Notwithstanding our preliminary conclusion, the Committee would not oppose an incremental approach being taken, beginning with decriminalisation of cannabis, proceeding in time to decriminalisation of other illicit drugs, before consideration is given to this regulatory model that we believe should ultimately be adopted.

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