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The Australian 'drug budget': Government drug policy expenditure 2021/22

Drug Policy Modelling Program
Monograph No. 36, June 2024

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THE DRUG MODELLING POLICY PROGRAM

This monograph forms part of the Drug Policy Modelling Program (DPMP) Monograph Series.

Drugs are a significant social and health issue. The aim of the Drug Policy Modelling Program (DPMP) is to create valuable new drug policy insights, ideas and interventions that will allow Australia and other nations to respond with alacrity and success. DPMP addresses drug policy using a comprehensive approach that includes consideration of law enforcement, prevention, treatment, and harm reduction, and we take a multi-disciplinary approach.

DPMP conducts rigorous research that provides independent, balanced, non-partisan policy analysis. The areas of work include developing the evidence-base for policy; developing, implementing and evaluating dynamic policy-relevant models of drug issues; and studying policy-making processes.

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24. Government drug policy expenditure in Australia – 2009/10
25. Evaluation of Australian Capital Territory drug diversion programs
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27. Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion
28. Engaging general practice and General Practitioners in alcohol and other drug treatment
29. Distilling our changing relationship with alcohol during COVID-19
30. Process Evaluation of the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program
31. A Cost Assessment of the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program
32. An evaluation of outcomes in the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program
33. A Data Linkage Evaluation of the Outcomes of the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program
34. The impact of the COVID-19 pandemic on the non-government alcohol and other drug sector: future implications
35. Making policy in emergencies – insights for routine policy-making. The case example of opioid pharmacotherapy maintenance
36. The Australian 'drug budget': Government drug policy expenditure 2021/22

DPMP strives to generate new policies, new ways of making policy and new policy activity and evaluation. Ultimately our program of work aims to generate effective new drug and alcohol policy. I hope this Monograph contributes to drug policy and that you find it informative and useful.

A handwritten signature in black ink, reading "Alison Ritter". The signature is fluid and cursive, with the first name "Alison" written in a larger, more prominent script than the last name "Ritter".

Professor Alison Ritter, Director, DPMP

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List of abbreviations

ABF	Australian Border Force
ABS	Australian Bureau of Statistics
ACIC	Australian Crime Intelligence Commission
AIHW	Australian Institute of Health and Welfare
AIVL	Australian Injecting and Illicit Drug Users League
ANAO	Australian National Audit Office
AOD	Alcohol and Other Drugs
AODTS-NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
BBV	Blood borne virus
BOCSAR	Bureau of Crime Statistics and Research
CAHMA	Canberra Alliance for Harm Minimisation & Advocacy
CHERE	Centre for Health Economics Research and Evaluation
CPI	Consumer Price Index
DEVS	Drug Education in Victorian Schools
DPMP	Drug Policy Modelling Program
DUO	Drug User Organisation
EMCDDA	European Monitoring Centre for Drugs and Drug Abuse
FFA	Federation Funding Agreements
FFR	Federal Financial Relations
GDP	Gross Domestic Product
GST	Goods and Services Tax
HRVic	Harm Reduction Victoria
IDDR	Illicit Drug Data Report
IDO	Illicit Drug Offence
MBS	Medicare Benefits Scheme
NIAS	National Ice Action Strategy
NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data collection
NUAA	NSW Users and AIDS Association
NWAU	National Weighted Activity Unit
OAT	Opioid Agonist Treatment
PBHRWA	Peer Based Harm Reduction WA
PBS	Pharmaceuticals Benefits Scheme
QuIVAA	Queensland Injectors Voice for Advocacy and Action
QuIHN	Queensland Injectors Health Network
RDT	Roadside Drug Testing
S/T	State and Territory
THN	Take Home Naloxone
TUHSL	The Tasmanian Users and Health Support League

Executive Summary

Illicit drugs in Australian society are associated with health, social, and economic burdens. Governments respond to the wide-ranging implications of illicit drug use and supply by mobilising the substantial social and economic resources represented across different portfolios – including policing and law enforcement, education, health, and community and welfare services.

Transparency and accountability are crucial in relation to public funds and drug policy. Understanding spending by governments provides a baseline for policymakers, stakeholder organisations, and the public. Governments are only able to spend a finite amount of money. Where governments spend money illustrates what they consider important in responding to drugs.

The first government expenditure estimate (known as the ‘drug budget’) across Australia was completed for the financial year 2002/2003 (Moore, 2005); the second was for the financial year 2009/2010 (Ritter et al. 2013). This report is the third so-called ‘drug budget’, estimating proactive spending on illicit drugs by governments across Australia.

This report provides an estimate of Australian governments’ proactive expenditure on illicit drugs for the financial year 2021/22. Four drug policy domains were included: prevention, treatment, harm reduction, and law enforcement. A top-down approach was employed to derive estimates, which was possible for prevention, treatment, and law enforcement. A bottom-up approach was employed to derive estimates for the domain of harm reduction.

Australian governments spent approximately \$5.45 billion in 2021/22 in proactive responses to illicit drugs. This estimate includes expenditure on prevention programs designed to prevent or delay drug use by young people—such as in-school education; treatment programs that aim to decrease drug use through medical and psychological services—such as specialist alcohol and other drug treatment; harm reduction programs that aim to reduce harms associated with drug use without necessarily reducing use—such as needle syringe programs; and law enforcement programs that aim to disrupt supply and inhibit demand for illicit drugs—such as policing and prosecution of drug crimes and interdiction of illicit drugs at Australian borders.

The \$5.45 billion amounts to 0.63% of government expenditure. In 2021/22, this represented a per person spend of \$209.61.

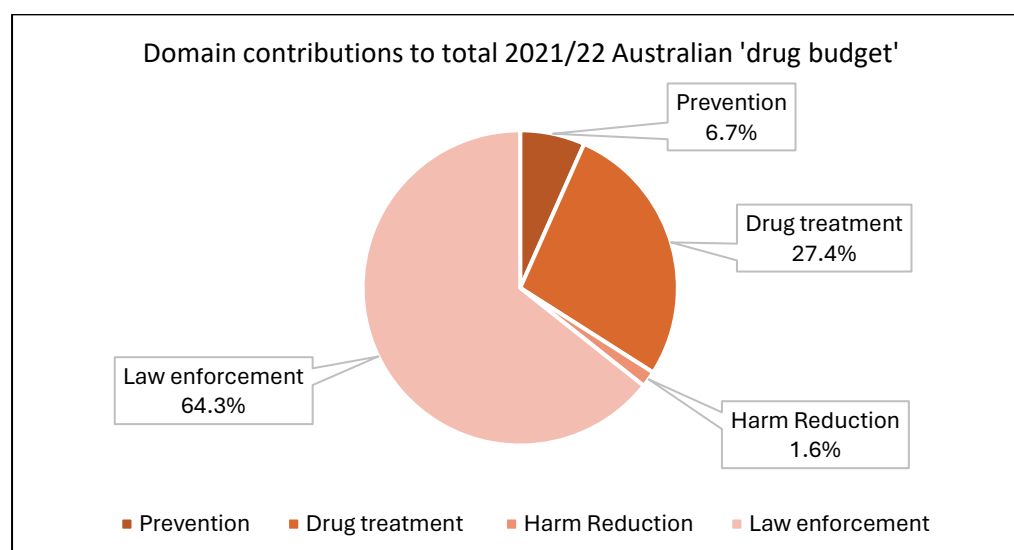
The relative investment across the four policy domains is given in Table E1.

Table E1: Expenditure estimates by domain and percentage contribution to total Australian ‘drug budget’ 2021/22

Domain	Expenditure (\$)	%
Prevention	\$362,711,455	6.7%
Treatment	\$1,491,306,732	27.4%
Harm Reduction	\$89,897,540	1.6%
Law Enforcement	\$3,506,017,286	64.3%
Total	\$5,449,933,013	100%

The majority of government spending on proactive responses to illicit drugs comprised law enforcement, at 64.3% of the total \$5.45 billion. This was followed by treatment at 27.4%, prevention at 6.7%, with the smallest proportion of 1.6% on harm reduction.

Figure E1: Percentage contribution to spending by domain



State and Territory governments were responsible for the majority of proactive expenditure on illicit drugs, spending 76% or \$4.11 billion of the total expenditure, the majority of which (\$2.87 billion) was for state law enforcement.

There are difficulties sourcing robust data for many of our estimates. As a result, we conducted sensitivity analyses to derive possible ranges for relative investment across domains, as shown below.

Table E2: Sensitivity analyses on 2021/22 expenditure estimates by domain (low, high) and % contribution (low, high)

Domain	Low Estimates	MAIN ESTIMATE	High Estimate	% contribution
Prevention	\$332,900,017	\$362,711,455	\$598,559,168	6.1% to 10.5%
Treatment	\$1,081,240,250	\$1,491,306,732	\$1,621,184,898	21.5% to 29.1%
Harm reduction	\$85,167,337	\$89,897,540	\$95,518,974	1.6% to 1.8%
Law enforcement	\$2,403,195,252	\$3,506,017,286	\$4,109,781,992	55.3% to 67.9%
TOTAL	\$3,902,502,856	\$5,449,933,013	\$6,425,045,032	

* Columns may not sum due to rounding.

There have been substantial methodological refinements across the three 'drug budgets'. The current report uses the most up-to-date available multipliers, and used a consistent top-down methodology across the three primary domains. It was not possible to use a top-down methodology for the harm reduction domain and this remains an important methodological limitation.

The total amount spent has substantially increased between 2002/03 (at \$1.3 billion) and 2021/22 (at \$5.45 billion). Yet government spending overall has also increased. The 2002/03 estimate represented 0.5% of all government expenses for all levels of government (Moore, 2005). The 2009/10 estimate represented 0.8% of government spending (Ritter et al., 2013). The 2021/22 estimate represents 0.63% of government spending. These figures suggest that despite a significant

increase in the amount of proactive government spending on drugs since 2002/03, this reflects overall growth in government spending, and not growth in spending on proactive responses to illicit drugs. Indeed, it could be argued that the decrease from 0.8% of total government spending to 0.63% now is a real reduction in proactive spending on illicit drugs by Australian governments.

Despite the various improved methods employed in this 2021/2022 ‘drug budgets’ analysis, it is striking that the distributions between the four main domains have remained almost identical to the previous versions.

Table E3: Comparison of the percentage distributions across domains between the 2002/03, 2009/10 and 2021/22 Australian ‘drug budgets’

	2002/03 (Moore, 2005)¹	2009/2010 (Ritter et al., 2013)¹	2021/2022 (current estimate)
Prevention	9% ²	9.5%	6.7%
Treatment	20.2%	22.0%	27.4%
Harm Reduction	3.9%	2.2%	1.6%
Law Enforcement	65.3%	64.9% ³	64.3%

1. The 2002/03 and 2009/10 estimates included an ‘other’ category, hence the column percentages do not sum to 100%

2. The original 2002/03 prevention estimate included social competencies training. These were excluded from subsequent prevention estimates and so were removed from here for comparability purposes. See Ritter et al., 2013, p. 2

3. An addendum was published to the 2009/10 estimate which provided an updated calculation for law enforcement expenditure. The figure reported here is the ‘new’ figure. See Ritter et al., 2013 for details.

Drug budget estimates rely on available data and methods of estimation using extrapolation and proxies. As a result, there are important limitations, assumptions, and caveats informing all of our estimates. One major limitation of a top-down costing approach is in the use of total budgets to derive specific illicit drug-related expenditure. This assumes all activities within an agency cost the same or take the same amount of time. Bottom-up estimates, by contrast, rely on identifying specific program expenditure, so may fall foul of missed programs and may result in underestimates. These significant assumptions and issues are unavoidable given current data limitations. All assumptions and caveats have been documented throughout this report and allow estimates using other assumptions or data sources as a point of comparison.

The relative value of the estimates is more important than any absolute value provided in the analyses. The report does not, however, provide an assessment of effectiveness of the investment across domains. This monograph provides a description of what is, not what should be.

The latest National Drug Strategy Household Survey (AIHW, 2024) asked respondents about the distribution of a hypothetical \$100.00 across three of the four domains covered in this ‘drug budget’. In 2019, Australians wanted \$36.50 spent on drug education; \$32.00 spent on drug treatment and \$31.50 spent on law enforcement responses to illicit drugs. This suggests that Australians are looking for similar government investment across proactive responses to illicit drugs.

Chapter 1: Introduction

Illicit drugs in Australian society are associated with health, social, and economic burdens. They shape social and cultural contexts, have biological and environmental impacts, and are commodities in black markets. Governments respond to the wide-ranging implications of illicit drug use and supply by mobilising the substantial social and economic resources represented across different portfolios – including policing and law enforcement, education, community and welfare services, and health services. Responding to illicit drug use and supply represents a substantial investment of public money. Understanding where and how this money is spent is an exercise in transparency and accountability.

Transparency and accountability are crucial in relation to public funds and drug policy. Understanding spending by governments provides a baseline for policymakers, stakeholder organisations, and the public. Governments are only able to spend a finite amount of money. Where governments spend money illustrates what they consider important in responding to drugs. In addition, the detailed breakdown of actions taken and funded by governments is a useful anchor for discussions and analysis of formal policy positions.

Drug budgets,¹ assessing what governments spend, were first established in the United States in the 1970s (Reuter, 2006). Federal drug spending estimates in the U.S. continue to be managed by the Office of National Drug Control Policy. Drug spending estimates have also been undertaken in several other countries including Sweden (Ramstedt, 2006), Canada (Debeck et al., 2009), the Netherlands (Rigter, 2006), and Germany (Mostardt et al., 2010). The European Monitoring Centre for Drugs and Drug Abuse (EMCDDA) also reports on expenditure in a number of European Union countries. The EMCDDA has published a framework for approaches to estimating public expenditure on drugs (European Monitoring Centre for Drugs and Drug Addiction, 2008).

Tim Moore (2005) conducted the first drug-related expenditure analysis in Australia as part of DPMP's first monograph series. Moore reported expenditure for 2002/03. This first drug budget reported two components of drug-related expenditure: direct costs associated with spending on activities and interventions ('proactive' spending); and indirect costs (or consequences) associated with drug use ('reactive' spending). The second drug-related expenditure analysis to estimate costs across Australia was conducted by Alison Ritter, Ross McLeod, and Marian Shanahan (2013). Ritter et al. reported expenditure for 2009/10. This second drug budget provided updated estimates and standardised the included costs in line with calls from EMCDDA (2008) and Reuter (2006) to focus on proactive elements only. This focus improves comparability across jurisdictions and different reference years, and avoids overlap with cost-of-illness studies.

The present report is Australia's third 'drug budget' and replicates the approach focussed on proactive spending only. The estimates in this monograph allow comparisons of government investment across the reference years: 2002/03, 2009/10, and 2021/22. This study does not provide advice about what the ideal spending proportions might be. Nor do proportions suggest a particular domain results in more effective drug policy. 'Drug budgets' do not cover whether government investment represents effective intervention, value for money, or an appropriate response to drug

¹ These exercises, completed in a number of countries including Australia, have become known as 'drug budgets' – even though technically it is not what might be announced in budget papers but rather it reflects actual expenditure by governments.

use, drug supply, and drug related harm. Rather, they are indicative of current funding arrangements and spending priorities.

This study aimed to:

1. Provide an account of the relative investment across drug policy domains (prevention, treatment, harm reduction, and law enforcement) by calculating expenditure on proactive programs for illicit drugs for the financial year 2021/22 by federal and state/territory governments in Australia;
2. Update the methodological framework for calculating expenditures developed by Moore (2005) and updated by Ritter et al. (2013) by applying a consistent method across activities, and refining methods for individual activities; and
3. Provide a transparent and replicable resource to those seeking to conduct costing work on Australian drug expenditures.

It has been over 10 years since the previous 'drug budget' in 2009/10. Substantial social, cultural, and political changes have impacted the drug policy landscape. This has included a shift towards the supply and consumption of crystal methamphetamine (Australian Criminal Intelligence Commission, 2023b; Man et al., 2022). Additionally, numerous developments in Australian drug policy have implications for government spending, such as new drug treatment interventions (for example the introduction of long-acting injectable buprenorphine, Daglish et al., 2024), ongoing developments in prevention (such as the Preventure programs, Mewton et al., 2018), as well as minor changes to drug laws increasing the availability of civil responses (fines) or health related options (ACT Government, n.d.).

At the same time, little has changed in the drug policy landscape since 2009/2010: we still have a National Drug Strategy focussed on an overarching harm minimisation goal (with supply, demand and harm reduction elements), the changes to drug laws around Australia have been very modest (with criminal charges for use/possession being largely retained), and harm reduction remains apparently difficult to progress - Australia now has two supervised injecting facilities (instead of the previous one).

Beyond the drug policy landscape itself, Australia has seen significant inflation in the period between 2009/10 and 2021/22. The Reserve Bank of Australia's inflation calculator² notes that the total change in cost over these 12 financial years is 29.5%. Additionally, government spending has increased from \$224.69 billion in 2009/10 to \$865.9 billion in 2021/22 (Australian Bureau of Statistics, 2023d). Applying CPI increases to the 2009/10 figure (\$291.01 billion) reveals that total government expenditure has risen by 198% (over and above CPI). As a result, we anticipated substantially higher government spending across all drug policy domains.

COVID-19 has had widespread impacts on health and everyday life with significant ramifications. Drug use patterns were temporarily disrupted (Baillie et al., 2021; Price et al., 2022; Sutherland et al., 2022). Drug treatment was also disrupted. Sutherland et al. (2022), in findings from the 2022 Illicit Drug Reporting System report (IDRS, data collected from May to June 2022), found that 49% of IDRS participants experienced a disruption to their drug treatment since COVID-19 pandemic began. However, policy changes were designed to ameliorate these negative effects at some drug treatment services (in particular, related to opioid maintenance therapy, Dunlop et al., 2020; Lintzeris et al.,

² <https://www.rba.gov.au/calculator/financialYearDecimal.html>.

2021; Mellor et al., 2022). The distorting effects of COVID-19 should be kept in mind when interpreting some of the data reported below. Some effects are explicitly identified in our sources, and noted in our results below (e.g. prevention expenditure reported by the Victorian Government); other potential COVID effects may be a factor in some changes between years (e.g. lower police arrests for drug crimes in 2020/21 from a high in 2019/20), although these are inferences only. We were not able to disaggregate any increases or decreases in expenditure as a result of COVID-19 related to the main expenditure estimates. Future drug budgets should be mindful of this context, particularly when comparing between years.

Scope

Which drugs?

This ‘drug budget’ is focused on government expenditure related to illicit drugs only. These drugs include heroin, cannabis, methamphetamine, cocaine, ecstasy, and hallucinogens. Legal frameworks classifying cannabis have seen substantial changes in recent years. Medicinal cannabis has been available across Australia with a prescription since 2016, and individuals are now able to possess, use and grow cannabis within certain limits in the Australian Capital Territory (ACT). Drugs such as tobacco, alcohol, performance and image enhancing drugs, and legal substances used for psychoactive effects are not included in the analysis. Non-medical use of prescription drugs, notably opioids, are included to the extent in which they are captured within the top-down approaches for drug treatment, and law enforcement estimates.

Which costs?

Estimates of government spending in relation to illicit drugs have traditionally been divided into *proactive* spending (i.e. activities that have a “clearly stated objective of reducing drug use or problems” (Godfrey et al., 2002, p. 1)) and *reactive* spending (i.e. costs incurred as a consequence of drug use, such as ambulance services).³ This analysis concerns proactive spending only – the provision of policing, harm reduction, treatment, and prevention services aimed at reducing drug use and associated harms. There are many reactive costs borne by government in relation to illicit drugs, including ambulance costs associated with drug overdose events, and treatment of drug withdrawal within hospitals in association with a primary non-drug presentation. There are also some government funded services where the distinction between proactive and reactive is less clear. One example is responding to blood borne virus (BBV) infections (screening, treatment). We have chosen to treat these as reactive government costs (a consequence of unsafe drug injection) and have not included them within our main estimates. (We provide costing details in Appendix 1 for the interested reader).⁴

There are various other costing approaches in relation to drugs, drug harms, and drug policy. These include social cost studies, which seek to determine *all* costs to governments and communities (i.e., lost workplace productivity and injury, and the intangible costs of premature death and reduced quality of life) (Whetton et al. 2020). Other approaches include cost-effectiveness studies, which

³ The terms ‘direct’ and ‘indirect’ costs are also used within economic assessments. Direct costs refer to the costs associated with adverse effects of substances which directly incur costs to government, such as healthcare services; indirect costs refer to costs such as lost productivity, and premature mortality. We do not use the terms ‘direct’ and ‘indirect’ because of the potential confusion that may create.

⁴ The categorisation of some activities as proactive or reactive expenditure is a fruitful site for future research and debate and will have implications for future drug budgets.

assess economic investment and outcomes achieved from specific treatments or interventions. This drug budget is not concerned with social costs associated with drug use, possession, and supply, nor is it an economic evaluation.

Which proactive interventions?

There are many ways to categorise the various activities that governments employ proactively to respond to the ‘drug problem’. In the Australian Government context, the policy priorities and interventions outlined in the National Drug Strategy 2017-2026 (‘the Strategy’) (Department of Health, 2017a) are classified under three categories: demand reduction, supply reduction, and harm reduction. There are, however, more than 20 ways to classify drug interventions (Ritter & McDonald, 2008).

We follow Reuter (2006) and the previous Australian drug budget (Ritter et al., 2013) by using the conventional four pillar approach for classifying activities. Some activities are concerned with preventing the commencement of drug use. These are generally labelled **prevention**. Another set of activities involve treating people to reduce their drug consumption (**treatment** interventions). A third set of activities is concerned with reducing the availability and accessibility of illicit drugs across the community through policing, punishment, and interdiction (**law enforcement** responses). Finally, there is a group of activities not concerned with reducing supply or demand, or reducing drug use per se, but concerned with reducing the harmful consequences of drug use including blood-borne viruses, overdose, and other harms. These interventions are known as **harm reduction**. These four pillars, or domains (a term we adopt throughout this study) provide a way of conceptualising relevant government expenditure.

This project began with mapping the activities and interventions related to drug policy. In part this was to ensure we were aware of all the activities that are government funded and needed to be accounted for in our total expenditure estimates. Additionally, we wanted to survey the field for new activities or drug policy innovations that had been implemented since the publication of the previous expenditure monograph in 2013. The activity list we generated emerged from expert advice, desktop research, and the various literature focused on drug policy interventions (Ritter & McDonald, 2008; Moore, 2005; Ritter, McLeod & Shanahan, 2013; National Drug Strategy, 2017). Strikingly, despite a comprehensive approach to identifying all proactive government responses to illicit drugs, including extensive consultation with experts, there were very few differences from lists generated in past drug budget exercises.

A full list of the activities related to each domain can be found in Appendix 2, including any exclusions. Table 1 provides a snapshot summary of the activities engaged with by governments to proactively respond to illicit drugs, and their inclusion (or exclusion) from this current ‘drug budget’.

Table 1: Activities by governments to proactively respond to illicit drugs

Domain	Included	Not included
Prevention	- School-based drug education - General prevention programs - Infancy and parental programs	Programs aimed to address the social determinants of health
Treatment	Drug treatment services, including across specialist and generalist settings and across all treatment types	- In-custody treatment services - Drug driving programs

Domain	Included	Not included
Harm reduction	• Needle syringe programs • Peer-led drug user organisations • Take home naloxone • Supervised injecting facilities	• Drug-checking • BBV prevention and education programs • Harm reduction in prisons
Law enforcement	• Customs and border control • Routine policing against drugs • Courts (Higher, Magistrate, Childrens courts) • Public Prosecutions & Legal Aid • Corrective services • Community corrections	• Roadside drug testing • Low aromatic fuel • Clandestine lab detection and destruction • Controls of precursor chemicals

Some activities and programs do not neatly fall into one domain. For example, take home naloxone can be provided in many drug treatment settings as well as harm reduction settings. In addition, the source of funding for some activities spans two domains: drug courts are a good example, where expenditure related to the courts would be classified as law enforcement, whereas the provision of drug treatment would be classified within treatment. We have taken a pragmatic approach, driven by the available data. (See Appendix 2 for more details).

Costing approach

The reference year for this project was the 2021/2022 financial year. This period provided the most up to date information and reported funding figures. Further, we chose not to use 2020/21 as this was the most heavily impacted by the COVID-19 pandemic. The accompanying financial distortions would undermine the utility of the drug budget, including comparisons across years. Context, data inclusions, and data availability should be taken into account for all comparisons between years.

Identifying proactive expenditure on drug policy interventions and activities is not a simple task of finding line items reported in Department financial reports. Nor can we rely on figures given in budget announcements.⁵ There is no systematically identifiable 'labelled' expenditure in Australian financial reports for specific drug program expenditure. One reason for this is that funding for particular agencies is not tied to specific activities. For instance, police are not funded a particular amount to police drug offences. Instead, the drug related activities are nested within broader agency activity.

In the absence of labelled drug-related expenditure, a top-down costing approach is recommended by the EMCDDA (2008); it is also the approach the previous drug budget employed (Ritter, McLeod and Shanahan, 2013). Ideally, all estimates would be derived using the same methodology. In practice, this is difficult. It was possible to use a top-down method for prevention, treatment, and law enforcement domains. We were unable to derive a top-down estimate for harm reduction. (Appendix 3 provides a detailed discussion of top-down and bottom-up costing approaches and the methods used for each activity costed in this report). In lieu of top-down approaches for all four domains, and to give further data on total estimates, we provide multiple methods of estimation for

⁵ Budget papers on the other hand include actual expenditure for previous years.

numerous items (e.g. NSPs) and provide bottom-up estimates as part of our sensitivity analysis (See Chapter 8).

Broadly, employing a top-down approach is reliant on a strong understanding of how drug policy activities are implemented; identifying a relevant and meaningful variable for drug-specific activities that allows us to calculate a proportion of the total; and having access to expenditure information for a whole agency, department, service, or program. Specifically, a top-down approach reports drug-related expenditure as a proportion of total agency expenditure. A limitation of top-down expenditure estimates is that they are less precise, and do not provide expenditure breakdowns for specific activities in a domain.

For any data from years other than 2021/22, inflation adjustments were made using the Reserve Bank of Australia's inflation calculator (<https://www.rba.gov.au/calculator/>). All final expenditure estimates are expressed in \$AUD in 2021/22 terms. For some activities, there were no new data or robust methods for calculating expenditure. In this instance, we relied on calculations and estimates from the previous two drug budgets. This is a key limitation, which we have avoided wherever possible. As with all assumptions informing our estimates, our data sources and methods have been noted throughout.

Chapter 2: Prevention

Prevention activities included school-based drug education programs; general prevention activities (such as general public education campaigns, targeted education programs, and local government health promotion plans reported in state expenditure); dedicated federal government spending on drug prevention; and prevention activities through services provided within intensive family support services and family support services. Differing methods were required to attain government spending estimates for each of these. Respectively these were: a top-down approach to school-based drug education (dividing the number of hours spent on drug education by the total available schools hours and then applying that proportion to the education budgets); bottom-up federal government general prevention spending announcements on specific programs; a per person estimate of state and territory governments general prevention spending (derived from two states with available prevention spending estimates: WA and Vic); and finally, applying the population prevalence of drug use disorders to spending on infancy and parental support programs.

Table 2: Summary of overall prevention expenditure

Prevention activity	Total
School-based drug education	\$276,084,744
Federal government general prevention	\$7,444,924
State and Territory governments general prevention	\$66,723,077
Infancy and parental support programs	\$12,458,711
Total	\$362,711,455

School-based drug education

School-based drug education (SBDE) is a prominent activity for early intervention prevention programs. Curriculum modules provide students information on the harms of drug use and seek to equip students with social skills to mitigate harms in situations where they themselves, or peers, are engaging in drug use. SBDE is considered an activity present in each state and territory's curriculum and as such, is calculated by proportion of school time spent on drug education. There are other prevention activities that are related to school education (i.e., Positive Choices – a school prevention program), however the expenditure on this activity is counted under federal general prevention, this is explained below. SBDE is predominantly taught within the Personal Development, Health and Physical Education courses in years 7-10, with years 11 and 12 requiring a mandatory life skills course (NSW specifically). However, there are a range of AOD education programs designed for schools to adopt in addition to the syllabus. These programs require additional costs to individual schools. They include:

- OurFutures
- SHAHRP – School Health and Alcohol Harm Reduction Project
- Drug Education in Victorian Schools (DEVS)/Get Ready
- Resilient Families
- Preventure
- School Drug Education and Road Aware (SDERA)

This project does not account for school spending on these available AOD programs, it only seeks to include illicit drug education outlined in the syllabus.

To estimate the expenditure on school-based drug education (SBDE) we applied the proportion of time spent on illicit drug education in schools to the total recurrent secondary school⁶ education expenditure.⁷ The most recently available data on recurrent government expenditure for all schools was for 2020/21, which was \$72,209,332,000 (Productivity Commission, 2023f). Within this, the total expenditure for secondary schools is approximately \$36,390,271,568.⁸ We need to apply CPI to this figure to convert it from 2020/21 to 2021/2022 for consistency.

To determine the proportion of time spent on illicit drug education we need to know possible school hours and time spent on drug education. Possible school hours are complex and specific to individual students (Australian Curriculum, Assessment and Reporting Authority, 2020). However, we assume that drug education, much like the rest of the curriculum, is taught whether or not individual students are in attendance or not. As such the assumption we make about possible school hours is determined by the average number of weeks of a school year (40 weeks) (Queensland Government Department of Education, 2023) and the average number of hours of education a student is required to attend (25 hours a week) (Victoria Government Department of Education, 2022). As such, we assume that the total annual hours for the entire secondary school curriculum to be taught is 1000 hours per student.

There is limited information about how much time is spent on drug education across state and territory curriculums, and which years receive illicit drug-specific education compared to other general life skills, mental health, and if illicit drug education is a component of alcohol education modules.

Drug Education in Victorian Schools (DEVS) offers the Get Ready resource which developed ten 1-hour lessons for each year level from 7-9 (Midford et al. 2012). We apply this 10 hours to years 7 to 9. In NSW, the Life Ready course is delivered to years 11 and 12 (NSW Government Department of Education, 2023). A breakdown of the modules taught in this program suggest there are approximately 3.5 (3.583) hours dedicated to illicit drug education in total combined across both years 11 and 12. However, this requires us to determine how many hours are taught in year 10. Without any other information available we assume that 10 hours of drug education is also programmed for year 10 students. Table 3 provides a summary of the time spent on drug education by year level.

⁶ SBDE is provided to all year groups from Kindergarten through to Year 12. However, students in Kindergarten to Year 2 learn to safely manage medicines at home and learn to contact emergency services if there is an accident. Students in years 3 to 6 learn about legal drugs and their effects and harms on the body. It is not until year 7 that the curriculum includes education about illicit drugs. Given the scope of this project, only secondary school education expenditure is relevant.

⁷ The definition of recurrent funding is provided by the Commonwealth Department of Education: "Annual funding to support the day-to-day operation of a school, including teaching and non-teaching staff salaries, and school operating costs." (<https://www.education.gov.au/recurrent-funding-schools/school-funding-glossary>)

⁸ To calculate how much of this expenditure was dedicated to secondary schools we multiply it by 50.4%. Rice et al. (2019) provide a breakdown of education expenditure for 2015. They estimate all school funding to be \$61,311,000,000, where secondary school expenditure accounts for 50.4% of the total.

Table 3: Time spent on drug education by year level

Year level	Estimated hours spent per year on illicit drug education	Source
Year 7	10 hours	Midford et al 2012
Year 8	10 hours	Midford et al 2012
Year 9	10 hours	Midford et al 2012
Year 10	10 hours	Assumption
Year 11	1.79 hours*	NSW Government Department of Education, 2023
Year 12	1.79 hours	NSW Government Department of Education, 2023
Average hours spent	7.264 (approx. 7 hours and 15 mins)	

*Time spent on illicit drug education in the Life Ready course, based on teacher delivery resources. The Life Ready course includes other lessons that focus on financial literacy, relationships, sexual health, mental health, safe travel, and are thus out of scope. The total for year 11 and 12 is 3.58 hours, and assumes an even split between these two years.

In relation to possible secondary school hours, the proportion of time spent on illicit drug education is approximately 0.007264% (given the maths: 7.264 hours of drug education divided by 1000 hours of possible secondary school hours). Applying this percentage to recurrent secondary school education expenditure estimated for 2021/22 results in a total expenditure on illicit drug education of \$276,084,744.

Assumptions and caveats – School-based drug education

This analysis assumed that all schools elect to teach illicit drug education modules; and that only secondary schools provide education on illicit drugs.

The average number of hours spent on drug education is an approximation, and it is assumed that this amount is applicable to all state and territory education systems.

All schools (public, private) are included given the assumption that the Productivity Commission Report on Government Services estimates government spending irrespective of type of school (i.e., public or private).

This approach does not rely on attendance rates and does not weight enrolments by years as the key assumption is the class will go ahead even if some students are in attendance or if there are lower enrolment rates in later years of secondary schools.

Federal government general prevention

A significant focus for federal prevention activities was the ongoing funding of programs tied to the National Ice Action Strategy (NIAS). As discussed in the introduction, crystal methamphetamine has been a key policy issue for the federal government and as a result most of the information reported about federal prevention funding was related to the NIAS. The key limitation with this approach is that this strategy only relates to methamphetamines. Specifically, the method for calculating federal prevention expenditure relied on organisations reporting programs that received federal government

funding. The two key organisations that the government funds to deliver prevention activities are the Alcohol and Drug Foundation and the Matilda Centre (University of Sydney).

An audit of the NIAS by the Australian National Audit Office (ANAO) (2019) reported that the federal government had announced \$313.2 million in funding over four years from 2016/2017. Prevention activities were identified as being a component of this funding package, however the amount directed to this activity was not announced. The audit outlined three key prevention activities the strategy had prioritised:

- “Deliver evidence-based targeted communication activities, including through social media and other innovative media.
- Support more than 1200 community sporting clubs to deliver prevention messages about ice, including sporting clubs in remote Indigenous communities.
- Develop strategies to increase prevention and education about ice in high-risk industries such as mining, construction and transport.” (ANAO, 2019, pp. 42-43)

We have no available data on the first dot point.

The second dot point, funding of the community sporting clubs, is an activity that is predominantly administered by the Alcohol and Drug Foundation. They implement prevention activities via the Good Sports program (a program intended for community sports clubs to encourage healthier behaviour, and become safer, more welcoming and family-friendly places to enjoy sport) and the Local Drug Action Teams (that support communities to work together to prevent and minimise the harm caused by alcohol and other drugs). Table 4 provides a breakdown of federal government funding to organisations to run these activities.

Table 4: Federal prevention expenditure to organisations to run federal prevention activities

Activity	Financial year 2021/22
Good Sports	\$5,719,765
Local Drug Actions Teams	\$6,660,650
Total	\$12,380,415
Expenditure only related to illicit drugs	\$6,190,208

Despite these activities emerging from the NIAS, as noted above they provide information and education about alcohol as well as other illicit drugs, not solely methamphetamines. No reliable estimates of the proportion spent on illicit drugs are available. Following the previous drug budget (Ritter et al., 2013), it was assumed that half of the general prevention expenditure was attributed to illicit drugs. As such we estimate \$6,190,208⁹ was spent on this activity in relation to illicit drugs.

We have no available data on the third dot point.

The federal government also funds Australia-wide prevention activities. These include Positive Choices (an online portal designed for schools to access resources and information about drug education and prevention programs)¹⁰ and Cracks in the Ice (a toolkit to provide evidence-based, and up-to-date information and resources about crystal methamphetamine).¹¹ These programs are designed and implemented by the Matilda Centre for Research in Mental Health and Substance Use

⁹ \$12,380,415 multiplied by 50% = \$6,190,208

¹⁰ <https://positivechoices.org.au/information/about-positive-choices>

¹¹ <https://cracksintheice.org.au/about-cracks-in-the-ice>

(the Matilda Centre) at the University of Sydney. Estimating expenditure for these programs is reliant on information derived from Senate Order 13 (SO13, also known as a 'Murray Motion') 'List of Grant Contracts active during 2021 Calendar Year - Department of Health' (Department of Finance, 2022). SO13 requires ministers to disclose contracts entered into, valued at or above \$100,000 (Department of Finance, 2021). There are three grants labelled "drug and alcohol – prevention and early intervention" (Department of Finance, 2022, p. 128). We assume this relates to Positive Choices and Cracks in the Ice, and if it is not directly these programs, the figure remains a strong proxy to determine estimated government expenditure for this activity. To derive a figure relevant for 2021/22, a calculation was made to adjust for a single year period.¹² As a result, it was estimated that government expenditure on these two prevention programs was \$1,254,716 in 2021/22.

Combining the spending across all the federal prevention program funding (\$1,254,716 + \$6,190,208) resulted in an overall total expenditure for federal prevention of \$7,444,924.

Assumptions and caveats – federal general prevention

This federal general prevention spending estimate relied on the NIAS, as an activity which is a significant focus for federal prevention. There may be other federal prevention activities not included here, notably any mass media campaigns (no data could be sourced about federal spending on these for 2021/2022).

We assume that the grants listed in the Murray Motion paid to The University of Sydney are relevant to the Positive Choices and Cracks in the Ice program.

State and Territory governments general prevention

Data for prevention activities and costs were publicly available for Western Australia and Victoria for 2021/22.

In Western Australia, the Mental Health Commission and Drug and Alcohol Office amalgamated in 2015, with all AOD prevention functions administered by the Mental Health Commission. The total for Alcohol and Other Drug Funding for 2021/22 was \$111.9 million, \$14.6 million (13%) of which was for prevention (Mental Health Commission, 2022). AOD prevention activities include general public education campaigns (e.g. Alcohol.Think Again campaign), targeted public education campaigns (e.g. WA Leavers Strategy for school leavers, including Drug Aware Party Smarter campaign), AOD management and community wellbeing plans, preventing Foetal Alcohol Spectrum Disorder project, local government health plans (illicit drugs), real time prescription monitoring, and high risk event illicit drug strategies (including advice on harm reduction strategies in entertainment zones). Naloxone programs are also detailed as another prevention strategy.

There were 2,660,026 people residing in Western Australia in 2021 (Australian Bureau of Statistics, 2021a). We estimated that the cost per person for AOD related prevention activities was \$5.49.

¹² Grants reported in the Murray Motion extend beyond the reference 2021/22 financial year. To only include money spent during this period we calculate a cost per month. To do this we determine how many months the grant lasted. Then we divided the total agreement value by duration in months to find a cost per month. This figure was then multiplied by 12 to give an estimate of yearly cost of program delivery.

In Victoria, prevention activities were implemented by the Victorian Department of Health. The Victorian Department of Health reported that they spent \$33.5 million on “Drug prevention and control” in 2021/22 (Department of Health, 2022a). This figure includes a broad scope of activities across education, prevention, early intervention and some administrative and regulatory activity related to treatment. Performance measures relate to telephone, website, and email contact requesting information for AOD and from family members seeking support; needles and syringes provided through NSPs and some administration costs (e.g. permit and licencing costs) (Department of Health, 2022a, p. 49). Programs include drug overdose prevention and education program (DOPE), Good Sports, and Prevent Alcohol and Risk-related Trauma in Youth (PARTY) program (Department of Health, 2017b). \$33.5 million is lower than the stated target of \$44.8 million for 2021/22 due to COVID-19 related delays. Given there were 6,503,491 people residing in Victoria in 2021 (Australian Bureau of Statistics, 2021a), average general AOD prevention expenditure was calculated as \$5.15 per person.

The Western Australian and Victorian prevention and population figures (as a proportion of total Australian population) were used to estimate an average per person spend of \$5.25. When we account for prevention activities related to alcohol¹³ it became \$2.62 per person. Using this cost per person and multiplying it by the total Australian population, we estimated total state and territory prevention expenditure attributed to illicit drugs to be approximately \$66,723,077.

Assumptions and caveats – State and Territory general prevention

The expenditure estimate for state/territory general prevention relied on estimates from two states alone. To derive the total prevention expenditure using publicly available data from WA and Vic, we assumed all states/territories spent an equal amount on prevention activities.

Another assumption is that 50% of the spend per person is related to illicit drugs.

Prevention activities address issues related to both mental health and AOD. However, we have used the funding numbers given for AOD prevention activities only and have excluded the figures given for mental health prevention activities. For WA, a total cost per capita for mental health and AOD prevention, promotion, and protection activities was given as \$10.67 (Mental Health Commission, 2022).

Differences in which prevention activities are included in reported spends may lead to our estimate being inflated with some activities accounted for elsewhere in this report, e.g. naloxone in WA, or needles provided through NSPs in Victoria.

Infancy and parental support programs

The Report on Government Services details total expenditure related to activities such as child protection and family support services (Productivity Commission, 2023a). To derive a cost for infancy and parental support and prevention activities we isolated costs associated with intensive family support services and family support services.

¹³ Following the previous drug budget (Ritter et al., 2013), it was assumed that half of the general prevention expenditure was attributed to illicit drugs. As such, accounting for this difference we multiply the above figure by 50%.

Intensive family support services are specialist services that prevent family separation, or address separations. These include services for drug and alcohol counselling. Total State, Territory and Commonwealth real recurrent expenditure for all intensive family support services in 2021/22 was \$563,485,000.

Family support services are non-intensive but also include counselling and support services, some of which are assumed to include drug and alcohol related issues (Productivity Commission, 2023a). Total State/Territory costs for all family support services in 2021/22 was \$748,563,000.

To apportion a percentage of these two expenditure activities (intensive and non-intensive family support) to illicit drugs, we used the proportion of persons 16-85 years of age with drug use disorders, present in the previous 12 months (this category includes drug abuse and drug dependence), as reported in the National Study of Mental Health and Wellbeing 2020-22 (Australian Bureau of Statistics, 2023e).¹⁴ The percentage of people that have drug use disorder is reported as 0.9%.

There are limitations with using this figure to derive cost estimates. We do not disaggregate this figure by proportion of people with drug use disorder with children. We assume that the proportion of people with drug use disorders is reflective of the broad parenting and family population accessing these intensive and family support services. This limitation may reflect an overestimate in our final estimates. Further, parenting and family support relevant to drug use is not exclusive to those who may be captured in these figures for drug use disorder. This limitation, by contrast, may reflect an underestimate. In the absence of further data, we have used the figures for drug use disorder as proxy for calculating final estimates.

To estimate the proportion of total intensive family support expenditure related to drug use disorders, we apply the percentage of the prevalence of drug use disorder (0.9%) to \$563,485,000. As such, we estimate this expenditure to be \$5,071,365. Using the same approach to estimate the proportion of total (non-intensive) family support program expenditure dedicated to drug use disorders, we apply 0.9% to \$748,563,000. This leaves us with approximately \$6,737,067.

Summing these two figures equates to a total State/Territory expenditure on parent and family programs related to persons with drug use disorders in 2021/22 to be \$11,808,432. Expenditure relevant to infancy, parent, and family support, however, may also include other services funded through grants.

The Australian Department of Social Services (DSS) delivers funding for Children and Parenting Support (CaPS) Services. As described: “These services use a prevention and early intervention family support approach to deal with the impacts of substance misuse problems, through integrated, long-term and intensive support” (Department of Social Services, 2023). These grants are delivered to a range of organisations not exclusively focussed on AOD-related support.

Total CaPS funding was retrieved from the DSS under Senate Order 13 (see federal general prevention for a description of SO13) (Department of Finance, 2021). Grants administered for ‘Children and Parent Support Services’ or ‘Children and Parenting’ and started in 2021 were

¹⁴ Previous iterations of the National Study of Mental Health and Wellbeing breakdown drug use disorders into drug harmful use and drug dependence (Australian Bureau of Statistics, 2022c).

included.¹⁵ The total cost of all children and parenting, and children and parent support services delivered via government grants in 2021/21 reported by DSS under SO13 was estimated to be \$72,253,227.

Similar to our approach above for estimating the expenditure of intensive and non-intensive family support programs proportioned to drug use disorder, we apply the percentage of people with a drug use disorder (0.9%) (Australian Bureau of Statistics, 2023e) to the total estimate for CaPS services. The proportion of total funding for CaPS programs that may relate to illicit drug use in 2021/22 was estimated to be \$650,279.

Summing the above figures for intensive family support programs, family support programs, and Children and Parenting Support services results in a total estimated illicit drug-related expenditure for infancy and parental programs in 2021/22 of \$12,458,711.

Assumptions and caveats – Infancy and parental programs

The proportion of persons 16-85 with drug use disorders was used to derive a proportion of total funding for parent programs relevant to drug use. Limitations with using this as a proxy include: other costs relevant to parents or prospective parents who use drugs are not explicitly included; and the proportion of people with drug use disorders are not disaggregated by proportion with/without children. These limitations are applicable to our calculations for intensive and family support programs, and for CaPS services.

¹⁵ Grants reported in the Murray Motion extend beyond the 2021/22 financial year. To only include money spent during this period we calculate a cost per month. To do this we determine how many months the grant lasted. Then we divided the total agreement value by duration in months to find a cost per month. This figure was then multiplied by 12 to give an estimate of yearly cost of program delivery.

Chapter 3: Drug Treatment

Drug treatment aims to reduce or cease drug use, and ameliorate the harms associated with drug use. There are a number of different treatment modalities: screening and brief interventions, withdrawal, counselling and psychosocial support, residential rehabilitation, alongside case management and aftercare. There are also medications – maintenance medications for opioid dependence such as methadone and buprenorphine, and medications within withdrawal management. Treatment is provided across a variety of settings: hospitals, community/ambulatory settings, within specialist AOD services, in-custody settings and in primary care settings. The diversity of drug treatment modalities and settings within which it is provided (spanning both generalist and specialist settings as it does) creates challenges for estimating the total expenditure on drug treatment for Australia.

Table 5: Summary of overall treatment expenditure

Activity	Total
Drug Treatment	\$1,491,306,732

Previous estimates of spending on drug treatment have taken a bottom-up approach, by obtaining data on specific drug treatment grant spending (from federal and S/T governments). This was the method used in the previous Australian drug budget (Ritter, McLeod & Shanahan, 2013) (at that time, the 2009/2010 estimate was \$361,800,000). In a later, also bottom-up approach which covered both alcohol and other drugs, government spending on treatment was estimated to be \$1,007,977,579 (for 2012/2013: Ritter et al 2014). For this current Australian drug budget project, we sought to improve the comparability of the methods across the policy domains. Given that the law enforcement approach has always been top-down, for this 2021/2022 expenditure estimate, we chose to use a top-down approach for drug treatment as well. (Details of a bottom-up approach to estimating treatment expenditure can be found in Appendix 4, and is discussed in the chapter 8 on sensitivity analyses).

The top-down method used here parallels that used in the law enforcement estimate: obtaining an overall expenditure estimate for the total activity, divided by some amount of activity presumed to be related to drugs.

How much is spent on health?

The total health expenditure for all levels of government for 2021/22 was \$176,000,000,000 (AIHW, 2023c). AIHW report the source of funding, with the Australian Government contributing \$105,845,000,000 and State and Territory governments contributing \$70,157,000,000 (AIHW 2023c). AIHW report expenditure under the following activities: public hospital services, private hospitals, primary health care, referred medical services, other services, research, capital expenditure, and medical expenses tax rebate. The total health expenditure includes the Pharmaceutical Benefits Scheme and Medicare Benefits Schedule (both funded through the Federal Department of Health and Aged Care).

We need to remove any obvious activities within the total health expenditure (\$176,000,000,000) that do not meet our criteria of proactive health spending.¹⁶ Using the activity categories provided by

¹⁶ This is the same step employed for customs and border control in law enforcement, removing immigration-related policing for example.

AIHW, we have excluded expenditure for “other services”, “research”, “capital expenditure” and “medical expenses tax rebate”. Research and capital expenditure do not directly contribute resources to the direct provision of healthcare. The category of “other services” was excluded because it includes administration spending and patient transport costs (i.e. ambulances), both of which are considered reactive expenditure.

Accounting for these excluded activities, the total health expenditure (that is proactive spending) is approximately \$153,857,000,000.

We note that the PBS accounts for a significant proportion of the Australian Government’s spending on health care. In 2021/22 the federal government spent \$12.1 billion on PBS subsidies, which represents approximately 11.4% of total federal government health expenditure. Arguably we should try and exclude some aspects of the PBS spending given that aside from the provision of opioid maintenance medications, drug treatment tends to not consume significant PBS-subsidised pharmaceutical costs (especially relative to other healthcare treatments such as for cardiovascular disease or cancers). However, there was no systematic method we could apply to reduce the total health expenditure by a suitable amount that could accommodate the PBS issue. This suggests that our top-down method is likely to be an over-estimate.

How many people receive drug treatment?

We need to find an estimate of how many people receive drug treatment across all treatment modalities and treatment settings. However, we only have treatment numbers for the treatment modalities and settings captured by the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS, AIHW, 2023a) and National Opioid Pharmacotherapy Statistics Annual Data collection (NOPSAD, AIHW, 2023d)

In 2021/22, the AODTS-NMDS reported 131,000 people were receiving treatment from publicly funded AOD treatment services. This total includes clients receiving treatment for alcohol, nicotine and misuse of prescription medicines (all excluded from this expenditure estimate). There were 57,640 people who received treatment for a primary drug of concern other than an illicit drug, leaving 72,849 people receiving drug treatment related to illicit drug use as recorded within the AODTS-NMDS. To this we add those receiving opioid agonist treatment (OAT) (as collated by the NOPSAD data based on a single day census). For 2022, there were 55,741 people receiving OAT. Combining these two data sources,¹⁷ we estimate a total of 128,590 drug treatment clients in treatment settings captured by the AODTS-NMDS and NOPSAD.

Clients receive illicit drug treatment in other settings such as primary care settings, hospitals, and general community health care settings. There are no readily available datasets to estimate this number for 2021/2022. In lieu of that, we apply a ratio to past research which has estimated the numbers in these settings not covered by the AODTS-NMDS and NOPSAD. In the New Horizons project (Ritter et al., 2014), they reported a low estimate of a total of 139,213 people (of which 55,892 people received drug treatment outside AODTS and NOPSAD counts) and a high estimate of a total of 234,153 people (of which 67,270 people received treatment outside the AODTS and NOPSAD counts).¹⁸ This suggests that between 40% (low estimate) and 28% (high estimate) of total people

¹⁷ We assume no overlap between the drug treatment counts within the AODTS-NMDS and NOPSAD.

¹⁸ We note that New Horizons included alcohol; and we assume that the proportions receiving drug treatment outside AODTS and NOPSAD are the same for alcohol compared to illicit drugs.

receiving illicit drug-related treatment are not counted within our 128,590 client total number above. In the absence of a better method, we take the mid-point of the ratio difference (0.537)¹⁹ to add to the existing sub-total client count (of 128,590). This means adding 69,046 clients to the sub-total count. The results in a total number of people in receipt of drug treatment in 2021/2022 of 197,636.

Deriving a top-down drug treatment estimate

Rather than simply dividing the derived health expenditure (\$153,857,000,000) by the 197,636 estimated number of people in receipt of drug treatment in 2021/2022, we also need to adjust for the number of people who accessed healthcare in 2021/2022 to determine the proportion of healthcare visits related to drug treatment. The ABS (2022d) estimated that in this same year 20,390,000 people saw a health professional. This is inclusive of people who saw a GP (including for urgent medical care and after hours), saw a dentist, saw a specialist, were admitted to hospital, or visited an emergency department, and/or had a telehealth consultation. Therefore, the proportion of all healthcare recipients who attended for drug treatment is 0.97% (197,636/20,390,000).

Applying the 0.97% to \$153,857,000,000 results in a top-down estimated drug treatment expenditure of \$1,491,306,732.

Assumptions and caveats - drug treatment

The overarching assumption is that all patients (across all healthcare) receive the same length and level of care. This applies both within the 197,636 people who are estimated to receive drug treatment and to the 20,390,000 people who receive any healthcare. In an ideal world, both the total pool of patients and the pool of people receiving drug treatment would be weighted against length of treatment or some other proxy for effort/resources. This would then parallel how parts of the law enforcement expenditure estimates were done – weighting by length of trial or by prison sentence. We explored multiple ways of doing weightings for the drug treatment estimates (NWAU, burden of disease, categorisations of health conditions) but there were insufficient data to enable us to apply any weights. Perhaps this is offset by features of the total health budget and the nature of healthcare – they are very diverse. Some people receive all care via their GP (with one consultation per annum), others receive intensive care in a hospital setting. The same is true of drug treatment (one-off brief intervention versus residential rehabilitation). In that sense, both the population pool of healthcare recipients and the drug treatment pool of recipients are equally diverse. In addition, the average cost per person for drug treatment (a back calculation from the final result) reveals that it is on average \$7,546 per person per annum. This has some broad face validity, taking into account that some people will receive care that costs far less than that over the course of a year; and other people will receive care that costs much more than that.

The bottom-up approach to estimating drug treatment expenditure (see Appendix 4) was deliberately avoided for the main estimate because of the lack of comparability with law enforcement. Any approach to estimating expenditure must try and make sure apples are compared with apples (and oranges with oranges). In this instance, our commitment to that principle means we have greater uncertainty for the drug treatment estimate in itself, but more comparability with law enforcement. Given that the drug budget project is ultimately aimed at examining the four domains and their respective spending contribution, the reduced certainty for the drug treatment figure is offset by greater comparability for the overall result.

¹⁹ We use a different ratio in the sensitivity analysis.

Chapter 4: Harm reduction

Harm reduction activities represent programs and policies that seek to reduce the harms from drugs without necessarily impacting on drug use per se. Harm reduction originated in drug-user advocacy and activist circles. Many harm reduction programs were first delivered in an unofficial capacity before they were adopted and adapted into state sanctioned programs (Harm Reduction International, 2022). For example, at the time of writing, drug checking services are being piloted in Australia and were recently legalised in New Zealand. However, in New Zealand, one of the current authorised drug checking services was providing ‘underground’ drug checking services long before they had government sanction to do so (Harm Reduction International, 2022). These considerations have direct implications for the funding of these activities, as programs are often first implemented as pilots, are globally reliant on external donors and grants, and receive ad-hoc funding.

As a result, government expenditure associated with harm reduction was difficult to assess. In addition, we could not ascertain an appropriate top-down approach to estimating spending. Taking a consistent top-down approach (where a budget for health or for law enforcement is then divided by some amount of drug-related activity) is simply not feasible for the harm reduction domain, as there is no one overriding budget overseeing harm reduction activities, nor is there an appropriate proxy through which to assess the percentage of harm-reduction related activity. (See section on top-down vs bottom-up, Appendix 3).

This means we relied on identifying harm reduction programs and then obtaining expenditure for those programs. We identified four activities: needle and syringe programs, peer-led drug user organisations, take home naloxone, and supervised injecting facilities. Drug checking services were not in operation in 2021/2022 (our reference year) but Appendix 5 provides estimates for future drug budgets.

Table 6: Summary of overall harm reduction expenditure

Harm reduction activity	Total
Needle and syringe programs	\$56,870,000
Peer-led drug user organisations	\$9,525,626
Take home naloxone	\$14,902,314
Supervised injecting facilities	\$8,599,600
Total	\$89,897,540

While opioid agonist treatments are often included within harm reduction, here we counted opioid agonist treatments as part of the ‘treatment’ domain.

Needle Syringe Programs

Needle and syringe programs (NSPs) have been established in all Australian states and territories and receive support at the federal and state level. They are an emblematic harm reduction strategy and feature in National Strategies for preventing BBVs and STIs, and in the National Drug Strategy. There were 4,388 NSP service sites (including primary, secondary, and pharmacy sites) and 414 syringe dispensing machines (SDMs) at June 2022 (Heard et al., 2022a). 47 million syringes were distributed in 2021/22.

There were three potential ways of calculating the spending estimates for NSP in Australia. The first used the previous 2009 expenditure estimates, which have not been updated since. Derived using the National Centre for HIV Epidemiology and Clinical Research (NCHECR) (2009) report, the costs included consumables (sterile injecting equipment, disposal costs, and safe sex equipment), operations support, and other costs including peer-support programs and telephone information services (Ritter et al., 2013). Using the number of NSPs and needles distributed in 2007/08 gives a cost of \$6,170.71 per NSP and \$.28 per needle syringe distributed. Applying CPI²⁰ to these numbers (cost per NSP = \$8,432.56 and per consumable = \$.38) and then multiplying by the 2021/2022 NSP data gives a total estimated cost of \$58,353,153.

The second method takes the 2007/2008 total cost of NSP operation including operation and consumables to determine a cost of \$.88 per needle syringe distributed. For 2021/22 NSP figures, if using this cost per needle syringe (CPI adjusted to \$1.20) as a proxy for total cost of the program, a total estimate was \$56,400,000.

There is a third option. Treloar et al. (2014, p. 45), in dialogue with health authority staff, used administrative and financial records to determine total recurrent costs including personnel, pharmaceuticals, and supplies “divided by the number of needles and syringes distributed to determine unit costs”. Unit cost of needle syringe distributed is a robust proxy for total NSP costs. Average costs per needle distributed across delivery types (primary, secondary, vending machine), excluding vending machine income, was \$.96 for 2010/11. This figure was inflated to \$1.21 in 2021/22.²¹ Using this figure gives a total cost estimate for NSP in Australia in 2021/22 of \$56,870,000.

Table 7: Three different methods for costing NSP program spending

Estimate	Total cost	Source/method
1.	\$58,353,153	2007/08 unit cost for program & equipment (CPI adjusted)
2.	\$56,400,000	2007/08 cost per needle syringe as proxy (CPI adjusted)
3.	\$56,870,000	Treloar, 2014 (CPI adjusted)

Given these three different estimates are all very similar (which also provides some comfort), we chose to take the most recent one (derived from research published in 2014). Hence the main estimate for NSP is \$56,870,000. (We used the other estimates in the sensitivity analyses, see Chapter 8).

Assumptions and caveats – Needle Syringe Programs

Working from cost per NSP and needle syringes distributed (method 1), or needle syringes distributed (methods 2 and 3) resulted in a final estimate based on delivered services. Needle syringes distributed are a reliable proxy (see above), however, this may not capture all related expenditure and so may be an underestimate.

²⁰ Calculated using RBA Inflation calculator, which notes that the total change in cost is 36.7 per cent, over 14 financial years from 2007/08 to 2021/22, at an average annual inflation rate of 2.3 per cent.

<https://www.rba.gov.au/calculator/financialYearDecimal.html>

²¹ The total change in cost reported by the RBA Inflation calculator from 2010/11 to 2021/22 is 25.6 per cent, over 11 financial years, at an average annual inflation rate of 2.1 per cent.

Peer-led drug user organisations

Peer-based drug user organisations (DUOs) provide a variety of harm reduction services.²² These include peer education, blood borne virus (BBV) prevention and education, outreach programs, overdose prevention programs, and prison programs.

As our focus is on government expenditure, we used annual reports and financial statements provided on organisational websites, and the Australian Charities and Not-for-profits Commission (<https://www.acnc.gov.au/>), as our sources for identifying relevant government funding (grants).

To account for DUO funding, we included the below organisations:

- Australian Injecting and Illicit Drug Users League (AIVL, 2022),
- NSW Users and AIDS Association (NUAA, 2022),
- Harm Reduction Victoria (HRVic, 2022),
- Peer Based Harm Reduction WA (PBHRWA) previously WASUA (PBHRWA, 2022),
- Canberra Alliance for Harm Minimisation & Advocacy (CAHMA, 2022),
- The Tasmanian Users and Health Support League (TUHSL) was unfunded,
- Queensland organisations QuIVAA (previously Queensland Injectors Voice for Advocacy and Action) (QuIVAA, n.d.), and
- Queensland Injectors Health Network (QuIHN) (No funding was able to be sourced for QuIVAA).

There is a risk of double counting portions of funding accounted for elsewhere in this report (e.g. NSPs, take-home naloxone). To address this risk, we sought to subtract a portion from total grant funding received by these organisations. We used number of units distributed through NSPs to calculate a cost to be subtracted as a proxy for funding accounted for elsewhere in this report. The number of units distributed were taken from two annual reports (NUAA, 2022; PBHRWA, 2022). This is a limited proxy in that it is based on two DUOs only, and likely represents a substantial underestimate of funding double counted elsewhere. However, in the absence of more robust proxies, we applied the same method used above in Needle Syringe Programs (cost per unit distributed) to derive a proportion of total funding. This method results in an estimate of 24% of total DUO budgets accounted for in our other activity estimates (with the exception of AIVL, who do not provide an NSP). DUO budgets were reduced by 24% to reflect this. In total, DUO budgets are estimated to reflect \$9,525,626 of harm reduction funding in 2021/22. Table 8 shows full figures and figures revised to exclude other activities.

The inclusion of these budgets also reflects the various work that peer organisations do that is not able to be accounted for directly. As Annie Madden (Madden in AIVL, 2006, p. ii), writing on peer education, notes: “It is important to remember that the best peer education does not happen because organisations are funded to do it or because governments want it done. It happens in response to an identified need within user networks and among individuals. The forms that peer education takes can vary significantly from project to project, issue to issue — as circumstances and contexts differ from place to place, so do the needs of the people and networks that we work with.”

²² State-based peak organisations representing the alcohol and other drugs sector have not been included here because they primarily advocate for and represent organisations that deliver programs across the domains of prevention, treatment, and harm reduction, rather than deliver directly funded activities.

Table 8: Funding estimates for peer-led drug user organisations

Organisation	Grant funding, 2021/22	Proportion of funding not double counted	Grant funding, 2021/22, excluding double counting
AIVL	\$1,337,634	100%	\$1,337,634
NUAA	\$2,383,067	76%	\$1,800,706
HRVic	\$1,830,715	76%	\$1,383,335
QuIVAA/QuIHN ²³	\$3,150,221	76%	\$2,380,388
PBHRWA	\$1,971,751.00	76%	\$1,489,905
CAHMA	\$1,500,288	76%	\$1,133,656
TUHSL	Unfunded	-	
Total	\$12,173,676		\$9,525,626

Note: Columns may not sum due to rounding

Assumptions and caveats – Peer-based drug user organisation funding

It was assumed the total figures included reflect a range of harm reduction activities undertaken by DUOs. Harm reduction activities do also occur in other organisations, notably BBV organisations. These were not included in the main estimate. Details are provided in Appendix 6.

The reduction of total budgets using units distributed through NSPs (and reported in Annual Reports) as a proxy for double counting is likely an underestimate, reflected in an inflated final figure. Another issue arising in including these final estimates is that these organisations are also involved in research and advocacy. While there are resonances, these other activities represent a domain separate to harm reduction, prevention, treatment, and law enforcement. Nevertheless, due to the important role of these organisations in program delivery, we include them as a part of government funding directed toward harm reduction.

The complex funding and reporting landscape DUOs operate within makes it difficult to apportion costs for individual activities included (e.g. peer education), excluded (e.g. NSPs), and other work done by these organisations (e.g. advocacy).

Take Home Naloxone Programs

Overdose prevention programs take a variety of forms and are provided by various organisations and bodies. Some programs are focussed on raising awareness and providing education about fatal and non-fatal overdoses. These programs may include training peers to administer naloxone. Other programs, such as DanceWize, involve peers offering safe spaces at parties and events that allow attendees to seek help and, or relax. In these settings, peers provide education about reducing harms of drug use and provide health resources.

²³ This funding figure is a third of QuIHN's total budget. QuIHN's website details the specific relationship between the organisations: "QuIHN was a result of a merger between three separate community-based organisations, including: Queensland Injectors Voice for Advocacy and Action (QuIVAA); Sunshine Coast Intravenous AIDS Association (SCIVAA); and the Gold Coast based Drug Users Network of Education Services (DUNES). Of these three organisations, the primary founding body, QuIVAA Inc, still exists and is active today in illicit drug advocacy and in the governance of QuIHN Ltd" (QuIHN, 2023). We sought to reflect the peer-led work done by QuIVAA and represented in QuIHN, while excluding the range of medical services (including a primary care GP clinic), also operated by QuIHN. Government grant monies for QuIHN were sourced and a third taken to represent peer-led harm reduction work (QuIHN, 2022).

There was limited information about the funding of these programs.²⁴ Most overdose prevention programs are provided by Drug User Organisations (accounted for above) and by health services (covered under treatment domain). As such, we assume that many overdose programs are captured in the DUOs expenditure estimates, or in the total treatment expenditure (reported in the previous chapter).

The Take Home Naloxone (THN) program is a federally funded program which makes naloxone free to people at risk of or who may witness an overdose. Recent papers have examined the costs of THN.

Nielsen et al., (2022) looked at costs of providing naloxone from a government perspective. The figures provided report the cost of ambulance attendances (considered an indirect cost in relation to this work and so should not be included), naloxone wholesale costs, and pharmacy staff time (\$34.36) and pharmacy dispensing fee (\$7.47). Costs are presented in 2018 Australian dollars. A paper from Monds et al. (2022) breaks down the costs of a specific THN intervention and reports a THN kit was estimated to cost \$50 and staffing cost for the intervention was approximately \$50 per hour. Further, Salom et al. (2021)'s evaluation of the THN Pilot under the PBS provides costs relating to community pharmacy fees, and social costs related to THN programs. However, the report does not provide further information about government expenditure on THN other than general funding announcements without detailed breakdowns of how these funds will be spent (this information is key for determining if expenditure is a direct cost and can be included in this report).

For the purposes of this 'drug budget' exercise and consistent with a more top-down approach, we used a previous study that outlined the cost of a THN program. We used the costs reported and adjusted them for inflation and then multiplied this by an estimated number THN programs. To estimate the number of THN programs operating, we use information from the Needle Syringe Program National Minimum Data Collection 2022 National Data Report, which reported, as of June 2022, there were 199 public sector needle syringe programs offering a take home naloxone program (Heard et al. 2022b).

In order to estimate the costs of providing THN programs, a 2012 evaluation of the I-ENAACT program was used, Australia's first take home naloxone program. The evaluation (Olsen et al. 2015, Table 11, p. 53) found that in 2012/2013 the total cost of the trial was \$62,380 excluding the cost of the naloxone itself²⁵ which indexed for 2021/22 is estimated to be \$74,886.²⁶ The cost included:

- Purchasing training materials
- Participant recruitment
- Staff training development
- Staff training delivery
- Participant reimbursement
- Syringes and needles
- Naloxone kit packaging

²⁴ Penington Institute and Burnet Institute helped in trying to find a comprehensive list of all available overdose prevention programs. But such a centralised resource is not available.

²⁵ This is covered under the PBS drug treatment spending.

²⁶ Calculated using RBA Inflation calculator, which notes that the total change in cost is 20 per cent, over 9 financial years from 2012/13 to 2021/22, at an average annual inflation rate of 2.1 per cent.
<https://www.rba.gov.au/calculator/financialYearDecimal.html>

Assuming this is a standard cost for all programs across the country we can estimate that for the 199 programs that provide THN, the total expenditure is \$14,902,314. Given the limited information available for Take Home Naloxone programs, this estimate is the closest funding figure we have.

Assumptions and caveats – overdose prevention programs

The expenditure estimated here for THN is based on multipliers from a research study, rather than on any reported government expenditure. This assumed that the estimated cost of the trial program was a strong proxy for estimating how much is actually spent on delivering these programs.

We appreciate this is not ideal. Appendix 7 provides more details about a different approach to costing THN.

The costs reported here are also partly accounted for in the DUOs estimates or State and Territory general prevention estimates (e.g. Victoria's DOPE program). The cost of naloxone itself has been excluded from these calculations. The PBS spending was included in the drug treatment expenditure estimates. This means that the harm reduction domain is likely to be an underestimate given the exclusion of the cost of naloxone itself.

Supervised injecting rooms

Prior to 2018, there was only one supervised injecting clinic operating in Australia. The Medically Supervised Injecting Clinic (MSIC) opened in Kings Cross, Sydney in 2001. In 2018, the second supervised injecting facility in Australia, the Medically Supervised Injecting Room (MSIR), opened in Richmond, Melbourne. MSIR opened as trial service from 2019-2022, and in 2023 the Victorian Government passed legislation, Drugs, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Bill 2023, to keep it open on an ongoing basis. MSIC and MSIR are funded by their respective state governments but are operated by external organisations (MSIC being operated by Uniting and MSIR operated by North Richmond Community Health).

In Uniting's annual report for 2021/22, they stated they served 1,225 clients at the MSIC. The number of clients was not available for the same time period for MSIR. However, MSIR reported they had 69,390 visits in 2021/22, and had a total of 6,191 (Victoria Department of Health, 2023) registered clients, with 599 clients registering during 2021/22 (North Richmond Community Health, 2022). During its first year of operation, it was reported MSIR was serving "50-75% more clients than Sydney" (Lyons, 2019).

In terms of costs, NSW Health has reported expenditure for the running of MSIC in their annual financial reports. For the year 2021/22 the cost to the NSW government for running MSIC was \$4,299,800 (NSW Health, 2022b). There was no reported expenditure figure for MSIR by Victorian Department of Health or North Richmond Community Health. However, the ACT Medically Supervised Injecting Facility Study (Kirwan et al. 2020) outlines staffing requirements for both MSIR and MSIC. Both sites "are legally required to be supervised by a medical director with qualifications as a medical practitioner. They are also required to have four registered nurses and four counsellors on staff at any one time" (p. 39). As such, we assume with each site requiring the same amount of staff, the costs would be similar. Without further information about costs to run MSIR we assume it costs the same as MSIC. We double the cost of MSIC²⁷ to estimate that supervised injecting facilities make up \$8,599,600 of government expenditure on harm reduction in 2021/22.

²⁷ \$4,299,800 multiplied by 2 = \$8,599,600

Chapter 5: Law enforcement

There are six major activities under the law enforcement domain: customs and border control; routine policing; court prosecutions; legal expenditure; corrective services; and community corrections. These items align with Reuter's (2006) classification of enforcement programs into supply disruption, targeting trafficker and producer, and programs directed at people who use drugs. This broad approach was followed by Moore (2005) and Ritter et al. (2013) and is replicated below.

Table 9: Summary of overall law enforcement expenditure

Law enforcement activity	Total
Customs and border control	\$598,930,008
Routine policing against drugs	\$1,802,400,000
Court prosecutions	\$164,590,924
Legal expenses (DPP & Legal Aid)	\$145,875,316
Corrective services	\$715,323,037
Community corrections	\$78,898,001
Total	\$3,506,017,286

There are other law enforcement related activities that are not covered in the above. These include the spending on laboratory testing for drug samples through Roadside Drug Testing (RDT); the spending associated with security for the medicinal cannabis market; the spending associated with clandestine laboratory clean-up; and the spending on precursor controls. These are detailed in Appendix 8, 9, 10 and 11 respectively.

Customs and border control

Customs and border control activities aim to intercept supplies of drugs entering the country. Australian Border Force (ABF) which now sits within the Department of Home Affairs,²⁸ intercepted and seized an estimated 10.46 tonnes of "major drugs, precursors and new psychoactive substances at the Australian border" across 27,934 interdictions in the year 2021/2022 (Department of Home Affairs, 2022). The ABF reports a 16.7% decrease in drug detections for 2021/2022 when compared to the previous year 2020/2021. The ABF reported that this reduction in detections was likely due to their own reduced capacity, noting that they had to shift resources to the "international traveller environment" resulting in "fewer resources and targeting efforts in the cargo environment", and not reflective of a reduction in the scope of international drug trade (Department of Home Affairs, 2022, p. 143).

As we could not find data (e.g. a senate estimate) for the proportion of Australian Border Force (which now includes customs) that is dedicated to drug related activity we followed the previous method, locating the most appropriate expenditure estimate and then applying a proportion assumed to reflect drug-related activity.

²⁸ Note: the previous Australian 'drug budget' estimates (Moore, 2005; Ritter et al., 2013) used the expenditure associated with the Customs and Border Protection Service. We now need to rely on expenditures from the (larger) Department of Home Affairs. The Department of Home Affairs in 2021/2022 consisted of the Australian Border Force alongside the Australian Federal Police, the Australian Transaction Reports and Analysis Centre, the Office of the Special Investigator, the Australian Institute of Criminology, the Australian Criminal Intelligence Commission and the Australian Security Intelligence Organisation (Department of Home Affairs, 2022).

Deriving an appropriate expenditure estimate

To obtain a total expenditure for customs and border control, we needed to look to the Department of Home Affairs (as the previous Australian Customs and Border Protection Services was merged within the larger Department of Home Affairs budget). The remit of the Department of Home Affairs includes mitigating national security threats and criminal threats through national coordination, policy and strategy development, emergency management, and regional cooperation (Department of Home Affairs, 2022). It also coordinates immigration and social cohesion policies and programs; and covers trade and travel facilitation and modernisation, effective customs, immigration, maritime and enforcement activities across the border continuum (Department of Home Affairs, 2022).

The Department of Home Affairs provides spending figures²⁹ against three Outcomes:

- Outcome 1: includes national coordination, policy and strategy development, emergency management, and regional cooperation.
- Outcome 2: includes effective coordination and delivery of immigration and social cohesion policies and programs.
- Outcome 3: trade and travel facilitation, modernisation, effective customs, immigration, maritime and enforcement activities across the border continuum.

Outcome 2 is concerned with immigration services; we excluded spending associated with Outcome 2 in this analysis. We note that Moore's (2005) calculation also excluded expenditure on immigration services. (For more details on the three Outcomes and their coverage, as well as the variously reported expenditure estimates, see Appendix 13).

For Outcomes 1 and 3 there are three slightly different spending estimates reported on - estimated actual; agency resourcing; and actual expenses figures. We use the actual expenses figures:

Outcome 1 – actual expenses: \$537,916,000

Outcome 3 – actual expenses: \$2,898,286,000

(Department of Home Affairs, 2022).

Proportion assumed to reflect drug-related activity

Moore (2005) applied 15.4% - a figure derived from the U.S. National Drug Strategy FY 2005 budget strategy – to the Australian Customs and Border Control budget. We update this Moore figure by applying more recent US data.

In the U.S. 2021/2022 Drug Budget, they estimated that drug resources made up 18.9% of the requested Customs and Border Protection budget (The Office of National Drug Control Policy, 2021), and 15.6% of the requested Coast Guard budget of \$2,039,359,000 (The Office of National Drug Control Policy, 2021). Moore weighted the average drug related spend on Customs and Coast Guard activities from the financial year 2003 (The Office of National Drug Control Policy, 2004). We do the same; the weighted average of the Customs and Border spend on drug-related activity and the Coast guard spend is 17.43%. We then apply this to the Home Affairs budget (as we do not have an Australian customs and border control spend). Table 10 below applies the presumed drug-related

²⁹ The expenditure associated with these outcomes is given in the Home Affairs Portfolio Budget Statements (Commonwealth of Australia, 2021b) and Budget Paper no.4: Agency Resourcing (Commonwealth of Australia, 2021a). Expenditure is further listed in the Department of Home Affairs Annual report 2021-2022 (Department of Home Affairs, 2022).

activities estimate to the total expenditure on Outcomes 1 and 3 as reported in the Department of Home Affairs annual report.

Table 10: Drug-related customs and border control activities by total expenditure estimates

Total Budget/ expenditure (Home Affairs)	Multiplier	Drug-related customs and border control expenditure
\$3,436,202,000 (Outcomes 1 & 3)	17.43%	\$598,930,008

The key driver of the estimate is the 17.43% for drug-related activities out of the Home Affairs budget for Outcomes 1 and 3. We sought to assess the veracity of this figure. The Australian Institute of Criminology estimated that 40% of the total Home Affairs budget for 2020/2021 was dedicated to addressing organised crime (Smith & Hickman, 2022). This included a variety of organised crime including human trafficking, financial crime and illicit drug trafficking (Smith & Hickman, 2022). This suggests that the 17.43% presumed drug-related activity might be a reasonable figure to apply to Home Affairs budget (Outcomes 1 and 3).

Assumptions and caveats – customs and border control

The key assumption and caveat here is the amount of drug-related activity used as a modifier (17.43%). As noted above, this has several limitations including the lack of transparency of actual activity in the Australian context, and comparability to similar activity in the U.S. context. This is discussed above and remains a core caveat to our final estimates.

Our final estimate was based on actual expenditure against portfolio outcomes. The assumption here is that all drug-related border activity is relevant to the two chosen outcomes. This may result in some drug-related activity being missed in our estimates.

Routine policing against drugs

Policing activity includes the detection, arrest, and charge of drug offences related to use, possession, and supply. Other activities included as part of routine policing against people who use drugs, drug use and possession, and drug supply include high visibility policing and use of drug detection dogs. Dedicated drug squads and taskforces, as well as drug-related activity of organised crime squads, represent additional police activities focussed on illicit drugs.

The lack of documentation by police services of activity-based time allocation remains a barrier to accounting for spending. Following the method adopted by Moore (2005) and Ritter et al. (2013), police time is apportioned on the basis of the composition of arrests. Similarly, shortcomings in these previous reports are also applicable to the current report. This refers to our use of offence data, see below, as this may not directly correlate with resource allocation, primarily due to different types of offences taking different amounts of time to detect and process, and total operational and non-operational staff time may not reflect offender data.

There are two different sources for the total number of illicit drug offences. The first is the Australian Criminal Intelligence Commission (ACIC) annual Illicit Drug Data Report (IDDR), which provides “a national picture of the illicit drug market” (Australian Criminal Intelligence Commission, 2023b, p. 1). The most recent report available is for 2020/21. The IDDR gives the total number of illicit drug arrests in 2020/21 as 140,624 (Australian Criminal Intelligence Commission, 2023b), a decrease from 166,321 in 2019/20 (Australian Criminal Intelligence Commission, 2021).

The second source of illicit drug offence data comes from the Australian Bureau of Statistics (ABS). The ABS offender statistics for 2020/21 note 62,698 illicit drug offences (Australian Bureau of Statistics, 2022e). This figure is substantially lower than the IDDR for the same year (140,624 compared to 62,698). The IDDR figures are more inclusive because they combine different encounters with police (arrest and charge, summons, diversion, infringement, and caution) as 'arrests' (Australian Criminal Intelligence Commission, 2023b, p. 6). The IDDR specifies that "In 2020-21, summons accounted for the greatest proportion of national drug arrests (43%), followed by arrest and charge (39%) and caution/diversion/ infringement (18%)" (Australian Criminal Intelligence Commission, 2023b, p. 6).

We required illicit drug arrests to be represented as a percentage of all arrests, therefore we needed to rely on the ABS figures rather than the IDDR figures because the ABS provides total offence numbers (irrespective of offence type). Additionally, the ABS statistics are publicly available for our reference year 2021/22. Given the fluctuations in arrests from year to year, using figures from the same year is preferable.

The ABS provides data on both offenders and offences proceeded against by police (Australian Bureau of Statistics, 2023h). Offenders are only counted once per incident, meaning multiple charges at the same time are not reflected in principal offence figures (Australian Bureau of Statistics, 2023i). As the expenditure estimate applies a percentage of all arrest activity to a police budget, we use the number of offences (not the number of offenders) in the below analysis. A further limitation of using the ABS data is that the offence numbers exclude diversion, caution, and issuing infringement notices (fines). As noted above, these represent around 18% of the IDDR figures. Our top-down method to estimating policing costs includes diversion in our final estimates. See Appendix 14 for more information regarding diversion.

Table 11 provides the total principal offences as recorded in the ABS data for each state and territory and the number of illicit drug offences by state/territory. The final column provides the percentages that we applied to policing expenditure.

Table 11: Percentage of illicit drug offences of total offences, 2021/22, by state and territory (ABS data)

States	Total principal offences	Illicit drug offence	Illicit drug offences (%)
NSW	134,571	11,591	8.6%
Vic	74,825	7,753	10.4%
Qld	81,469	17,036	20.9%
SA	25,217	6,726	26.7%
WA	34,579	5,844	16.9%
Tas	7,809	1,010	12.9%
NT	8,690	775	8.9%
ACT	2,328	186	8.0%
Total	369,488	50,921	13.8%

Source: Australian Bureau of Statistics, 2023h

Police services real recurrent expenditure was sourced from the Productivity Commission's Report on Government Services (See Table 12) (Productivity Commission, 2023d).

As with previous drug budgets (Moore, 2005; Ritter et al., 2013), real recurrent expenditure needs to be adjusted by some percentage to take out costs for traffic safety and management (because they are not reflected in the offence statistics). We applied a 10% reduction to account for this factor, as per Moore (2005) (see Appendix 15 for further details justifying this figure).

Police real recurrent expenditure minus 10% was multiplied by the proportion of illicit drug offences for each state/territory (see above) to estimate illicit drug related police expenditure. This method results in the estimated state and territory government spending on illicit drug offences in 2021/22 of \$1,802.4 million (or \$1.8 billion), as detailed in Table 12.

Table 12: State and territory police drug-specific expenditure, 2021/22

States	S/T Police real recurrent expenditure 2021/22, minus 10% (\$)	Illicit drugs percentage (%)	2021/22, Police illicit drug expenditure (\$)
NSW	\$3,890,340,000	8.6	\$334,570,000
Vic	\$3,757,140,000	10.4	\$390,740,000
Qld	\$2,425,230,000	20.9	\$506,870,000
SA	\$1,613,430,000	16.9	\$272,670,000
WA	\$799,560,000	26.7	\$213,480,000
Tas	\$276,750,000	12.9	\$35,700,000
NT	\$184,680,000	8	\$14,770,000
ACT	\$377,280,000	8.9	\$33,580,000
Total	\$13,324,400,000		\$1,802,400,000

Note: Columns may not sum due to rounding

Assumptions and caveats – Routine policing against drugs

Illicit drug offences as a proportion of total offences are used to derive our estimates. This assumes that all offences take the same amount of time to detect and process. This is a limitation of the datasets we rely on, and reporting around police time. We are unable to disaggregate offences by relative time spent on detection and processing. Relatedly, these offence statistics may also be an underestimate. As discussed above, the IDDR reports much higher numbers of ‘arrests’ related to illicit drugs. This includes a much broader range of policing activities (e.g. cautions) that are not reflected in ABS data we have used (see also Appendix 14). Our methodology for estimating the cost of policing illicit drug use uses proportional allocation of total policing budget and so captures police diversion program cost in its total estimate. See Appendix 14, for more information regarding diversion.

Our estimates rest on proportions of activity. It is assumed other non-drug offences may also index a broader range of activities that are, likewise, not accurately reflected in the ABS data. Clearly, this is not uniform across all offences and represents a limitation of our top-down approach.

ABS data relates to principal offence. Illicit drug offences that are not principal offences are subsequently not reflected in our estimates, but we note that the denominator is principal offence as well. Likewise, illicit drugs as a contributing factor in other offences is also not reflected in our estimates.

Our deduction of 10% to reflect traffic and safety and management remains an assumption (see Appendix 15).

Other specific police activities have not been included separately due to the risk of double-counting in our top-down costing approach. We have included appendices which address these: roadside drug testing (Appendix 8), medicinal crop security (poppy and cannabis, Appendix 9), clandestine laboratory clean-up (Appendix 10), and precursor controls (Appendix 11).

Court and legal expenditure

Court and legal costs associated with the prosecution of drug offences include judicial resources on court prosecutions by court level (Higher, Magistrate and Children's court costs) and legal expenses (Public Prosecutions and Legal Aid).

Court prosecutions

Illicit drug related spending associated with court prosecutions applied a top-down approach, taking the total court budgets and dividing by the number of cases (weighted by the length of cases). We tested this figure against two other methods, detailed in Appendix 16, and applied all three in the sensitivity analyses (Chapter 8).

Consistent with previous expenditure estimates, the contribution of illicit drugs to overall court activity was determined using Australian Bureau of Statistics (ABS) data relating to total number of cases finalised by principal offence. ABS data is reported by three court levels; it is important to note that Higher courts data consolidates Supreme and Intermediate Courts (District or County Courts), and that finalisations in drug courts are not reported in the Criminal Courts data (Australian Bureau of Statistics, 2023c). ABS data for illicit drug offences and all offences were extracted by finalisation (acquitted/guilty) for Higher (Supreme and District/County courts), Magistrates and Children's courts (Australian Bureau of Statistics, 2023b). Average duration of cases was also extracted. The proportion of illicit drug offences at each court is multiplied by recurrent cost expenditure to estimate illicit drug-specific costs, given a weighting for length of proceedings,³⁰ as detailed below.

Higher courts

Some 3,583 (24.80%) defendants had illicit drugs as the principal offence out of the total of 14,450 acquitted and guilty defendants in Higher Courts in 2021/22 (See Table 13). To determine expenditures in the Higher Courts relating to illicit drugs we assumed that expenditure is related to the proportion of court time devoted to illicit drug defendants with cases finalised, adjusted by the relative duration of the drug cases. To derive a figure for relative duration, we divided the mean duration of illicit drug court cases with guilty findings (41.9 weeks) by the mean duration for all offences with guilty findings (46.7 weeks). The relative duration of illicit drug court cases was lower (by 10.28%). To reflect the lower duration of illicit drug cases, we multiplied the proportion of defendants with an illicit drugs offence as principal offence finalised in Higher Courts (24.8%) by the

³⁰ We sought to test whether average weeks reported by the ABS would be an accurate way to weight by proportion of time, or if the most frequent case length (mode) would more accurately reflect the proportions that result in lower average case length. Applying a method to derive frequency of case length resulted in slightly higher proportions of illicit drug related court activity at all court levels, resulting in higher overall estimates. These calculations are detailed in Appendix 15, and the figures applied in the sensitivity analyses (Chapter 8).

relative duration of illicit drug court cases (89.72%). As a result, it was estimated that 22.25% of Australia's 2021/22 Higher Court activity was associated with illicit drug activities.

Total Higher Courts real net recurrent expenditure, criminal in 2021/22 was \$533,853,000 (Supreme: \$134,958,000, District/county: \$389,895,000) (Productivity Commission, 2023c). By multiplying net recurrent expenditure by the proportion of court activity assumed to represent illicit drugs - weighted by proceedings time (22.25%) - a total Higher Courts expenditure relating to illicit drugs of \$118,767,548 for 2021/22 was estimated.

Table 13: Court cases: illicit drug cases, by court type, total number of cases, and duration to finalisation

	# of cases	<13 weeks	13-25 weeks	26-39 weeks	39-51 weeks	52 & over weeks	Average weeks
Higher courts							
Acquitted							
Illicit Drugs	48						
All Offences	1017						74.7
Guilty Finding							
Illicit Drugs	3535	195	1080	925	499	839	41.9
All Offences	13433	854	3749	3,179	1847	3802	46.7
Magistrates Courts							
Acquitted							
Illicit Drugs	344						
All Offences	11513						40.7
Guilty							
Illicit Drugs	35875	25798	3702	2058	1338	2984	15.3
All Offences	396785	254403	55248	31379	18524	37237	18.1
Children's Courts							
Acquitted							
Illicit Drugs	15						
All Offences	1120						30.9
Guilty							
Illicit Drugs	726	496	121	40	31	41	13.7
All Offences	18801	10851	3789	1877	997	1285	17.5

Source: Australian Bureau of Statistics, 2023b

Numbers may not sum due to minor inclusions/exclusions in ABS data.

Magistrates Courts

In 2021/22, there were 36,219 (8.9%) defendants (of 408,298) whose principal offence by finalised case related to illicit drugs. The mean duration of illicit drug court cases with guilty findings was 15.3 weeks, which was shorter than the mean duration for guilty finalisations for all offences of 18.1 weeks. To reflect the lower duration of illicit drug cases, we multiplied the percentage of defendants with an illicit drugs offence as principal offence finalised in Magistrates Courts (8.9%) by the relative duration of illicit drug court cases (84.53%). As a result, it was estimated that 7.50% of Australia's 2021/22 Magistrates Court activity was associated with illicit drug activities.

Magistrates Courts real net recurrent expenditure, criminal in 2021/22 was \$592,247,000 (Productivity Commission, 2023c). By multiplying net recurrent expenditure by the percentage of

court activity devoted to illicit drugs - weighted by proceedings time (7.50%) - a total Magistrates Courts expenditure relating to illicit drugs of \$44,409,402.31 for 2021/22 was estimated.

Children's Courts

In 2021/22, there were 741 (3.72%) defendants (of 19,921) whose principal offence by finalised case related to illicit drugs. The mean duration of illicit drug court cases with guilty findings was 13.7, which was shorter than the mean duration for guilty finalisations for all offences of 17.5 weeks. The relative duration of Children's Court illicit drug cases was 78.29%. To reflect the lower duration of illicit drug cases, we multiplied the percentage of defendants with an illicit drugs offence as principal offence finalised in Children's Courts (3.72%) by the relative duration of illicit drug court cases (78.29%). As a result, it was estimated that 2.91% of Australia's 2021/22 Children's Court activity was associated with illicit drug activities.

Children's Courts real net recurrent expenditure, criminal in 2021/22 was \$48,557,000 (Productivity Commission, 2023c). By multiplying net recurrent expenditure by the percentage of court activity devoted to illicit drugs - weighted by proceedings time (2.91%) - a total Children's Courts expenditure relating to illicit drugs of \$1,413,974.05 for 2021/22 was estimated.

Table 14: Illicit drug court cases, by court type, average weighting, and total court related expenditure

	Illicit drug cases (acquitted and guilty) (%)	Illicit drug court cases, weighted by Average case duration (%)	Total court expenditure relating to illicit drug offences (weighted by mean duration)
Higher Courts	24.80	22.25	\$118,767,548
Magistrates Courts	8.87	7.50	\$44,409,402
Children's Courts	3.72	2.91	\$1,413,974
Total			\$164,590,924

In total, apportioning by proportion of overall court activity on illicit drug offences, weighted by mean duration of illicit drug offences with guilty findings, results in all Higher, Magistrates and Children's Court activity that could be regarded as illicit drug specific in 2021/22 estimated to be \$164,590,924.54. We use this figure as our final estimate for all illicit drug specific court prosecutions in 2021/22.

Assumptions and caveats – Court prosecutions

There were a number of assumptions made in the above analyses. ABS Criminal court data does not include appeal cases, nor withdrawn cases which would represent a further cost. ABS Criminal court data also does not include finalisations in Drug Courts, or pre-court diversionary programs (including drug diversions) (Australian Bureau of Statistics, 2023c). Drug Courts are a program of court-based interactions with treatment and support services for drug offenders, to divert people away from serving a prison sentence and instead complete their sentence in the community (Lind et al., 2002). Offenders are referred to the drug court via a local or district court, given their willingness and eligibility. There is limited information about expenditure on drug courts. A NSW Bureau of Crime Statistics and Research (BOCSAR) and Centre for Health Economics Research and Evaluation (CHERE)

cost-effectiveness report (Lind et al., 2002) shows a breakdown of the activities involved in the NSW Drug Court program. However, each state's program has varying capacities for participants. An evaluation of the Drug Court of Victoria (KPMG, 2014, p. 84) stated, "the drug court operates within an allocation from the courts budget, designed to cover the additional costs incurred in its operation". However, the Report on Government Services (Productivity Commission, 2023c) excludes drug courts activity from the report, although it is unclear if this exclusion is only of court activity or if it includes the drug court allocation referred to in the KPMG report. Additionally, given our top-down approach to courts and corrective services, and to treatment, some of the costs associated with Drug Courts are assumed to be reflected in the top-down estimates here and elsewhere in this report. With that said, a more robust methodology for estimating Drug Court costs and accounting for any overlap with other estimates would be a welcome refinement to the current methodology.

The length of cases before the courts were derived from the differences in length only for guilty cases (not acquitted cases). There are no data on duration of illicit drug offence cases finalised by acquittal. Acquitted cases result in a higher-than-average duration. Yet acquitted illicit drug offences are a much smaller proportion of total acquitted cases (Higher Courts 4.72%, Magistrates 2.99%, Children's 1.34%) (compared to guilty finalisations, see above). By contrast, acquitted cases (all offences) are much longer cases, by average weeks (Acquitted finalisations are 59.96% longer than guilty finalisations in Higher Courts, 124.86% longer than guilty finalisations in Magistrates Courts, and 76.57% longer than guilty finalisations in Children's Courts).

Court diversion programs (bail-based programs, pre- and post-sentence programs) are not able to be disaggregated separately within the ABS criminal court data used above to derive a top-down funding estimate of court expenditure. Court costs associated with diversion are captured in our court figures. Other diversion costs (e.g. treatment provided by AOD treatment services) are captured in the treatment domain. See Appendix 14.

Restorative justice programs (see Appendix 17) were not costed separately. We are unable to extract reliable estimates of use of these programs. As any method would rely on guilty finalisations, this inclusion would represent double counting of the expenditure estimates given above, and so has not been included. An estimate figure for one restorative justice program (youth group conferencing) is given in Appendix 17.

Legal expenses

Public prosecutions

Public Prosecutions expenditure and Legal Aid expenditure comprise the category of legal expenses. The Director of Public Prosecutions prosecutes offences against Commonwealth law. Total state and territory government expenditure on public prosecutions was \$434,929,077 in 2021/22 (Attorney-General's Department, 2022; Director of Public Prosecutions ACT, 2022; Director of Public Prosecutions Northern Territory, 2022; Director of Public Prosecutions Tasmania, 2022; Office of Public Prosecutions Victoria, 2022; Office of the Director of Public Prosecutions NSW, 2022; Office of the Director of Public Prosecutions Queensland, 2022; Office of the Director of Public Prosecutions Western Australia, 2022). The Federal Government spent \$89,186,000 million on public prosecutions in 2021/22 (Commonwealth Director of Public Prosecutions, 2022).

We needed to apply a multiplier to those total expenditures to derive drug-specific legal expenditure. We chose the average of the Higher and Magistrates' illicit drug-specific court activity figures (see

preceding section), weighted by mean duration. This average was chosen instead of an all court average primarily due to DPP activity likely being concentrated in Higher Courts, as Moore (2005) argued. The low numbers and proportions of illicit drug offences in Children's Courts risk a substantial underestimate of total DPP expenditure (see sensitivity analysis Chapter 8). The average of Higher and Magistrate court activity related to illicit drug offences (IDO), weighted by duration, was 14.87%. State and federal public prosecutions were multiplied by this factor to estimate expenditure relating to illicit drugs. A total of \$64,584,469 was estimated at the state level and \$13,264,499 federally for Public Prosecutions, as detailed in Table 15. Total combined State, Territory, and Federal funding for public prosecutions relating to illicit drugs in 2021/22 was estimated to be \$77,848,968.

Table 15: Legal expenditure on illicit drug cases: Public prosecutions 2021/22

States	Drug-specific court activity (%)	DPP (\$ million)	Drugs Expenditure (\$ million)
NSW	14.87	171.78	\$25,548,134
VIC	14.87	81.13	\$12,066,937
QLD	14.87	56.16	\$8,351,997
WA	14.87	54.92	\$8,167,722
SA	14.87	27.47	\$4,085,274
TAS	14.87	11.03	\$1,640,475
ACT	14.87	16.36	\$2,432,454
NT	14.87	15.41 [^]	\$2,291,475
Sub-Total			\$64,584,469
Federal	14.87	89.19	\$13,264,499
Grand total			\$77,848,968

Columns may not sum to total due to rounding

* Legal Aid Commission figures are total expenses, not total income.

[^] NT DPP budget figures given in the 2021/22 Annual Report were attributed as 'Expenditure 30 June 2021'. This is assumed to be a typographical error as all other financial details are given for the 21/22 reference year. The previous 2020/21 Annual Report also uses the same attribution but gives a different figure. We did not CPI the figure included.

Legal Aid

State and territory governments also have legal aid commissions to resource legal support in criminal, civil, and family law matters. The total Legal Aid commission expenditure across Australia in 2021/22 was \$1069.6 million (Legal Aid ACT, 2022; Legal Aid New South Wales, 2022; Legal Aid Queensland, 2022; Legal Aid WA, 2022; Legal Services Commission South Australia, 2022; Northern Territory Legal Aid Commission, 2022; Tasmania Legal Aid, 2022; Victoria Legal Aid, 2022). We need to focus on criminal cases, and then within those, drug-related cases. The first step is to remove non-criminal cases. Criminal legal aid funding was identified in annual reports where possible. NSW was the only jurisdiction to provide explicit proportion of criminal cases at 46.9% (Legal Aid New South Wales, 2022). Proxies in other jurisdictions suggest criminal costs may account for 51-85% of total costs. 46.9% was applied to other jurisdictions to derive a proportion for criminal expenditure. Total legal aid expenditure on criminal cases in 2021/22 was estimated to be \$501,739,945.

We then apply a proportion of those criminal cases assumed to be drug related. The 14.87% proportion for court activity related to illicit drugs was again used to estimate drug-specific legal aid. 14.87% of drug-related activity was applied to the state and territory criminal legal aid funding of

(see Table 16). As a result, it is estimated that total legal aid funding relevant to drug-related activity was \$74,623,024 for 2021/22.

Legal Aid commissions receive primary funding from state and federal sources (see Chapter 3). However, a portion of funding is received from other sources (including other grants, revenue from services, and interest). We used a simple average of all reported funding from state and federal sources (detailed further in Chapter 6) to derive an estimate of total funding from government sources – average state funding was estimated to be 56.91%, average federal funding was estimated to be 34.25%, resulting in an estimated total funding from government sources of 91.16%. Our final estimate (\$74,623,024) was multiplied by 0.9116 to reflect expenditure from government sources only. This results in our final estimate of \$68,026,349 for government-funded Legal Aid relevant to drug-related activity in 2021/22.

Table 16: Legal expenditure on illicit drug cases: Legal Aid 2021/22

States	Legal Aid Commission funding (\$ million)	% funding on criminal cases, 46.9% (\$ million)	Drug-specific court activity (%)	Drugs Expenditure (\$)
NSW	426	199.9	14.87	\$29,730,825
VIC	268.45	125.9	14.87	\$18,725,161
QLD	163.93	76.9	14.87	\$11,434,508
WA	96.92	45.5	14.87	\$6,760,385
SA	56.84	26.7	14.87	\$3,964,728
TAS	19.62	9.2	14.87	\$1,368,337
ACT	18.76	8.8	14.87	\$1,308,300
NT	19.08	8.9	14.87	\$1,330,779
Total	1,069.6	501.8		\$74,623,024
Gov \$ sources only (91.16%)				\$68,026,349

Assumptions and caveats – Legal expenses

Previous research (Ritter et al., 2013) was able to derive criminal expenditure for Legal Aid from NSW, Victoria, SA, and NT. Criminal expenditure was around 50% of total legal aid expenditure. In this report, an explicit figure for total criminal law services was only able to be found for NSW. Other figures provided for other jurisdictions (e.g. QLD) could be used to derive total criminal law services using proxies (e.g. reported expenditure on private lawyers, criminal law), which suggest criminal law service expenditure may be 51%. Using duty law services by law type for SA results in an estimate as high as 85% of expenditure. The NSW figure was used for its alignment with previous estimates. As the figure conforms to at least one other jurisdiction when using proxies, this suggests that around 50% was a reliable estimate.

We use the average of Higher and Magistrates courts time spent on illicit drug offences to inform our DPP and Legal Aid estimates. Disaggregating by court level and including Children's Court proportions would be preferable. However, we are unable to apportion DPP and Legal Aid activity by court level and so have used the higher averages to reflect assumed DPP and Legal Aid time.

Corrective services

Similar to the above estimates for courts and policing costs, a top-down method is utilised to estimate the costs borne by governments associated with corrections: costs associated with the management of people in prisons, and people on community corrections orders.

For prison-based corrective services costs, we used ABS data on people in prison in Australia to derive the percentage with illicit drug offences as the most serious offence/charge.

On 30 June 2022, there were 40,591 people in Australian prisons (Australian Bureau of Statistics, 2023f). This represented a national imprisonment rate of 201 people in prisons per 100,000 adult population. There were 5,515 (13.6%) people in Australian prisons with an illicit drug offence (IDO) as their most serious offence/charge (Australian Bureau of Statistics, 2023f). The percentage of people in prisons with illicit drug offences as their most serious offence by state/territory can be seen in Table 17. These figures include all sentenced and unsentenced (on remand, awaiting outcome of trial) people. Of the total 5,515 people in prisons with IDO as their most serious offence charge, 3,601 were sentenced and 1,898 were unsentenced (rounding errors due to differences in ABS data). Total people in prison with most serious offence/charge IDO was used in the final estimates to allow for weighting by sentence length, see below.

Table 17: People in prisons with illicit drug offences as their most serious offence by state/territory, 2021/22

	People in Australian prisons (2022)	People in prison with most serious offence/charge of IDO	People in prison with most serious offence/charge of IDO (%)
NSW	12,372	1883	15.2%
VIC	6,569	891	13.6%
QLD	9,376	1180	12.6%
WA	6,276	1132	18%
SA	3,049	261	8.6%
Tas	630	46	7.3%
ACT	381	18	4.7%
NT	1934	105	5.4%
Aust	40,591	5,515	13.6%

Real net operating expenditure for all Australian prisons in 2021/22 was \$4.435 billion (Productivity Commission, 2023b). This figure does not include community corrections.

Real net operating expenditure was multiplied by the percentage of people in prison with an illicit drug offence as the most serious offence/charge by State/Territory in order to estimate drug-specific prison costs in 2021/22. This came to \$608.1 million (see Table 18).

We sought to weight this figure to account for differences in sentence length that impact illicit drug-related corrective service expenditure. Aggregate sentence length (a phrase used to refer to longest period able to be detained, or maximum sentence length (Australian Bureau of Statistics, 2023g)) for all offences across Australia is a mean of 5.6 years. For illicit drug offences, the mean aggregate sentence length is 6.9 years (Australian Bureau of Statistics, 2023f), meaning that illicit drug offences

receive, on average, a maximum sentence length which is 23% longer than the average maximum sentence length of all offences. Expected time to serve refers to the time to earliest date of release (Australian Bureau of Statistics, 2023g), with all offences expected time to serve 4.2 years and illicit drug offences 4.4 years (5% longer) (Australian Bureau of Statistics, 2023f). An average of these two figures shows that illicit drug offences receive an average sentence length which is 14% longer than the average sentence length for all offences. This varies substantially by State/Territory, with maximum sentence length being 66.67% longer in the Northern Territory, and 26.42% shorter in Tasmania; and earliest date of release being 24% longer in Queensland, and 36.36% shorter in South Australia.

To take into account the State/Territory variations we multiplied the base estimate (\$608.1 million: total expenditure multiplied by percentage of people in prisons with illicit drug offences as most serious charge) by expected time to serve (i.e. earliest date of release) in each State/Territory to derive an estimate of \$655,195,995. Weighting by aggregate sentence length (i.e. maximum sentence length) in each State/Territory generates a total estimate of \$775,540,079. We then derived an average sentence length by taking a simple average of minimum and maximum sentence length by State/Territory. Our final estimate of all State/Territory spending on drug-specific prison costs, weighted by average sentence length, in 2021/22 was \$715,323,037, see Table 18.

Table 18: Drug-specific prison costs, by state and territory and sentence length, 2021/22

	Real net operating expenditure, 21/22 (\$)	People in prisons with most serious offence/charge of IDO (%)	Total drug-specific expenditure by proportion of IDO (\$)	Average sentence length, Illicit drug offences (average earliest date of release and maximum sentence) (%)	Total drug-specific expenditure by percentage of IDO, weighted by average sentence length
NSW	\$1,308,905,000	15.22	\$199,213,394	19.72	\$238,494,443
VIC	\$1,009,427,000	13.56	\$136,915,734	4.81	\$143,494,801
QLD	\$843,375,000	12.59	\$106,141,478	26.13	\$133,876,707
WA	\$693,396,000	18.04	\$125,067,602	29.55	\$162,019,393
SA	\$250,994,000	8.56	\$21,485,547	-18.18	\$17,579,084
Tas	\$101,348,000	7.30	\$7,400,012	-26.67	\$5,426,496
ACT	\$74,274,000	4.72	\$3,509,007	-22.58	\$2,716,785
NT	\$153,321,000	5.43	\$8,324,046	40.74	\$11,715,324
Aust	\$4,435,039,000		\$608,056,822		\$715,323,037

* Columns may not sum due to rounding

Assumptions and caveats – Corrective Services

The Report on Government Services notes that real net operating expenditure excludes other costs where they can be disaggregated by jurisdiction (Productivity Commission, 2023b). The most relevant excluded cost here is expenditure on the health of people in prisons. While costs associated

with the health of people in prisons relative to illicit drugs, such as pharmacotherapy, withdrawal and counselling, are captured in total treatment expenditure (see Chapter 3), other items relevant to the limited harm reduction available in prisons would be missed. This would include minor costs such as the provision of bleach to people held in prisons.

Our approach to weighting by duration was to derive average sentence length (i.e. mean). This approach was utilised in the absence of further data on frequency and sentence length (i.e. mode). As a result, we are unable to account for the effects of parole on average duration (parole may be granted at the earliest eligibility, i.e. expected time to serve, or minimum sentence (Australian Bureau of Statistics, 2023g).

Community corrections

Community corrections are responsible for supervising people released into the community under relevant custodial or non-custodial orders. Sanctions administered by community corrections are supervised bail, conditionally deferred or suspended conviction/sentence, fine or fine conversion, community service order, probation, community-based order, supervised good behaviour bond, supervised suspended sentence, intensive corrections orders, home detention, post-prison orders (e.g. parole), and post-sentence supervision orders (Productivity Commission, 2023b). As can be seen in this list, there are both community non-custodial orders, and community custodial orders (including intensive corrections orders and home detention). For the purposes of this analysis, we do not distinguish between community custodial and community non-custodial.³¹

Figures for defendants finalised with non-custodial orders were sourced from the ABS (Australian Bureau of Statistics, 2023b). There were 367,037 defendants finalised with non-custodial orders across Australia and across court levels. 34,198 or 9.3% of these had an illicit drug offence as principal offence. Fines account for a large proportion of non-custodial orders for all offences (235,410 or 64.14%) and also for illicit drug offences (22,328 or 65.29%). For the purposes of estimating spending on community corrections, we excluded fines. This means that there were 131,627 defendants finalised with non-custodial community orders excluding fines. Additionally, there were 8,101 defendants finalised with a community custodial order across Australia and across court levels (Australian Bureau of Statistics, 2023b). 12,711 or 9% of these had an illicit drug offence as principal offence. However, this proportion varies substantially by state/territory. State/territory figures, see Table 19, were used to derive final estimates.

³¹ For reference, of the total of 12,711 illicit drug offences managed within community corrections and excluding fines, there were 841 finalised defendants with an illicit drug offence held in custody in the community in 2021/22.

Table 19: State/territory, community orders (non-custodial and custody in community): total offences, illicit drug offences (less fines). (ABS data)

	Total non-custodial orders, All offences; all courts	Total non-custodial community orders - minus fines	Illicit drug offences, non-custodial orders, all courts	Illicit drug offences, non-custodial orders, all courts, less fines	Total custody in community, all offences, all courts	Illicit drug offences, custody in the community	Total Illicit drug offences (less fines) combining both non-custodial and community custody
NSW	118332	54,434	11018	4,269	6,459	652	4,921
VIC	76642	35,196	3982	2,529	271	9	2,538
QLD	91135	26,502	11907	4,000	198	12	4,012
WA	53865	5,860	5724	351	0	0	351
SA	14047	5,451	1106	549	928	145	694
Tas	6140	1,938	322	116	149	11	127
ACT	3358	1,097	35	15	71	9	24
NT	3518	1,149	104	41	25	3	44
Aust	367,037	131,627	34,198	11,870	8,101	841	12,711

Source: Australian Bureau of Statistics, 2023b

Before applying the percentage of illicit drug offences managed by community corrections to the total expenditure, we need to account for differing lengths of community orders (the costs associated with a community corrections order will vary by the length of the order). There are no ABS data separating out the lengths of community corrections orders by offence type. NSW Bureau of Crime Statistics and Research (BOCSAR) data for NSW, however, does provide a breakdown of offence types by length of sentence (<https://sentencingtool.bocsar.nsw.gov.au/>).³² The distribution of the differing community order lengths for illicit drug offences compared to all offences is given the table below.

Table 20: BOCSAR data on length of community orders (supervised)

Length of community order	0-6 months	>6-12 months	>12-18 months	>18-24 months	>2years	Total %
% Illicit drug offences - supervised community	7.80%	42.13%	25.00%	18.44%	6.63%	100.00%
% All offences - supervised community	11.85%	49.04%	22.42%	13.93%	2.77%	100.00%

Source: NSW Bureau of Crime Statistics and Research, NSW Adult Criminal Sentencing, 2018/19 to 2022/23. Offence division: Illicit drug offences; Year: 21/22 <https://sentencingtool.bocsar.nsw.gov.au/>

³² BOCSAR data are given for both supervised community corrections orders, and for unsupervised community corrections orders. We took the community corrections order lengths for the supervised orders as these more closely reflect costs incurred in the supervision.

In order to accommodate these distributions, we distributed the ABS offence data for each state/territory into the differing length categories using the BOCSAR proportions as a guide (i.e. total illicit drug offences in community corrections for each state was multiplied by 7.8% to derive total number of cases serving 0-6 month sentences, and so on). We then calculated out the number of days (using the midpoint of each period, e.g. the midpoint of 0-6 months is 90 days) to derive a percentage of all offence days to apply to expenditure by state/territory (total days served for illicit drug offences in community corrections for each state/territory divided by total days served in community corrections for all offences for each state/territory).

Total real net operating expenditure on community corrections in Australia by State/Territory in 2021/22 was \$803.3 million (Productivity Commission, 2023b). The percentage of defendants finalised for an illicit drug offence for each state/territory, weighted by the lengths of the community corrections order, was applied to the overall real net operating expenditure for community corrections in 2021/22. The resulting estimate was \$78,898,001.

Assumptions and caveats – Community corrections

Costs related to people on parole are not included in these estimates. We used criminal court finalisation data to extract non-custodial community-based orders. Parole data is accessible via ABS corrective services data (Australian Bureau of Statistics, 2022b). However, these data do not disaggregate by offence type, and reports by number of people in community-based corrections by number on first day of the month.

We excluded fines prior to deriving the proportion of non-custodial orders that were illicit drug-related because the costs of fines did not reflect community corrections expenditure per se.

The weighting by lengths of community orders was derived from NSW data, and assumed to apply nationally, all things being equal.

Finally, we were unable to extract total allocation of funds or unit cost differences between custody in the community and non-custodial orders.

Chapter 6: State/Territory and Federal expenditure

Australia is a federated nation with a division of responsibilities across three levels of government: the federal government, state and territory governments (hereafter state governments), and local councils. This 'drug budget' does not include expenditure at the local council level. While distinctions between the jurisdictional level of spending are not necessary to understand total expenditure, details of whether the expenditure occurs at the federal or state level is useful.

The federal government's responsibilities and powers to legislate over certain issues are set out in the Constitution. Determining the expenditure distributions for the activities covered in this drug budget is based on divisions between specific powers (specific law-making provisions given to the Federal Parliament), exclusive powers (exclusive power to legislate resting with the federal government), concurrent powers (where different aspects of an area, such as education or health, are regulated by federal and state governments), and residual powers (which cover all other areas and are retained by the states).

The financial relationships between the Commonwealth and state governments are managed under the Federation Funding Agreements (FFA) Framework,³³ which includes governance structures, principles, and National Agreements determining responsibilities for service delivery and funding flows.

As per the Federal Financial Relations (FFR) framework shaping the funding relationship between the federal and state governments, the federal government provides specific and general-purpose payments (transfers) to states and territories to fund things such as health services and general activities (not specified). For example, health funding transfers as specific purpose payments are covered by the 2020-25 National Health Reform Agreement. The central considerations when deciding which level of government to allocate the expenditure to comes down to where decisions get made. This means that while large portions of specific funding and general funding (primarily the GST entitlements) are transferred from federal to state/territory governments, the central decision-making around where and how money is spent rests largely with the states/territories and so determines where we allocate the expenditure for the purposes of this report.

The division of powers and funding arrangements means that some activities are unambiguously able to be attributed to either federal or state governments. For example, the federal government is responsible for the Pharmaceutical Benefits Scheme (PBS) from where medications in the Opiate Agonist Treatment program are funded and for border control to restrict the importation of illicit drugs and precursor materials. State governments are responsible for decisions around health spending (not including Medicare and PBS items), for example, and, importantly, for large expenditures on law enforcement including policing, court, and corrections. Other activities require a delineation of different parts of the activity or specific grant sources to be attributed accurately. We have included these distinctions where possible. For some activities, we were unable to determine the distribution between levels of government. One example here is with reference to peer-led drug user organisations. In other cases, averages were needed to derive a federal and state/territory funding split, e.g. Legal Aid funding.

³³ <https://federalfinancialrelations.gov.au/federation-funding-agreements-framework>

The split between state and federal expenditure for each of the activities covered in the main body of this report are discussed below. See each individual chapter, above, for detailed discussion of approach.

State/territory vs federal expenditure: Prevention

Schools, teachers, and vocational education are the responsibility of states/territories. Funding for schools, however, comes from both state/territory and federal governments. For 2020/21 (the most up to date figures) recurrent expenditure, the Productivity Commission reported that state and territory government expenditure accounted for 69.2% of real recurrent expenditure and commonwealth government expenditure accounted for 30.8% (Productivity Commission, 2023f). As such, we split the total expenditure based on those figures. The state and territory governments contribution was \$191,050,643, and the federal government contribution was \$85,034,101.

For the general prevention activities, as detailed in Chapter 2, the two sites of expenditure (state/territory vs federal) were already accommodated in the methodological approach taken to generate the overall general prevention expenditure estimates.

Infancy and parental support programs were funded by both federal and state/territory governments. State/territory expenditure on intensive family support programs was \$4,975,173; state/territory expenditure on family support programs was \$6,737,067; federal expenditure on intensive family support programs was \$96,192; and federal expenditure on CaPS services \$650,279 in 2021/22.

Table 21: Prevention: split between federal and state/territory expenditure

Prevention	Federal 2021/22	State/territory 2021/22	Total
School-based drug education	\$85,034,101	\$191,050,643	\$276,084,744
General prevention	\$7,444,924	\$66,723,077	\$74,168,001
Infancy and parental programs	\$746,471	\$11,712,240	\$12,458,711
TOTAL	\$93,225,496	\$269,485,959	\$362,711,455

State/territory vs federal expenditure: Treatment

The funding of AOD treatment in Australia is complex. The New Horizons review into AOD treatment services in Australia (Ritter et al., 2014) sought to identify and describe funding sources and flows of AOD treatment. Despite the report's comprehensive insight into these sources, the authors' noted the degree of confusion and lack of clarity when it comes to AOD treatment funding.

Given we used the top-down method (for comparability with law enforcement) for drug treatment, we cannot assign each individual activity spending (e.g. withdrawal, OAT, counselling) to different levels of government. In lieu of that, we rely on the New Horizons analysis from 2014 which analysed drug treatment expenditure by the different levels of government. In Table 4.4 (page 67) from that report, they report that 39% of drug treatment expenditure came from the federal government and 61% came from state/territory governments.

Table 22: Drug treatment: split between federal and state/territory expenditure

	Federal	State/Territory	Total
Drug treatment services	\$581,609,625	\$909,697,106	\$1,491,306,732

State/territory vs federal expenditure: Harm Reduction

Needle and syringe programs (NSPs) receive support at the federal and state level (Australian Institute of Health and Welfare, 2007). Despite awareness of contributions from both levels of government, previous drug budget estimates were not able to determine amounts to be apportioned to different levels of government (Ritter et al., 2013). No updated figures on the split between federal and state/territory funding for NSPs were able to be sourced. In the absence of further information and to remain consistent with previous estimates, we have attributed all NSP funding to the states/territories.

Funding for peer-led drug user organisations comes from multiple sources.³⁴ Some organisations provide an explicit breakdown of funds received by Federal and/or State/Territory governments (QuiHN), while others are able to be cross-referenced with State Health portfolio Annual Reports (NSW Health, 2022a) and/or Federal health portfolio Murray Motions (SO13) (Department of Health, 2022b). However, data are incomplete and we cannot differentiate between state/territory and federal funding for each drug user organisation included in these spending estimates. As a result, we do not apportion this activity between levels of government.

While there are many overdose prevention programs, we have only estimated costs for Take Home Naloxone Programs (THN). These estimates came from federal funding and are attributed to the federal government. Australia had two supervised injecting facilities in 2021/22, one in NSW and one in Victoria. They are funded by their respective state governments so represent state expenditure.

Table 23: Harm reduction: split between federal and state/territory expenditure

	Federal	State/Territory	Total
Needle syringe programs		\$56,870,000	\$56,870,000
Peer-led drug user organisations			\$9,525,626
Take home naloxone	\$14,902,314		\$14,902,314
Supervised injecting facilities		\$8,599,600	\$8,599,600
TOTAL	\$14,902,314	\$65,469,600	\$89,897,540 (col)

State/territory vs federal expenditure: Law Enforcement

Determining funding sources for law enforcement is a relatively straightforward process. Across the four main areas of illicit drug-related law enforcement: the federal government is responsible for customs and border control; state governments are responsible for routine policing against drugs; and courts and legal expenditure is also a state expenditure.

The only two areas of law enforcement expenditure that are split between federal and state/territory governments are public prosecutions and Legal Aid.

Each state and territory fund their respective Director of Public Prosecutions. The Commonwealth Director of Public Prosecutions prosecutes offences against Commonwealth Law. The Federal Government spent \$13,264,499 on public prosecutions relevant to illicit drug offences in 2021/22, whereas State/Territory governments spent \$64,584,469.

³⁴ Drug user Organisations receive funding from multiple sources beyond state/territory and federal governments, so Federal and State/Territory funding does not represent 100% of the funding these organisations received.

Each state/territory has a Legal Aid Commission, which receives federal and state government funding. Minor proportions of revenue are also received from other grants, services, and interest. Commonwealth funding is provided under the National Legal Assistance Partnership agreement. Almost all Legal Aid Commissions report the breakdown of funds received via state and commonwealth grant contributions. A simple average of all reported state and commonwealth grants (as a proportion of total funds) was used to derive a proportion of 34.25% federal funding and 56.91% state funding³⁵ for Legal Aid.

Table 24: Law enforcement: split between federal and state/territory expenditure

	Federal	State/Territory	Total
Customs and border control	\$598,930,008		\$598,930,008
Routine policing against drugs		\$1,802,400,000	\$1,802,400,000
Higher Courts		\$118,767,548	\$164,590,924
Magistrates Courts		\$44,409,402	
Children's Courts		\$1,413,974	
Public Prosecutions	\$13,264,499	\$64,584,469	\$77,848,968
Legal Aid	\$25,558,386	\$42,467,963	\$68,026,349
Corrective services		\$715,323,037	\$715,323,037
Community corrections		\$78,898,001	\$78,898,001
TOTAL	\$637,752,893	\$2,868,264,394	\$3,506,017,286

³⁵ These do not sum to 100% because the proportion of legal aid funding from non-government sources takes up the remaining percentage, see Chapter 5.

Summary: State/territory vs federal expenditure

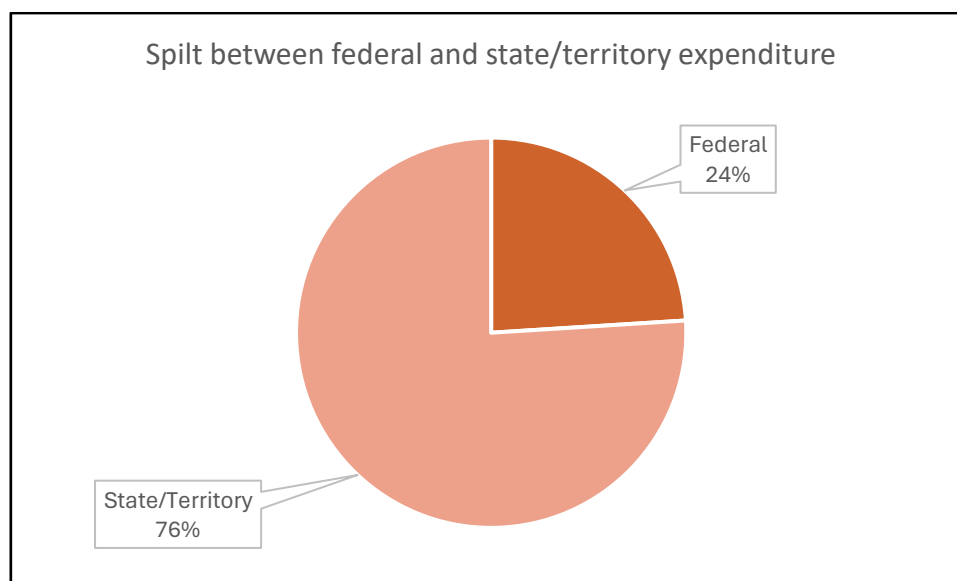
Table 25 provides the summary table of all the expenditure breakdowns between federal and state/territory governments. As can be seen in Table 25, State/Territory governments spend more than double the federal government on drugs.

Table 25: Federal and State/Territory funding sources for each costed activity

Domain and Activity	21/22 Federal	21/22 State	21/22 Total
Prevention			
School-based drug education	\$85,034,101	\$191,050,642	\$276,084,744
General prevention	\$7,444,924	\$66,723,077	\$74,168,001
Infancy and parental programs	\$746,471	\$11,712,240	\$12,458,711
SUB-TOTAL	\$93,225,496	\$269,485,960	\$368,918,254
Treatment			
Drug treatment services	\$581,609,625	\$909,697,106	\$1,491,306,732
SUB-TOTAL	\$581,609,625	\$909,697,106	\$1,491,306,732
Harm Reduction			
Needle syringe programs		\$56,870,000	\$56,870,000
Peer-led drug user organisations			\$9,525,626
Take home naloxone	\$14,902,314		\$14,902,314
Supervised injecting facilities		\$8,599,600	\$8,599,600
SUB-TOTAL	\$14,902,314	\$65,469,600	\$89,897,540
Law enforcement			
Customs and border control	\$598,930,008		\$598,930,008
Routine policing against drugs		\$1,802,400,000	\$1,802,400,000
Higher Courts		\$118,767,548	\$164,590,924
Magistrates Courts		\$44,409,402	
Children's Courts		\$1,413,974	
Public Prosecutions	\$13,264,499	\$64,584,469	\$77,848,968
Legal Aid	\$25,558,386	\$42,467,963	\$68,026,349
Corrective services		\$715,323,037	\$715,323,037
Community corrections		\$78,898,001	\$78,898,001
SUB-TOTAL	\$637,752,893	\$2,868,264,394	\$3,506,017,286
TOTAL	\$1,327,490,328	\$4,112,917,060	\$5,449,933,013 (col)

Of the total expenditure of \$5.45 billion, state and territory expenditure accounts for 76% or \$4.11 billion. Federal expenditure accounts for 24% or \$1.33 billion of total expenditure, as shown in the below Figure.

Figure 1: Proportion of total drug expenditure by federal and state/territory



For the federal government, their investment is 48% in law enforcement, and 43.8% in treatment. Only a very small proportion of federal investment is towards prevention (7%) and 1.1% towards harm reduction. This distribution of state/territory expenditures is more heavily weighted towards law enforcement (at 69.7%), with a corresponding 22.1% expenditure in drug treatment, followed by 6.6% prevention and 1.6% harm reduction. (See Table 26).

Table 26: Distributions of federal vs state/territory expenditures between domains

Domain	Federal	State/Territory
Prevention	7%	6.6%
Treatment	43.8%	22.1%
Harm reduction	1.1%	1.6%
Law enforcement	48%	69.7%
TOTAL	100%	100%

Columns may not sum to 100% due to rounding

Chapter 7: Putting it all together

In 2021/2022 it is estimated that Australian governments spent a total of \$5.26 billion in proactive responses to illicit drugs. This spanned prevention, treatment, harm reduction, and law enforcement spending. The 2021/2022 Australian ‘drug budget’ is summarised in Table 27, below.

Table 27: Australian ‘drug budget’ 2021/2022, estimated expenditure by activity and domain

Domain and Activity	21/22 Total expenditure
Prevention	
School-based drug education	\$276,084,744
General prevention	\$74,168,001
Infancy and parental programs	\$12,458,711
Sub-total	\$362,711,455
Treatment	
Drug treatment services	\$1,491,306,732
Sub-total	\$1,491,306,732
Harm reduction	
Needle syringe programs	\$56,870,000
Peer-led drug user organisations	\$9,525,626
Take home naloxone	\$14,902,314
Supervised injecting facilities	\$8,599,600
Sub-total	\$89,897,540
Law Enforcement	
Customs and border control	\$598,930,008
Routine policing against drugs	\$1,802,400,000
Courts	\$164,590,924
Public Prosecutions	\$77,848,968
Legal Aid	\$68,026,349
Corrective services	\$715,323,037
Community corrections	\$78,898,001
Sub-total	\$3,506,017,286
TOTAL	\$5,449,933,013

As can be seen, the largest expenditure occurs for the law enforcement domain (\$3.5 billion), and within law enforcement, for routine policing against drugs, at \$1.8 billion. The second highest expenditure domain is drug treatment at \$1.49 billion, followed by prevention, then harm reduction.

This study does not provide advice about what the ideal spending proportions might be. Nor does the total expenditure amount suggest that a particular domain results in more effective drug policy. For example, there is evidence that harm reduction activities are cost-effective (Harm Reduction International, 2020; Wilson et al., 2015); in part because they are highly successful at achieving their aims, but more importantly, because the estimated cost of delivering harm reduction activities is low when compared to other types of interventions (Wilson et al., 2015; Harm Reduction International, 2022).

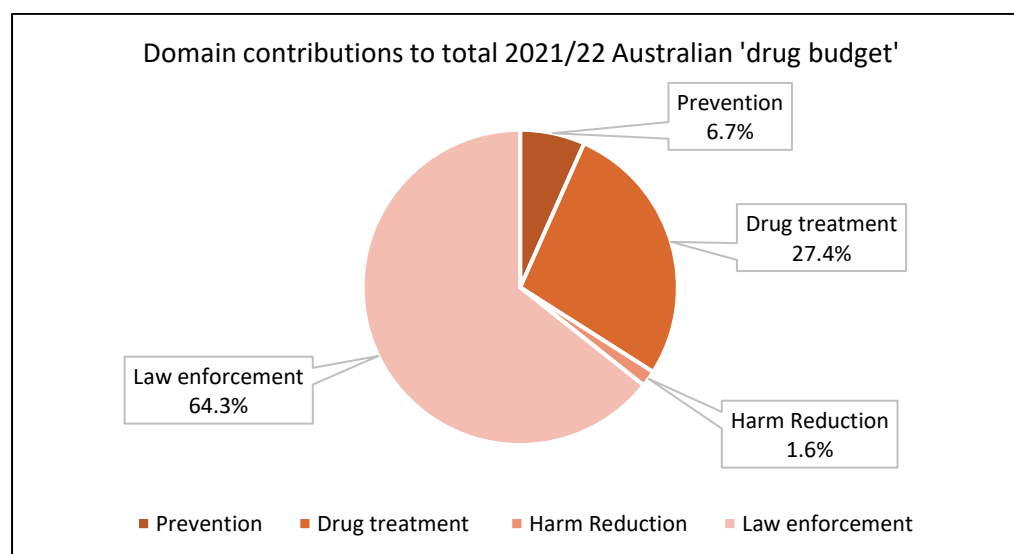
Balance is a term routinely used in the context of drug policy. Like the previous national drug strategy, the current Strategy seeks “a balanced approach” to drug policy across the three pillars: demand reduction, supply reduction, and harm reduction (Department of Health, 2017a).

Balance can mean many different things in drug policy (Ritter, 2010). For example, balance in the Strategy signals that multiple approaches are necessary to dealing with harms arising from alcohol, tobacco, and other drugs, and that these approaches should be spread in some way between supply, demand, and harm reduction. Balance can also refer to an appropriate investment in different domains judged against policy goals, government priorities, or community values; policy attention to drug types or areas of particular harm; and ‘balance’ can operate as a rhetorical tool to justify or critique expenditure and investment (Ritter, 2010).

Given the uncertainty surrounding our estimates (noted throughout), the relative distribution of the total ‘drug budget’ between domains is more important than any absolute expenditure figure provided in the analysis. We focus on the distribution of expenditure between the policy domains. How this relates to balance as conceptualised in the National Drug Strategy, and in terms of value for investment, reduction of drug-related harms, and investment in evidence-based policy are fruitful avenues for further research and analysis.

Of the total proactive spending on illicit drugs by Australian governments, 64.3% was spent in law enforcement; 27.4% in drug treatment; 6.7% in prevention and 1.6% in harm reduction.

Figure 2: Government expenditure estimates (proportion) across four policy domains



The latest National Drug Strategy Household Survey (AIHW, 2024) asked respondents about the distribution of a hypothetical \$100.00 across three of the four domains covered in this ‘drug budget’. In 2019, Australians wanted \$36.50 spent on drug education; \$32.00 spent on drug treatment and \$31.50 spent on law enforcement responses to illicit drugs. This suggests that Australians are looking for similar government investment across proactive responses to illicit drugs.

General government expenses (across all levels of government) in 2021/22 were \$865,903,000,000 (Australian Bureau of Statistics, 2023d). The 2021/22 Australian ‘drug budget’ estimate represents 0.63% of all government spending.

In terms of the spend per person, assuming a population estimate of 26 million people, the Australian ‘drug budget’ estimate suggests that governments spent \$209.61 per person in 2021/2022.

The first Australian drug budget estimates of proactive government spending in 2002/03 was estimated as \$1.33 billion (Moore, 2005).³⁶ The second Australian drug budget estimate in 2009/10 was \$1.7 billion (Ritter et al., 2013). The present estimate for 2021/22 is \$5.45 billion.

The 2002/03 estimate represented 0.5% of all government expenses for all levels of government (Moore, 2005). The 2009/10 estimate represented 0.8% of government spending (Ritter et al., 2013). The 2021/22 estimate represents 0.63% of government spending.

These figures suggest that despite a significant jump from \$1.7 billion in 2009/10 to \$5.45 billion in 2021/22, this largely reflects overall growth in government spending, rather than growth in spending on proactive responses to illicit drugs. However, the percentage change in total government spending between 2009/10 and 2021/22 was a 285% increase (over and above CPI).³⁷ For the ‘drug budgets’, the percentage change between 2009/10 and 2021/22 was 221%. On these figures it appears that proactive illicit drug spending falls short of increases in government spending on other, non-drug related activities.

Turning to the percentages between domains, the table below provides the percentage contributions across the four domains for the two previous ‘drug budgets’ compared to this year’s results.

Table 28: Comparison of the percentage distributions between domains between ‘drug budget’ estimates

	2002/03 (Moore, 2005) ¹	2009/2010 (Ritter et al., 2013) ¹	2021/2022 (current estimate)
Prevention	9% ²	9.5%	6.7%
Treatment	20.2%	22.0%	27.4%
Harm Reduction	3.9%	2.2%	1.6%
Law Enforcement	65.3%	64.9% ³	64.3%

1. The 2002/03 and 2009/10 estimates included an ‘other’ category, hence the column percentages do not round to 100%

2. The original 2002/03 prevention estimate included social competencies training. These were excluded from subsequent prevention estimates and so were removed from here for comparability purposes. See Ritter et al., 2013, p. 2

3. An addendum was published to the 2009/10 estimate which provided an updated calculation for law enforcement expenditure. The figure reported here is the ‘new’ figure at 70% of the original estimate. See Ritter et al., 2013 for details.

As can be seen, despite methodological advances for the 2021/2022 expenditure estimates (see Appendix 19), the percentage spending between the four domains remains remarkably similar. This suggests significant stasis in Australian government spending between the four domains.

³⁶ The Moore (2005) work also included reactive spending which we have not included in here. Further, Moore (2005) and Ritter et al (2013) had an ‘other’ category in the direct proactive sending estimates, which represented 1% of the total 2002/03 estimate (\$18.4 million) and 1.4% (\$23.1 million) in the 2009/10 estimate. Appendix 17 shows the details when this small contribution is removed.

³⁷ Government spending in 2009/10 was \$224,690 million; in 2021/22 it was \$865,903 million.

Chapter 8: Sensitivity analyses

The 2021/22 drug budget estimate is reliant on many assumptions. A number of these are subject to estimation uncertainty and definitional issues, which we have noted throughout the report and in the assumptions and caveats for each activity.

How confident can we be in the estimates between the four domains? We conducted a series of sensitivity analyses, deriving alternative expenditure estimates for as many of the items as possible, and then comparing the resulting percentages between the four domains.

The items examined in the sensitivity analysis were:

- School-based drug education (SBDE)
- General prevention – state/territory
- Drug treatment services
- Needle syringe programs
- Take-home naloxone
- Peer-led drug user organisations
- Customs and border control
- Routine policing
- Court prosecutions
- Public prosecutions
- Corrective services

Where alternative data were available, those numbers were tested in the sensitivity analyses. Where the total amount contributed significantly, but there were no known alternatives, a standard 10% variation was applied. Those items that were varied in the sensitivity analysis are shown in Table 29, where the rationale for the low and high estimates is provided along with their estimated values.

Table 29: Sensitivity analysis: selected drug budget items

	Low	Main	High	Notes
Prevention				
School-based drug education	\$252,134,228	\$276,084,744	\$504,268,456	The key variable in calculating SBDE expenditure is the average hours spent on drug education. The main estimate used average hours derived from NSW and Victorian curriculum documents (7.26 hours). The low estimate uses the average hours that Moore used in the 2002/03 drug budget (6.5 hours), and the high estimate uses the average hours Ritter et al., used in the 2009/10 drug budget (13.00 hours).
General prevention – states and territories	\$60,862,154	\$66,723,077	\$74,387,078	The driver of the general prevention spending was a cost per person, applied to the population. To derive the low and high estimates we changed the driver (cost per person) by 10%. The main variable is based on a cost of \$2.66 per person. The low estimate uses \$2.39 per person and the high estimate uses \$2.93 per person.
Treatment				
Drug treatment services	\$1,081,240,250	\$1,491,306,732	\$1,621,184,898	The main estimate is a top-down approach that applies the proportion of people accessing health care services for illicit drug use to the total health expenditure. The proportion used in this estimate includes assumptions from the New Horizons report (see Chapter 3). For the low estimate, we used a bottom-up approach, a combination of individual activities, each derived using bottom-up methods. These are described in Appendix 4. For the high estimate, we increased the number of clients receiving AOD treatment (to 214,849 people) by applying the higher multiplier from New Horizons.
Harm Reduction				
NSPs	\$56,400,000	\$56,870,000	\$58,353,153	The main estimate is the most robust, based on published data reliant on direct communication with health departments and access to financial reports. This method derives cost per needle syringe distributed as proxy for service cost, multiplied by units distributed in 2021/22. The low estimate is based on cost per needle using older cost estimates. The high estimate indexes cost of each NSP service and consumable, CPI adjusted, and multiplied by current NSP and units distributed. See Chapter 4 for details.
Take home naloxone	\$13,412,082	\$14,902,314	\$16,392,545	Our main estimates for overdose prevention programs relied on the cost and scope of take-home naloxone programs. Our low and high estimates adjust the main estimate by 10% in the absence of any further data to assess sensitivity of the main figure.

	Low	Main	High	Notes
Peer-led drug user organisations	\$6,755,655	\$9,525,626	\$12,173,676	The main estimate for peer-led drug user organisations used total budgets modified by total proportion of time spent on activities not covered elsewhere (76% to reflect activities elsewhere e.g. NSPs). Our low estimate uses a higher proportion of activity counted elsewhere (50%). The high estimate uses total organisation budget.
Law enforcement				
Customs and border control	\$525,395,285	\$598,930,008	\$932,646,547	Our main estimate for customs and border control used a weighted average of US Customs and Border spend on drug-related activity as a proportion from which to derive our estimates (17.43%). The low estimate used a weighted average across Customs and Border, Immigration and Customs, and Coast guard (15.29%). The high estimate averages these ratios applied to three different figures given in government reports for a relevant total Home Affairs budget (See Appendix 13).
Routine policing	\$906,059,880	\$1,802,400,000	\$1,983,391,650	We chose to adjust the proportion of illicit drug related activity as the variable, instead of modifying the total policing budget used. The low estimate uses a much lower figure of illicit drug related policing (6.8% taken from NSW BOCSAR data, applied to all states) than that sourced from the ABS and used in our main estimate (8-26.7%, varied by state). The high estimate inflates the state-based ABS data used in our main estimates by 10% (in the absence of any other indicative data).
Court prosecutions	\$112,729,690.98	\$164,590,924	\$185,645,502	The main estimate derived a proportion of total court related expenditure by using the proportion of illicit drug offence cases weighted by mean case length. The low estimate is a bottom-up approach which costs court finalisations. Details are given in Appendix 16. The high estimate uses the same approach to derive a proportion of total expenditure but weighted using 'defendant weeks' instead. Details of this calculation are given in Appendix 16.
Legal expense - DPP	\$56,980,053	\$77,848,968	\$85,633,864	The main estimate assumed that 14.9% of court time is spent on illicit drug matters. This was based on Higher and Magistrate court data. The low estimate uses a proportion derived from all courts which is approximately 10.9%. To derive a high estimate we varied the main estimate by 10.89% for a high scenario assuming that 16.4% of court time is spent on illicit drugs.
Corrective services	\$655,105,995	\$715,323,037	\$775,540,079	The main estimate is the proportion of people in prisons with primary offence related to illicit drugs weighted by average sentence length and applied to the total cost of prisons. The low estimate adjusts the sentence length (to earliest date of release). The high estimate adjusts the sentence length to a maximum sentence length.

For the remaining items (federal prevention, infancy and parental programs, supervised injecting facilities, Legal Aid, and community corrections) no sensitivity analyses were conducted. These items make up 3.4% of the total budget, and hence not subjecting them to variations in estimation should not impact the overall sensitivity analysis.

Table 30: Sensitivity analysis: low, main and high estimates for each activity and domain

	Low Estimates	MAIN ESTIMATE	High Estimates
Prevention			
School-based drug education	\$252,134,228	\$276,084,744	\$504,268,456
State prevention	\$60,050,769	\$66,723,077	\$74,387,078
Federal prevention	\$7,444,924	\$7,444,924	\$7,444,924
Infancy and parental programs	\$12,458,711	\$12,458,711	\$12,458,711
Sub-Total	\$332,900,017	\$362,711,455	\$598,559,168
Treatment			
Drug treatment services	\$1,081,240,250	\$1,491,306,732	\$1,621,184,898
Sub-Total	\$1,081,240,250	\$1,491,306,732	\$1,621,184,898
Harm reduction			
Needle syringe programs	\$56,400,000	\$56,870,000	\$58,353,153
Overdose prevention programs	\$13,412,082	\$14,902,314	\$16,392,545
Supervised injecting facilities	\$8,599,600	\$8,599,600	\$8,599,600
Peer-led drug user organisations	\$6,755,655	\$9,525,626	\$12,173,676
Sub-Total	\$85,167,337	\$89,897,540	\$95,518,974
Law enforcement			
Customs and border control	\$525,395,285	\$598,930,008	\$932,646,547
Routine policing against drugs	\$906,059,880	\$1,802,400,000	\$1,983,391,650
Court prosecutions	\$112,729,690	\$164,590,924	\$185,645,502
Public Prosecutions	\$56,980,053	\$77,848,968	\$85,633,864
Legal Aid	\$68,026,349	\$68,026,349	\$68,026,349
Corrective services	\$655,105,995	\$715,323,037	\$775,540,079
Community corrections	\$78,898,001	\$78,898,001	\$78,898,001
Sub-Total	\$2,403,195,252	\$3,506,017,286	\$4,109,781,992
GRAND TOTAL	\$3,902,502,856	\$5,449,933,013	\$6,425,045,032

As can be seen in the above table, the overall 'drug budget' estimate might be as low as \$3.9 billion, or as high as \$6.4 billion, depending on the assumptions behind the expenditure estimates.

Given uncertainty in the actual dollar amounts, and our overriding focus on the distributions between the domains, we used the sensitivity analyses to examine whether adjustments to expenditure figures would result in a different proportional distribution of total budget between domains (recalling that for the main estimate, 64.3% of expenditure was in law enforcement; 27.4% in treatment; 6.7% in prevention and 1.6% in harm reduction). The distributions for the low estimate and for the high estimate are given in the below table.

Table 31: Distribution of Australian drug budget by domain: for the low estimate and the high estimate (total)

Domain	LOW	HIGH
Prevention	8.5%	9.3%
Treatment	27.7%	25.2%
Harm Reduction	2.2%	1.5%
Law enforcement	61.6%	64.0%
	100%	100%

As can be seen, despite uncertainty within the main estimates, law enforcement remains the significant expenditure item. The relative investment across domains remains consistent across the low, main, and high estimates.

Another way of employing the sensitivity analyses is to assess the extent of change in contribution to the total 'drug budget' by varying each domain alone. For example, taking the low and high estimates for prevention alone (retaining the main estimates for the other three domains) and examining the potential range of each domain's contribution. These results are given in Table 32, below.

Table 32: Ranges of percentage contribution to total 'drug budget' (low and high estimates varying singly by domain).

Domain	LOW	HIGH
Prevention	6.1%	10.5%
Treatment	21.5%	29.1%
Harm reduction	1.6%	1.8%
Law enforcement	55.3%	67.9%

Note: for each domain, the low and high estimate are used to derive a percentage contribution to the total drug budget, keeping the other domains constant (i.e. using their main estimates).

With this analysis, the contribution of law enforcement does not fall below 55.3%. The range for prevention may lie between 6.1% and 10.5% of the total drug budget; for treatment it falls between 21.5% and 29.1% contribution; and for law enforcement the plausible contribution reaches 67.9% of total 'drug budget' under these scenarios.³⁸

³⁸ The plausible range for harm reduction remains very small (between 1.6% and 1.8%) given that there is little variation across the alternative parameters for this domain.

References

- ACON. (2022). *Annual Report 2021-2022*. https://www.acon.org.au/wp-content/uploads/2022/10/Annual-Report-2021-2022_final.pdf
- ACT Government. (n.d.). *Cannabis*. <https://www.act.gov.au/cannabis>
- AIVL. (2006). *A framework for peer education by drug-user organisations*.
- AIVL. (2022). *Financial Statements For the Year Ended 30 June 2022*. https://acncpubfilesprodstorage.blob.core.windows.net/public/dca1171b-38af-e811-a961-000d3ad24182-a5597493-ab3b-4c4c-ab51-a14a48b46d48-Financial%20Report-731a1a64-6cb2-ed11-83ff-000d3acbbbfb-20221118_Financial_Statements_30.6.22_approved_&_signed.pdf
- Alcohol and Drug Foundation. (2022). Financial Report for the Year Ended 30 June 2022. Retrieved from <https://adf.org.au/adf-annual-report-2021-22/>
- Aldridge, J., Stevens, A., and Barratt, M. J. (2018) Will growth in cryptomarket drug buying increase the harms of illicit drugs?. *Addiction*, 113: 789–796. doi: [10.1111/add.13899](https://doi.org/10.1111/add.13899)
- ASHM. (2022). *Annual Report 2021-2022*. https://acncpubfilesprodstorage.blob.core.windows.net/public/3adda895-39af-e811-a963-000d3ad244fd-760a06b5-8c7c-415b-be60-2fc95293e574-Financial%20Report-266b6c0c-b96b-ed11-81ac-002248110683-ASHM_Annual-Report-2022_FA-WEB21098.pdf
- Attorney-General's Department. (2022). *Annual Report 2012-22*. Adelaide: South Australian Government <https://www.agd.sa.gov.au/documents/annual-reports/AGD-Annual-Report-2021-22.pdf>
- Australian Association for Restorative Justice. (n.d.-a). *Adult Justice*. Australian Association for Restorative Justice,. Retrieved 12 September 2023 from <https://www.aarj.org.au/restorative-justice/adult-justice/>
- Australian Association for Restorative Justice. (n.d.-b). *Youth Justice*. Australian Association for Restorative Justice,. Retrieved 12 September 2023 from <https://www.aarj.org.au/restorative-justice/youth-justice/>
- Australian Bureau of Statistics (2022d). *Patient Experiences*. Canberra: Australian Bureau of Statistics
- Australian Bureau of Statistics. (2021a). *Census 2021*. Canberra: Australian Bureau of Statistics <https://www.abs.gov.au/census>
- Australian Bureau of Statistics. (2021b). *Recorded Crime - Offenders*. Canberra: Australian Bureau of Statistics <https://www.abs.gov.au/statistics/people/crime-and-justice/recorded-crime-offenders/2019-20>
- Australian Bureau of Statistics. (2022a). *Australian National Accounts: National Income, Expenditure and Product*. Canberra: Australian Bureau of Statistics <https://www.abs.gov.au/statistics/economy/national-accounts/australian-national-accounts-national-income-expenditure-and-product/jun-2022#data-downloads>
- Australian Bureau of Statistics. (2022b). *Corrective Services, Australia - June Quarter 2022*. Canberra: Australian Bureau of Statistics <https://www.abs.gov.au/statistics/people/crime-and-justice/corrective-services-australia/jun-quarter-2022>
- Australian Bureau of Statistics. (2022c). *National Study of Mental Health and Wellbeing 2020-21*. Canberra: Australian Bureau of Statistics <https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/2020-21>
- Australian Bureau of Statistics. (2022e). *Recorded Crime - Offenders*. Canberra: Australian Bureau of Statistics
- Australian Bureau of Statistics. (2023a). *COVID-19 Mortality in Australia: Deaths registered until 30 June 2023*. Canberra: Australian Bureau of Statistics
- Australian Bureau of Statistics. (2023b). *Criminal Courts, Australia*. Canberra: Australian Bureau of Statistics <https://www.abs.gov.au/statistics/people/crime-and-justice/criminal-courts-australia/latest-release>

- Australian Bureau of Statistics. (2023c). *Criminal Courts, Australia methodology*. Canberra: Australian Bureau of Statistics <https://www.abs.gov.au/methodologies/criminal-courts-australia-methodology/2021-22>
- Australian Bureau of Statistics. (2023d). *Government Finance Statistics, Annual*. A. B. o. Statistics
- Australian Bureau of Statistics. (2023e). *National Study of Mental Health and Wellbeing 2020-2022*. Canberra: Australian Bureau of Statistics <https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release>
- Australian Bureau of Statistics. (2023f). *Prisoners in Australia*. Canberra: Australian Bureau of Statistics <https://www.abs.gov.au/statistics/people/crime-and-justice/prisoners-australia/latest-release>
- Australian Bureau of Statistics. (2023g). *Prisoners in Australia methodology*. Canberra: Australian Bureau of Statistics <https://www.abs.gov.au/methodologies/prisoners-australia-methodology/2022>
- Australian Bureau of Statistics. (2023h). *Recorded Crime - Offenders*. Canberra: Australian Bureau of Statistics <https://www.abs.gov.au/statistics/people/crime-and-justice/recorded-crime-offenders/latest-release>
- Australian Bureau of Statistics. (2023i). *Recorded Crime - Offenders methodology*. Canberra: Australian Bureau of Statistics <https://www.abs.gov.au/methodologies/recorded-crime-offenders-methodology/2021-22>
- Australian Criminal Intelligence Commission. (2019). *Illicit Drug Data Report, 2018-2019*. Canberra: Australian Criminal Intelligence Commission
- Australian Criminal Intelligence Commission. (2021). *Illicit Drug Data Report, 2019-20*. Canberra: Australian Criminal Intelligence Commission
- Australian Criminal Intelligence Commission. (2023a). Commonwealth of Australia. <https://www.acic.gov.au/about>
- Australian Criminal Intelligence Commission. (2023b). *Illicit Drug Data Report, 2020-21*. Canberra: A. C. I. Commission https://www.acic.gov.au/sites/default/files/2023-10/illicit_drug_data_report_2020-21_forweb.pdf
- Australian Curriculum, Assessment and Reporting Authority. (2020). *National Report On Schooling In Australia 2020*. https://www.acara.edu.au/docs/default-source/default-document-library/national-report-on-schooling-in-australia-2020a9662f404c94637ead88ff00003e0139.pdf?sfvrsn=1af24c07_0
- Australian Government COVID-19 Epidemiology and Surveillance Team. (2023). COVID-19 Australia: Epidemiology Report 75. Communicable Diseases Intelligence, Year 2023, Volume 47. <https://doi.org/10.33321/cdi.2023.47.38>. Retrieved from [https://www1.health.gov.au/internet/main/publishing.nsf/Content/99424DA2A5F3A488CA2589BA0019141B/\\$File/covid_19_australia_epidemiology_report_75_reporting_period_ending_4_june_2023.docx#:~:text=International%20situation%20%E2%80%93%20According%20to%20the,as%20of%204%20June%202023](https://www1.health.gov.au/internet/main/publishing.nsf/Content/99424DA2A5F3A488CA2589BA0019141B/$File/covid_19_australia_epidemiology_report_75_reporting_period_ending_4_june_2023.docx#:~:text=International%20situation%20%E2%80%93%20According%20to%20the,as%20of%204%20June%202023)
- Australian Institute of Health and Welfare. (2007). *Developing a nationally consistent data set for needle and syringe programs*. Canberra: AIHW
- Australian Institute of Health and Welfare. (2022a, 7 July 2022). *Medicines in the health system*. Australian Government. Retrieved 15 September 2023 from <https://www.aihw.gov.au/reports/medicines/medicines-in-the-health-system>
- Australian Institute of Health and Welfare. (2022b, 23 November 2022). *Rapid growth in government health spending during the pandemic*. Australian Government. Retrieved from <https://www.aihw.gov.au/news-media/media-releases/2021/november/rapid-growth-in-government-health-spending-during>
- Australian Institute of Health and Welfare. (2022c, 15 August 2023). *Social determinants of health*. Australian Institute of Health and Welfare. Retrieved 28 November 2023 from <https://www.aihw.gov.au/reports/australias-health/social-determinants-of-health>

- Australian Institute of Health and Welfare. (2023a). *Alcohol and other drug treatment services in Australia annual report*. Australian Government <https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services-australia/contents/about>
- Australian Institute of Health and Welfare. (2023b). *Diversion programs in Australia Data*. Australian Government <https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia/contents/diversion-in-australia>
- Australian Institute of Health and Welfare. (2023c, 25 October 2023). Health expenditure. Australian Government. Retrieved from <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure>
- Australian Institute of Health and Welfare. (2023d). *A National Opioid Pharmacotherapy Statistics Annual Data collection*. Australian Government <https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics/contents/summary>
- Australian Institute of Health and Welfare. (2024). *National Drug Strategy Household Survey 2022-23*. Canberra: AIHW Retrieved from <https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey/contents/about>
- Australian National Audit Office. (2015). *ANAO Report No.35 2014-2015 Performance Audit: Delivery of the Petrol Sniffing Strategy in Remote Indigenous Communities, Department of the Prime Minister and Cabinet*. Retrieved from https://www.anao.gov.au/sites/default/files/ANAO_Report_2014-2015_35.pdf
- Australian National Audit Office. (2019). Auditor-General Report No.9 2019–20 Performance Audit: National Ice Action Strategy Rollout. Retrieved from <https://www.anao.gov.au/work/performance-audit/national-ice-action-strategy-rollout>
- Baillie, G., Peacock, A., Hammoud, M., Memedovic, S., Barratt, M., Bruno, R., Dietze, P., Ezard, N., Salom, C., Degenhardt, L., Hughes, C. & Sutherland, R. (2021). Key findings from the 'Australians' Drug Use: Adapting to Pandemic Threats (ADAPT)' Study Wave 4. ADAPT Bulletin no. 4. Sydney: National Drug and Alcohol Research Centre, UNSW Sydney. doi:10.26190/n5wf-2x04
- Black, E., Dolan, K., & Wodak, A. (2004). Supply, demand and harm reduction strategies in Australian prisons: Implementation, cost and evaluation. *ANCD Research Paper 9*. Canberra: Australian National Council on Drugs. http://www.ancd.org.au/images/PDF/Researchpapers/rp9_australian_prisons.pdf?php
- Bureau of Infrastructure and Transport Research Economics. (2022). Roadside drug tests, Australia. <https://app.powerbi.com/view?r=eyJrljoiZTAxY2EyOTAtYTdhMS00NTRiLWlONdktM2U1ZDI0NzY0ZTU5liwidCI6ImFhMjFiNjQwLWJhYzItNDU2ZC04NTA1LWYyY2MwN2Y1MTc4NCJ9>
- Burnet Institute and Kirby Institute. (2022). *Australia's progress towards hepatitis C elimination: annual report 2022*. <https://www.burnet.edu.au/media/1trbt5iy/australias-progress-towards-hepatitis-c-elimination-annual-report-2022-anna-wilkinson.pdf>
- CAHMA. (2022). *Financial Statements for the year ended 30 June 2022*.
- Chalmers, J. & Ritter, A. (2012), Subsidising patient dispensing fees: The cost of injecting equity into the opioid pharmacotherapy maintenance system. *Drug and Alcohol Review*, 31: 911-917. <https://doi.org/10.1111/j.1465-3362.2012.00472.x>
- Chidwick, K., Pollack, A., Busingye, D., Norman, S., Grulich, A., Bavinton, B., Guy, R., & Medland, N. (2022). Utilisation of pre-exposure prophylaxis (PrEP) for HIV prevention in the Australian general practice setting: a longitudinal observational study. *Sexual Health*, 19(2), 101-111. <https://doi.org/https://doi.org/10.1071/SH21207>
- Commonwealth Director of Public Prosecutions. (2022). *Annual Report 2021-22*. Canberra: Commonwealth of Australia <https://www.cdpp.gov.au/system/files/CDPP%20Annual%20Report%202021-22.pdf>

- Commonwealth of Australia. (2021a). *Agency Resourcing Budget Paper No. 4 2021–22*.
https://parlinfo.aph.gov.au/parlInfo/download/library/budget/2021_04/upload_binary/bp4_2021-22.pdf;fileType=application%2Fpdf#search=%22library/budget/2021_04%22
- Commonwealth of Australia. (2021b). *Portfolio Budget Statements 2021–22, Budget Related Paper No. 1.8: Home Affairs Portfolio*. <https://www.homeaffairs.gov.au/reports-and-pubs/budgets/2021-22-home-affairs-pbs-full.pdf>
- Daglish, M.R.C., Hayllar, J.S., & McDonough, M. (2024) An Australian retrospective observational cohort comparison of the use of long-acting injectable buprenorphine products. In-press, Journal pre-proof, <https://doi.org/10.1016/j.josat.2024.209348>
- Debeck, K., Wood, E., Montaner, J., & Kerr, T. (2009). Canada's new federal 'National Anti-Drug Strategy': an informal audit of reported funding allocation. *Int J Drug Policy*, 20(2), 188-191. <https://doi.org/10.1016/j.drugpo.2008.04.004>
- Degenhardt, L., Webb, P., Colledge-Frisby, S., Ireland, J., Wheeler, A., Ottaviano, S., Willing, A., Kairouz, A., Cunningham, E. B., Hajarizadeh, B., Leung, J., Tran, L. T., Price, O., Peacock, A., Vickerman, P., Farrell, M., Dore, G. J., Hickman, M., & Grebely, J. (2023). Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review. *The Lancet Global Health*, 11(5), e659-e672. [https://doi.org/10.1016/s2214-109x\(23\)00057-8](https://doi.org/10.1016/s2214-109x(23)00057-8)
- Department of Finance. (2021). *Meeting the Senate Order for Entity Contracts (RMG 403)*. Australian Government. <https://www.finance.gov.au/publications/resource-management-guides/meeting-senate-order-entity-contracts-rmg-403>
- Department of Finance. (2022). List of Grant Contracts active during 2021 Calendar Year - Department of Health. Retrieved from <https://www.health.gov.au/sites/default/files/documents/2022/03/departamental-and-agency-contracts-senate-order-13-listing-grant-contracts-for-2021.pdf>
- Department of Health. (2017a). *National Drug Strategy 2017-2026*.
- Department of Health. (2017b, 28 April 2017). *Prevention and harm reduction programs*. Victorian State Government. Retrieved 6 November 2023 from <https://www.health.vic.gov.au/aod-treatment-services/prevention-and-harm-reduction-programs>
- Department of Health. (2018). *Fifth National Hepatitis C Strategy: 2018-2022*. Canberra: Department of Health
- Department of Health. (2021). *Budget 2021-2022. Portfolio Budget Statements 2021-2022. Budget Related paper No.1.7. Health Portfolio*. Canberra: Department of Health
- Department of Health. (2022a). *Annual Report 2021-2022*. Melbourne: Victorian Government <https://www.health.vic.gov.au/department-of-health-annual-report>
- Department of Health. (2022b). *Senate Order 13 (Murray Motion) List of Grant Contracts active during 2021 Calendar Year*. Department of Health <https://www.health.gov.au/sites/default/files/documents/2022/03/departamental-and-agency-contracts-senate-order-13-listing-grant-contracts-for-2021.pdf>
- Department of Health. (2022c). *Department of Health Annual Report 2021-2022*. Canberra: Department of Health
- Department of health. (2023). *Home > About us > Licences and permits > Service standards and performance – Import, export and narcotic manufacture*. <https://www.odc.gov.au/about-us/licences-and-permits/service-standards-and-performance-import-export-and-narcotic-manufacture>
- Department of Health. Department of Health. (2020). *Budget 2020-2021. Portfolio Budget Statements 2020-2021. Budget Related paper No.1.7. Health Portfolio*. Canberra: Department of Health
- Department of Home Affairs. (2019). *Home Affairs Portfolio: Illicit Drugs Action Plan*. <https://www.homeaffairs.gov.au/about-us-subsite/files/homeaffairs-illicit-drug-action-plan.pdf>

- Department of Home Affairs. (2022). *Annual Report, 2021-22*. Department of Home Affairs <https://www.homeaffairs.gov.au/reports-and-pubs/Annualreports/home-affairs-annual-report-2021-22.pdf>
- Department of Natural Resources and Environment Tasmania. (2023). *Annual Report 2022-23*. Tasmanian Government <https://nre.tas.gov.au/Documents/NRE%20Tas%20Annual%20Report.PDF>
- Department of Social Services. (2023). *Children and Parenting Support (CaPS)*. Canberra: Department of Social Services <https://www.dss.gov.au/families-and-children-programs-services-families-and-children-activity/children-and-parenting-support-caps>
- Director of Public Prosecutions ACT. (2022). *Annual Report 2021-2022*. ACT Government https://www.dpp.act.gov.au/__data/assets/pdf_file/0020/2102807/Annual-Report-2021-2022.pdf
- Director of Public Prosecutions Northern Territory. (2022). *Annual Report 2021-2022*. Northern Territory Government https://dpp.nt.gov.au/__data/assets/pdf_file/0005/1179095/2021-2022-annual-report-dpp.pdf
- Director of Public Prosecutions Tasmania. (2022). *Annual Report 2021-22*. Tasmanian Government https://www.dpp.tas.gov.au/__data/assets/pdf_file/0003/683121/AR_DPP_2021-22.pdf
- Duffy, J. (2019). Environmental Health (Clandestine Labs). Presented at 44th *Environmental Health Australia National Conference, Protecting People. Saving Lives*. Adelaide
- Dunlop, A., Lokuge, B., Masters, D., Sequeira, M., Saul, P., Dunlop, G., . . . Haber, P. (2020). Challenges in maintaining treatment services for people who use drugs during the COVID-19 pandemic. *Harm reduction journal*, 17(1), 1-7. doi:<https://doi.org/10.1186/s12954-020-00370-7>
- Equity Economics. (2021). *At what cost? The human and economic cost of Australia's offshore detention policies 2019*. <https://static1.squarespace.com/static/61b14c4abbc81a1543f55180/t/621875e307adbe435cc3071d/1645770225727/1912-At-What-Cost-report.pdf>
- European Monitoring Centre for Drugs and Drug Addiction. (2008). *Towards a better understanding of drug-related public expenditure in Europe*.
- Godfrey, C., Eaton, G., McDougall, C., Culyer, A. & The economic and social costs of Class, A. (2002) *Drug use in England and Wales, 2000*. London: Home Office. Retrieved from <https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=81239e878789f0accb4adb9c7a87e2aa1a17b94c>
- Gough, C. (2015). Is PrEP a realistic and ethical intervention for people who inject drugs? *HIV Australia*, 13(2), 45-47. <https://search.informit.org/doi/pdf/10.3316/informit.303665663010616>
- Government of Western Australia. (2022). *Western Australia State Budget 2021-2022: Budget Paper No. 2, Budget Statements Volume 1*. Perth: Government of Western Australia.
- Hajarizadeh, B., Grebely, J., Martinello, M., Matthews, G. V., Lloyd, A. R., & Dore, G. J. (2016). Hepatitis C treatment as prevention: evidence, feasibility, and challenges. *Lancet Gastroenterol Hepatol*, 1(4), 317-327. [https://doi.org/10.1016/s2468-1253\(16\)30075-9](https://doi.org/10.1016/s2468-1253(16)30075-9)
- Harm Reduction International. (2020). *Making the investment case: Cost-effectiveness evidence for harm reduction*. https://hri.global/wp-content/uploads/2020/04/COST_EFFECTIVENESS_BRIEFING-APRIL-2020-ENG.pdf
- Harm Reduction International. (2022). *Global State of Harm Reduction 2022*.
- Heard S, Iversen J, Geddes L, Kwon JA and Maher L. (2022b). *Needle Syringe Program National Minimum Data Collection: National Data Report 2022*. https://www.kirby.unsw.edu.au/sites/default/files/documents/NSP-NMDC-2022_National-Data-Report.pdf
- Heard, S., Iverson, J., & Maher, L. (2022a). *Australian Needle Syringe Program Survey National Data Report 2017-2021: Prevalence of HIV, HCV and injecting and sexual behaviour among NSP*

- attendees. https://www.kirby.unsw.edu.au/sites/default/files/documents/ANSPS_National-Data-Report-2017-2021.pdf
- Heard, S., Zolala, F., & Maher, L. (2023). *Australian Needle Syringe Program Survey National Data Report 2018-2022: Prevalence of HIV, HCV and injecting and sexual behaviour among NSP attendees*. https://www.kirby.unsw.edu.au/sites/default/files/documents/ANSPS_National-Data-Report-2018-2022.pdf
- Heath equity matters. (2023). *Pre-Exposure Prophylaxis (PrEP)*. Health equity matters,. Retrieved 10 October 2023 from <https://healthequitymatters.org.au/our-work/policy-and-submissions/prep/>
- Hepatitis Australia. (2022). *Financial Statements for the year ended 30 June 2022*. https://acncpubfilesprodstorage.blob.core.windows.net/public/bfb88ce0-2daf-e811-a961-000d3ad24182-17804a2b-d25c-40c2-b198-34a8c492fc76-Financial%20Report-44aaecfa-b996-ed11-aad1-00224811425f-Hepatitis_Australia_signed_Financial_Statement_2021-22.pdf
- Hepatitis C Virus Infection Consensus Statement Working Group. (2022). *Australian recommendations for the management of hepatitis C virus infection: a consensus statement (2022)*. Melbourne: <https://www.hepcguidelines.org.au/screening-and-diagnosis/>
- Hepatitis NSW. (2022). *HNSW Services & Annual Report 2021-2022*. https://www.hep.org.au/wp-content/uploads/2022/11/HNSW_2022_AnnualReport.pdf
- Hepatitis Queensland. (2022). *Annual Report 2021-2022*.
- Hepatitis SA. (2022). *Annual Report 2022*. https://acncpubfilesprodstorage.blob.core.windows.net/public/6637b10f-2caf-e811-a961-000d3ad24182-8ac365f8-6b31-41d3-af8b-2a5cd09ebb2b-Financial%20Report-10b9b62f-646c-ed11-81ac-000d3acbbbfb-21-22_AUDIT_Hepatitis_SA.pdf
- HRVic. (2022). *Annual Report 2021-2022*. <https://harmreductionvic.wixsite.com/annualreport-21-22>
- Hughes, C., & Ritter, A. (2008). *Monograph No. 16: A summary of diversion programs for drug and drug-related offenders in Australia* (DPMP Monograph Series, Issue.
- Hughes, C., Seear, K., Ritter, A., & Mazerolle, L. (2019). *Monograph No. 27: Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion* (DPMP Monograph Series, Issue.
- Joudo Larsen, J. (2014). *Restorative justice in the Australian criminal justice system*. Australian Institute of Criminology
- King, J., McManus, H., Kwon, A., Gray, R., & McGregor, S. (2022). *HIV, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2022*. Sydney: U. S. The Kirby Institute https://www.kirby.unsw.edu.au/sites/default/files/documents/Annual-Surveillance-Report-2022_HIV.pdf
- Kirby Institute. (2022). *Monitoring HIV pre-exposure prophylaxis (PrEP) uptake in Australia (Issue 7)*. https://www.kirby.unsw.edu.au/sites/default/files/documents/Monitoring-HIV-PrEP-uptake-in-Australia-newsletter_Issue7.pdf
- Kirby Institute. (2023). *Tracking the Progress 2022: National Hepatitis C Strategy*. Sydney: The Kirby Institute https://www.kirby.unsw.edu.au/sites/default/files/documents/Tracking-the-progress-2022_National-Hep-C-Strategy.pdf
- Kirwan, A., Winter, R., Gunn, J., Djordjevic, F., Curtis, M. & Dietze, P. (2020). *Final Report of the ACT Medically Supervised Injecting Facility Feasibility Study*. Melbourne: Burnet Institute & Canberra Alliance for Harm Minimisation and Advocacy. Retrieved from https://www.health.act.gov.au/sites/default/files/2021-03/ACT%20DCR%20report_February_2021_Final_18022021.pdf
- KPMG. (2014). *Evaluation of the Drug Court of Victoria: Final Report*. Magistrates' Court of Victoria. Retrieved from <https://www.mcv.vic.gov.au/sites/default/files/2018-10/Evaluation%20of%20the%20Drug%20Court%20of%20Victoria.pdf>

- Lancaster, K., Ritter, A., & Colebatch, H. (2014). *Problems, policy and politics: making sense of Australia's 'ice epidemic'*. *Policy Studies*, 35:2, 147-171. DOI: 10.1080/01442872.2013.875144
- Laurie, K., & McDonald, J. (2008). *A perspective on trends in Australian Government spending*. T. Treasury
- Legal Aid ACT. (2022). *Annual Report 2021/2022*. Canberra: Legal Aid ACT
https://www.legalaidact.org.au/sites/default/files/files/publications/Legal_Aid_Commission_Annual_Report_2021-2022_Final_4_Oct_2022.pdf
- Legal Aid New South Wales. (2022). *Annual Report 2021-2022*. Sydney: Legal Aid New South Wales
<https://www.legalaid.nsw.gov.au/about-us/annual-reports/annual-report-2021-2022>
- Legal Aid Queensland. (2022). *Annual Report 2021-22*. Brisbane: Legal Aid Queensland
<https://www.legalaid.qld.gov.au/About-us/Corporate-publications/Annual-reports/2021%E2%80%9322-annual-report>
- Legal Aid WA. (2022). *Annual Report 21-22*. Perth: Legal Aid WA
https://www.legalaid.wa.gov.au/sites/default/files/LAWA_Annual%20report%202022_Final_WEB.pdf
- Legal Services Commission South Australia. (2022). *Annual Report 2021-22*. Adelaide: Legal Services Commission South Australia
<https://lsc.sa.gov.au/resources/LSC%20Annual%20Report%2023028%20006%20Digital.pdf>
- Lim, M., Devine, A., Gray, R. T., Kwon, J. A., Hutchinson, J. L., & Ong, J. J. (2022). Lifetime cost of HIV management in Australia: an economic model†. *Sexual Health*, 19(6), 517-524. <https://doi.org/https://doi.org/10.1071/SH21250>
- Lind, B., Weatherburn, D., Chen, S., Shanahan, M., Lancsar, E., Haas, M., & De Abreu Lourenco, R. (2002). *New South Wales Drug Court Evaluation: Cost-effectiveness*.
<https://drugcourt.nsw.gov.au/documents/l15.pdf>
- Lintzeris, N., Deacon, R. M., Hayes, V., Cowan, T., Mills, L., Parvaresh, L., . . . Leung, M. C. (2021). Opioid agonist treatment and patient outcomes during the COVID-19 pandemic in south east Sydney, Australia. *Drug and Alcohol Review*. doi:<https://doi.org/10.1111/dar.13382>
- LiverWELL. (2022). *Annual Report 2021-2022*. <https://liverwell.org.au/wp-content/uploads/2021/10/LiverWELL-Annual-Report-for-web-1.pdf>
- Lyons, A. (30 January 2019). Inside North Richmond's safe injecting room. *The Royal Australian College of General Practitioners*. Retrieved from
<https://www1.racgp.org.au/newsgp/professional/inside-north-richmond%E2%80%99s-safe-injecting-room>
- Man N; Yang A; Sadaphale V; Linghu Q; Bruno R; Barratt M; Sutherland R; Peacock A. (2023). *Trends in the availability and type of drugs sold on the internet via cryptomarkets, October 2022 - September 2023*. NDARC, Sydney. <http://dx.doi.org/10.26190/rrwd-2g43>,
<https://ndarc.med.unsw.edu.au/resource/trends-cryptomarket-drug-listings-oct2022-sep2023>
- Man, N., Sisson, S.A., McKetin, R., Chrzanowska, A., Bruno, R., Dietze, P.M., Price, O., Degenhardt, L., Gibbs, D., Salom, C. and Peacock, A. (2022), *Trends in methamphetamine use, markets and harms in Australia, 2003–2019*. *Drug Alcohol Rev.*, 41: 1041-1052.
<https://doi.org/10.1111/dar.13468>
- Mayhew P. (2003). Counting the costs of crime in Australia. *Trends & issues in crime and criminal justice* no. 247. Canberra: Australian Institute of Criminology.
<https://www.aic.gov.au/publications/tandi/tandi247>
- McFadden, M., & Mwesigye, S.-E. (2001). Estimating the economic value of AFP fraud and drug investigations. *Platypus Magazine*, 73, 11-14.
- Mellor, R., Kearnes, M., Lancaster, K., McLauchlan, L., & Ritter, A. (2022). *Established Tables and Emergent Huddles: Exploring the Processes of Participation Associated With the Policy Changes to Opioid Pharmacotherapy Treatment in Australia in the Context of COVID-19*.

- Contemporary Drug Problems, 49(4), 385-404.
<https://doi.org/10.1177/00914509221123001>
- Mental Health Commission. (2022). *Annual Report 2021-22*. Perth: Government of Western Australia
<https://www.mhc.wa.gov.au/media/4480/annual-report-2021-22-interactive.pdf>
- Mewton, L., Visontay, R., Chapman, C., Newton, N., Slade, T., Kay-Lambkin, F. and Teesson, M. (2018). Universal prevention of alcohol and drug use: An overview of reviews in an Australian context. *Drug Alcohol Rev.*, 37: S435-S469. <https://doi-org.wwwproxy1.library.unsw.edu.au/10.1111/dar.12694>
- Midford, R., Cahill, H., Foxcroft, D. *et al.* (2012). Drug education in victorian schools (DEVS): the study protocol for a harm reduction focused school drug education trial. *BMC Public Health* **12**, 112. <https://doi.org/10.1186/1471-2458-12-112>
- Monds, L.A., Bravo, M., Mills, L., Malcolm, A., Gilliver, R., Wood, W., Harrod, M.E., Read, P., Nielsen, S., Dietze, P.M., Lenton, S., Bleeker, A.M. and Lintzeris, N. (2022), The Overdose Response with Take Home Naloxone (ORTHN) project: Evaluation of health worker training, attitudes and perceptions. *Drug Alcohol Rev.*, 41: 1085-1094. <https://doi.org/10.1111/dar.13474>
- Moore, T. J. (2005). *Monograph No. 01: What is Australia's "drug budget"? The policy mix of illicit drug-related government spending in Australia*. (DPMP Monograph Series, Issue.
- Mostardt, S., Flöter, S., Neumann, A., Wasem, J., & Pfeiffer-Gerschel, T. (2010). Schätzung der Ausgaben der öffentlichen Hand durch den Konsum illegaler Drogen in Deutschland. *Das Gesundheitswesen*, 72(12), 886-894. <https://doi.org/10.1055/s-0029-1243212>
- National Indigenous Australians Agency. (2023). *Low aromatic fuel*.
<https://www.niaa.gov.au/indigenous-affairs/health-and-wellbeing/low-aromatic-unleaded-fuel>
- NCHECR. (2009). *Return on investment 2: Evaluating the cost-effectiveness of needle and syringe programs in Australia*. Canberra: Department of Health and Ageing
- Newell, P., Hugel, J., Valley, P., Wright, J., Makin, S., Borysko, L., & Lau, A. (2011). *Guidelines for Environment Investigations, Remediation and Validation of former Clandestine Drug Laboratory Sites (Guidelines)*. Canberra: Commonwealth of Australia
- Nielsen S, Scott N, Tidhar T, Quiroga MM, Lenton S, Dietze P. (2022). The cost and impact of distributing naloxone to people who are prescribed opioids to prevent opioid-related deaths: findings from a modelling study. *Addiction*, 117: 1009–1019.
<https://doi.org/10.1111/add.15727>
- North Richmond Community Health. (2022). *Annual Report 2021-22*. Retrieved from
https://nrch.com.au/wp-content/uploads/2022/12/NRCH_AR-2022.pdf
- Northern Territory Legal Aid Commission. (2022). *Annual Report 2021/2022*. Darwin: Northern Territory Legal Aid Commission <https://www.legalaid.nt.gov.au/wp-content/uploads/NTLAC-Annual-Report-2021-22-WEB.pdf>
- NSW Bureau of Crime Statistics and Research (n.d). *NSW Adult Criminal Sentencing, 2018/19 to 2022/23*. <https://sentencingtool.bocsar.nsw.gov.au/>
- NSW EPA. (2021). *NSW Environment Protection Authority Annual Report 2020-2021: Protecting, restoring and enhancing the environment*. Sydney: NSW EPA
- NSW EPA. (2023). *NSW State of Environment > Contaminated Sites*.
<https://www.soe.epa.nsw.gov.au/all-themes/human-settlement/contaminated-sites>
- NSW Government Department of Education. (2023). *Support materials*.
<https://education.nsw.gov.au/teaching-and-learning/curriculum/pdhpe/planning-programming-and-assessing-pdhpe-k-12/planning-programming-and-assessing-pdhpe-11-12/about-life-ready/support-materials>
- NSW Health. (2022a). *Annual Report 2021-22*. St Leonards: N. Health
<https://www.health.nsw.gov.au/annualreport/Publications/annual-report-2022.pdf>
- NSW Health. (2022b). *Annual Report 2021-22: Finances*. Retrieved from
<https://www.health.nsw.gov.au/annualreport/Publications/2022/finances.pdf>

- NSW Police Force. (2012). *Annual Report 2011-12*. Retrieved from https://media.opengov.nsw.gov.au/pairtree_root/0f/c2/de/44/96/96/46/ea/89/00/b4/1a/1e/99/66/0e/obj/2011_12_NSWPF_Annual_Report.pdf
- NSW Police Force. (2013). *Annual Report 2012-13*. Retrieved from https://media.opengov.nsw.gov.au/pairtree_root/67/08/c3/d6/41/ba/45/db/a5/f3/1f/dc/c9/ed/5a/58/obj/document.pdf
- NSW Police Force. (2014). *Annual Report 2013-14*. Retrieved from https://media.opengov.nsw.gov.au/pairtree_root/4f/03/32/9f/fd/ce/46/92/a5/32/71/f6/1b/73/b9/39/obj/NSW_Police_Force_2013_14_Annual_Report.pdf
- NSW Police Force. (2015). *Annual Report 2014-15*. Retrieved from https://media.opengov.nsw.gov.au/pairtree_root/63/9c/80/94/3b/6f/45/7a/97/cb/d7/2f/e5/a9/58/55/obj/NSW_Police_Force_Annual_Report_2014_15.pdf
- NSW Police Force. (2016). *Annual Report 2015-16*. Retrieved from https://media.opengov.nsw.gov.au/pairtree_root/da/e4/24/fd/bc/64/42/5b/bd/f6/26/29/d8/12/6c/b8/obj/NSW_Police_Force_Annual_Report_2015_16.pdf
- NTAHC. (2022). *Financial Report for the year ended 30 June 2022*. <https://irp.cdn-website.com/7a46c311/files/uploaded/NTAHC-%202022%20Signed%20Financial%20Audit%20Report%20final.pdf>
- NUAA. (2022). *Annual Report 2021-2022*. <https://static1.squarespace.com/static/61bc083a85af43143a2eb69a/t/640e6029d7b9b40cf39f9857/1678663727861/NUAA+Annual+Report+2021-2022+-with+Financials.pdf>
- Office of Drug Control. (March 2023). *Cost Recovery Implementation Statement Regulation of Medicinal Cannabis 2021-22*. Canberra: Office of Drug Control <https://www.odc.gov.au/sites/default/files/2023-07/cris-regulation-of-medicinal-cannabis-2023-24.pdf>
- Office of Drug Control. (n.d.). *Office of Drug Control*. Department of Health and Aged Care. Retrieved 15 September 2023 from <https://www.odc.gov.au/>
- Office of Public Prosecutions Victoria. (2022). *Annual Report 21-22*. Victorian Government <https://www.opp.vic.gov.au/wp-content/uploads/2022/12/Office-of-Public-Prosecutions-Annual-Report-2021-2022-Final.pdf>
- Office of the Director of Public Prosecutions NSW. (2022). *Annual Report 2021/2022*. NSW Government https://www.odpp.nsw.gov.au/sites/default/files/2022-11/ODPP_Annual_Report_2021-2022.pdf
- Office of the Director of Public Prosecutions Queensland. (2022). *Annual Report 2021-2022*. Queensland Government <https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/f273b83e-d79c-4e32-a7a2-8d98de5011e0/odpp-annual-report-2021-22.pdf?ETag=47f0f361c91e2d5a8fbbba146896fc277>
- Office of the Director of Public Prosecutions Western Australia. (2022). *Annual Report 2021-22*. Western Australian Government <https://www.wa.gov.au/system/files?file=2022-10/ODPP%20Annual%20Report%202021-22.pdf>
- Olsen A, Baillie G, Bruno R, McDonald D, Hammoud M, Peacock A (2022). CanTEST Health and Drug Checking Service Program Evaluation: Interim Report. Australian National University: Canberra, ACT.
- Olsen A, McDonald D, Lenton S & Dietze P. (2015). *Independent evaluation of the 'Implementing Expanded Naloxone Availability in the ACT (I-ENAACT) Program', 2011-2014; final report*. Canberra.
- Palmer, A. Y., Wade, A. J., Draper, B., Howell, J., Doyle, J. S., Petrie, D., Thompson, A. J., Wilson, D. P., Hellard, M. E., & Scott, N. (2020). A cost-effectiveness analysis of primary versus hospital-based specialist care for direct acting antiviral hepatitis C treatment. *International Journal of Drug Policy*, 76, 102633. <https://doi.org/https://doi.org/10.1016/j.drugpo.2019.102633>

- PBHRWA. (2022). *Annual Report 2021/2022*. <https://harmreductionwa.org/wp-content/uploads/2023/07/Annual-Report-2022.pdf>
- Price, O., Man, N., Bruno, R., Dietze, P., Salom, C., Lenton, S., ... Peacock, A. (2022). *Changes in illicit drug use and markets with the COVID-19 pandemic and associated restrictions: findings from the Ecstasy and Related Drugs Reporting System, 2016–20*. *Addiction* (Abingdon, England), 117(1), 182–194. <https://doi.org/10.1111/add.15620>
- Productivity Commission. (2023a). *Report on Government Services 2023: Child protection services*. Productivity Commission <https://www.pc.gov.au/ongoing/report-on-government-services/2023/community-services/child-protection>
- Productivity Commission. (2023b). *Report on Government Services 2023: Corrective Services*. Productivity Commission <https://www.pc.gov.au/ongoing/report-on-government-services/2023/justice/corrective-services>
- Productivity Commission. (2023c). *Report on Government Services 2023: Courts*. Productivity Commission <https://www.pc.gov.au/ongoing/report-on-government-services/2023/justice/courts>
- Productivity Commission. (2023d). *Report on Government Services 2023: Police services*. Productivity Commission <https://www.pc.gov.au/ongoing/report-on-government-services/2023/justice/police-services>
- Productivity Commission. (2023e). *Report on Government Services 2023: Youth Justice Services*. Productivity Commission <https://www.pc.gov.au/ongoing/report-on-government-services/2023/community-services/youth-justice>
- Productivity Commission. (2023f). *Report on Government Services 2023: School education*. Productivity Commission <https://www.pc.gov.au/ongoing/report-on-government-services/2023/child-care-education-and-training/school-education>
- Queensland Government Department of Education. (2023). *School holidays and term dates*. Retrieved from <https://education.qld.gov.au/about-us/calendar/term-dates>
- QuIHN. (2022). *Financial Report 30 June 2022*. https://acncpubfilesprodstorage.blob.core.windows.net/public/8bfd0cec-38af-e811-a963-000d3ad24077-840dc4a4-2086-4426-9f9a-b18feefdf7b3-Financial%20Report-163cdd13-3e7b-ed11-81ad-000d3ad1400f-20220630_Final_Annual_Financial_Statements_150922_Signed.pdf
- QuIHN. (2023). *Our History*. QuIHN. Retrieved 10 September 2023 from <https://www.quihn.org/about/our-history/>
- QuIVAA. (n.d.). *What is QuIVAA?* QuIVAA. Retrieved 10 September 2023 from <https://quivaa.org.au/about/>
- Ramstedt, M. (2006). What drug policies cost: estimating drug policy expenditures in Sweden, 2002: work in progress. *Addiction*, 101(3), 330-338. <https://doi.org/10.1111/j.1360-0443.2005.01344.x>
- Read, P., Chronister, K. J., Kostovski, C., Harrod, M. E., Salmon, A., & Jauncey, M. (2019). Perceptions of people who inject drugs towards HIV pre-exposure prophylaxis in Australia. *Sexual Health*, 16(4), 383-388. <https://doi.org/https://doi.org/10.1071/SH18228>
- Reuter, P. (2006). What drug policies cost. Estimating government drug policy expenditures. *Addiction*, 101(3), 315-322. <https://doi.org/10.1111/j.1360-0443.2005.01336.x>
- Rice, J. M., Edwards, D., & McMillan, J. (2019). *Education Expenditure in Australia*. Australian Council for Educational Research (ACER). https://research.acer.edu.au/policy_analysis_misc/29
- Rigter, H. (2006). What drug policies cost. Drug policy spending in the Netherlands in 2003. *Addiction*, 101(3), 323-329. <https://doi.org/https://doi.org/10.1111/j.1360-0443.2006.01337.x>
- Ritter, A. (2010). Conceptualising 'balance' in national drug policy. *Drug and Alcohol Review*, 29(4), 349-351. <https://doi.org/https://doi.org/10.1111/j.1465-3362.2010.00210.x>

- Ritter, A., & McDonald, D. (2008). Illicit drug policy: Scoping the interventions and taxonomies. *Drugs: Education, Prevention and Policy*, 15(1), 15-35.
<https://doi.org/10.1080/09687630701204344>
- Ritter, A., Berends, L., Chalmers, J., Hull, P., Lancaster, K., & Gomez, M. (2014). *New Horizons: the review of alcohol and other drug treatment services in Australia*. Drug Policy Modelling Program, National Drug and Alcohol Research Centre.
- Ritter, A., McLeod, R., & Shanahan, M. (2013). *Monograph No. 24: Government drug policy expenditure in Australia - 2009/10* DPMP Monograph Series, UNSW.
- Rollings K 2008. Counting the costs of crime in Australia: a 2005 update. Research and public policy series no. 91. Canberra: Australian Institute of Criminology.
<https://www.aic.gov.au/publications/rpp/rpp91>
- Scott, N., Palmer, A., Tidhar, T., Stooze, M., Sacks-Davis, R., Doyle, J. S., Pedrana, A., Thompson, A. J., Wilson, D. P., & Hellard, M. (2022). Assessment of the cost-effectiveness of Australia's risk-sharing agreement for direct-acting antiviral treatments for hepatitis C: a modelling study. *The Lancet Regional Health - Western Pacific*, 18, 100316.
<https://doi.org/10.1016/j.lanwpc.2021.100316>
- Shanahan, M. (2011). *Assessing the economic consequences of two cannabis policy options*. PhD Dissertation. Drug Policy Modelling Program, UNSW.
- Smith, R. G., & Hickman, A. (2022). *Estimating the costs of serious and organised crime in Australia, 2020–21*. Australian Institute of Criminology
- Smith, R.G., Jorna, P., Sweeney, J., & Fuller, G. (2014). Counting the costs of crime in Australia: A 2011 estimate. Research and public policy series no. 129. Canberra: Australian Institute of Criminology. <https://www.aic.gov.au/publications/rpp/rpp129>
- Špacírová, Z., Epstein, D., García-Mochón, L., Rovira, J., Olry de Labry Lima, A., & Espín, J. (2020). A general framework for classifying costing methods for economic evaluation of health care. *Eur J Health Econ*, 21(4), 529-542. <https://doi.org/10.1007/s10198-019-01157-9>
- Spooner, C., & Hetherington, K. (2004). *Social determinants of Drug Use* (Technical Report, Issue. <https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/TR.228.pdf>
- Sutherland, R., Uporova, J., King, C., Jones, F., Karlsson, A., Gibbs, D., Price, O., Bruno, R., Dietze, P., Lenton, S., Salom, C., Daly, C., Thomas, N., Juckel, J., Agramunt, S., Wilson, Y., Que Noy, W., Wilson, J., Degenhardt, L., Farrell, M. & Peacock, A. (2022). *Australian Drug Trends 2022: Key Findings from the National Illicit Drug Reporting System (IDRS) Interviews*. Sydney: National Drug and Alcohol Research Centre, UNSW Sydney. DOI: 10.26190/5czp-af24
- Tan, S. S., Rutten, F. F. H., van Ineveld, B. M., Redekop, W. K., & Hakkaart-van Roijen, L. (2009). Comparing methodologies for the cost estimation of hospital services. *The European Journal of Health Economics*, 10(1), 39-45. <https://doi.org/10.1007/s10198-008-0101-x>
- Tasmania Legal Aid. (2022). *Annual Report 21/22*. Tasmania Legal Aid
https://www.legalaid.tas.gov.au/wp-content/uploads/2022/11/TLA-Annual-Report-21_22-1.pdf
- Teperski, A., & Rahman, S. (2023). *Why are Aboriginal adults less likely to receive cannabis cautions?* (Crime and Justice Bulletin No. 258, Issue.
<https://www.bocsar.nsw.gov.au/Publications/CJB/CJB258-Report-Cannabis-cautioning-2023.pdf>
- The Australian Government the Department of the Prime Minister and Cabinet. (2021). *Budget 2021-2022: Portfolio Budget Statements 2021-2022, Budget Related Paper No.1.11, Prime Minister and Cabinet Portfolio*. Canberra: The Australian Government the Department of the Prime Minister and Cabinet
- The Office of National Drug Control Policy. (2004). *National Drug Control Strategy: FY 2005 Budget Summary*. Washington, D.C.: T. W. House <https://www.ojp.gov/pdffiles1/ondcp/203723.pdf>
- The Office of National Drug Control Policy. (2021). *National Drug Control Strategy: FY 2022 Budget and Performance Summary*. Washington, D.C.: The White House

- <https://www.whitehouse.gov/wp-content/uploads/2023/03/NDCS-FY2022-Budget-Summary.pdf>
- Treloar, C., McLeod, R., Yates, K., & Mao, L. (2014). What's the Cost of Finding the Right Fit? The Cost of Conducting NSP Business in a Range of Modalities. *Contemporary Drug Problems*, 41(1), 41-56. <https://doi.org/10.1177/009145091404100103>
- Victoria Department of Health. (2023). *Review of the Medically Supervised Injecting Room: Final Report*. Retrieved from <https://content.health.vic.gov.au/sites/default/files/2023-03/review-of-the-msir-final-report-february-2023.pdf>
- Victoria Government Department of Education. (2022). *School Hours (including variation to hours)*. <https://www2.education.vic.gov.au/pal/school-hours/policy>
- Victoria Legal Aid. (2022). *Annual Report 2021-22*. Victoria Legal Aid <https://www.legalaid.vic.gov.au/annual-report>
- Whetton, S., Tait, R.J., Chrzanowska, A., Donnelly, N., McEntee, A., Muhktar, A., Zahra, E., Campbell, G., Degenhardt, L., Dey, T., Abdul Halim, S., Hall, W., Makate, M., Norman, R., Peacock, A., Roche, A., Allsop, S. (2020). *Quantifying the Social Costs of Pharmaceutical Opioid Misuse and Illicit Opioid Use to Australia in 2015/16*, Tait, R.J., Allsop, S. (Eds.). ISBN 978-0-6487367-0-7, Perth, WA, National Drug Research Institute, Curtin University
- Williams, O. D., Dean, J. A., Crothers, A., Gilks, C. F., & Gow, J. (2021). Economic evaluation of alternative testing regimes and settings to detect undiagnosed HIV in Australia. *BMC Health Services Research*, 21(1). <https://doi.org/10.1186/s12913-020-06040-5>
- Wilson, D. P., Donald, B., Shattock, A. J., Wilson, D., & Fraser-Hurt, N. (2015). The cost-effectiveness of harm reduction. *International Journal of Drug Policy*, 26, S5-S11. <https://doi.org/https://doi.org/10.1016/j.drugpo.2014.11.007>

Appendix 1: BBV testing and treatment

This ‘drug budget’ reports on proactive spending only (see Chapter 1). There are, however, some government funded services where the distinction between proactive (i.e. activities aiming to reduce drug use or harms) and reactive spending (i.e. costs incurred as a consequence of drug use, such as ambulance services) is less clear. One example is responding to blood borne virus (BBV) infections (screening, treatment). We have chosen to treat these as reactive government costs (a consequence of unsafe drug injection) and have not included them within our main estimates. However, it may be argued that provision of screening and treatment is a proactive cost aiming to reduce individual and collective harms associated with BBV infections. We provide an approach to costing, screening, and treating Hepatitis C and HIV below.

Hepatitis C testing and treatment

Hepatitis C testing and treatment represents a government expenditure with relevance for illicit drug use. Direct-acting antivirals (DAAs) have been listed on the Pharmaceutical Benefits Scheme since 2016. DAAs are an effective treatment for the hepatitis C virus (HCV) and represent a cure for many living with HCV, including people who inject drugs (PWID). The Fifth National Hepatitis C Strategy, 2018-2022 notes that expanding access to DAAs is crucial to reaching the international target of “elimination of viral hepatitis as a major public health threat by 2030” (Department of Health, 2018, p. 5). The costs associated with PWID with HCV may be seen as a reactive cost borne by governments. However, given the national strategies and international targets toward elimination, as well as investment in treatment for PWID living with HCV representing a government intervention in transmission and population prevalence of HCV, costs here could be argued to represent a proactive cost borne by government. This is particularly the case when considering treatment-as-prevention paradigms (Hajarizadeh et al., 2016).

There are two costs directly associated with HCV testing. Antibody tests, which test for hepatitis antigens or antibodies, and RNA tests, which confirm current HCV infection. Costs per test and staff costs (GP visits) were retrieved from Medicare Benefits Schedule Online. Antibody tests (item 69475) are \$15.65. RNA tests (item 69499) are \$92.20. GP visits (item 23) are listed as \$41.20.

Treatment costs were derived from Scott et al. (2022). Cost estimates per treatment in 2021-2025 are \$12,500, with staff and pathology costs in 2021 at \$1,166 (see also Palmer et al. (2020).

To apportion government expenditure relative to drug use, we would need to account for HCV antibody prevalence and treatment uptake. Research specific to PWID (Degenhardt et al., 2023) regarding antibody prevalence and treatment uptake provide substantially higher positivity rates than those given by Scott et al. (2022). There are approximately 98,500 PWID (between 70,500 and 125,000) in Australia (Degenhardt et al., 2023, supplementary material). Using figures given in Kirby Institute data tracking the progress of the National Hepatitis C Strategy, the current incidence of HCV among PWID is 16.1% (The Kirby Institute, 2023). Combining these figures gives an approximate estimate of 15,859 PWID with current HCV.

Testing and treatment expenditure in 2021

46.5% of PWID were tested for Hepatitis C in the previous 12 months in 2021 (The Kirby Institute, 2023), resulting in an estimate of 45,803 tests. This may be an overestimate as antibody tests are not typically used when a previous HCV infection is known. However, given antibody testing and staff costs, we estimate the total cost of this stage of testing to be \$2,603,872.

HCV antibody prevalence among PWID is 36% (Heard et al., 2022a). This is then applied to these testing numbers, resulting in an estimate of 16,489 positive antibody results.

Accessing PBS-subsidised DAAs requires “evidence of chronic infection documented by repeated HCV antibody positivity and HCV RNA positivity” (Hepatitis C Virus Infection Consensus Statement Working Group, 2022). Given this, the proportion of PWID receiving HCV treatment also received an RNA test confirming current infection. Other pathology tests required as per Australian treatment guidelines (Hepatitis C Virus Infection Consensus Statement Working Group, 2022; Palmer et al., 2020) are aggregated in pathology costs associated with treatment (included in the figures used by Scott et al. (2022), derived from Palmer et al. (2020)). To determine treatment figures in 2021, we use figures from the Australian Needle Syringe Program National Data Report 2017-2021. The ANSPS reports that the proportion of people with positive HCV antibody results, after excluding for spontaneous and treatment-induced clearance of HCV, reporting HCV treatment in previous 12 months was 28% in 2021 (Heard et al., 2022a) and 34% in 2022 (Heard et al., 2023). Applying the 2021 (28%) proportion to the estimated 16,489 positive antibody results gives a total of 4,617 PWID estimated to have received HCV treatment in 2021.

For RNA testing, this represents an estimated cost of \$615,893 in 2021/22. This is an underestimate. However, RNA testing represents a smaller proportion of total expenditure related to HCV. If all PWID who return a positive HCV antibody test receive an RNA test, this results in an estimated cost of \$2,199,619.

HCV treatment for 4,617 people represents an estimated cost of \$62,863,601 in 2021/22. The total estimate including antibody tests, RNA tests, and DAA treatment in 2021/22 was estimated to be \$66,083,366.

Treatment costs were derived from Scott et al. (2022). Scott et al. (2022) give sensitivity figures of treatment cost in 2021-25: low \$5000 + \$1116 staff and pathology costs; high \$25,000 + \$1116 staff and pathology costs. Using these figures, we get a low treatment estimate of \$28,236,911 and a high estimate of \$120,574,751 for 2021/22.

If using low (70,500) and high (125,000) estimates of # of PWID in Australia (Degenhardt et al., 2023, supplementary material) and retaining the 2021 estimated cost of treatment and associated pathology costs (\$13,616):

For low estimates: antibody testing is \$1,863,685, RNA testing is \$440,817 and treatment cost is \$44,993,745 for a combined total estimate of \$47,298,247.

For high estimates: antibody testing is \$3,304,406, RNA testing is \$781,590 and treatment cost is \$79,776,144 for a combined total estimate of \$83,862,141.

HIV testing and treatment

HIV testing and treatment represents another site of expenditure for governments relevant to PWID. In addition, the listing of pre-exposure prophylaxis (PrEP) on the PBS in April 2018 has allowed for an increase in access to the drug for preventing seroconversion for PWID. In 2021, the HIV prevalence for PWID was 1.5% (Heard et al., 2022a).

Testing

PWID report a 38% HIV testing rate in the past 12 months (Heard et al., 2022a), representing an estimated number of PWID testing for HIV as high as 37,430. Costs per test were retrieved from Williams et al. (2021), who determine the cost of HIV tests across six different regimes (e.g. Private GP, Sexual health clinic, home test), as well as the different federal/state funding arrangements for each. Probabilities for false positive/negatives and associated costs are also included. Minimum and maximum costs were taken for each setting and averaged to estimate costs for positive diagnoses, inflated to 2021/22,³⁹ of \$157.93 and negative diagnoses of \$137.07. Using 1.5% HIV prevalence rate for PWID, it is estimated that 36,869 tests returned negative results at a cost of \$5,053,572, and 561 returned positive results at a cost of \$88,670.

Treatment

HIV Surveillance data from the Kirby Institute reports there are 29,460 people living with HIV at the end of 2021 (King et al., 2022). 91% (26,830) received a diagnosis, and 92% (24,560) are receiving Anti-Retroviral Treatment (ART). Using these figures, of the 1.5% of PWID who are living with HIV, 1,345 are estimated to have received a diagnosis. The ANSPS national data report gives a much lower figure of 75% for PWID who live with HIV receiving ART. It is estimated 1,008 PWID are receiving ART. 1-year treatment costs (discounted by 3.5%) are taken from Lim et al.'s (2022) analysis, which gives a figure for 1-year treatment at \$14,916. This may be a slight overestimation as we do not take into account reductions in cost of treatment across multiple years. We use this figure to estimate the total cost for PWID receiving ART to be \$15,041,201.

PreP

Data relevant to PrEP was taken from the Kirby Institute reports monitoring PrEP uptake in Australia. Their second most recent report (at the time of writing), gives the number of people who had received PBS-subsidised PrEP at least once by end June 2022 as 56,994 (Kirby Institute, 2022). Dispensing figures provided in the most recent report allow us to estimate an average number of persons dispensed PrEP per month (quarterly average for 21/22, divided by three). This figure was then multiplied by 0.06 (the % of PWID across the population, Degenhardt 2023), to arrive at an estimate of 66 PWID being dispensed PrEP per month. A PrEP medication list was sourced from Chidwick et al. (2022, supplementary material) and searched on the PBS (<https://www.pbs.gov.au/pbs/home>) to derive an approved ex-manufacturer price (AEMP, the manufacturer unit price) in 2021/22 of \$35.10 and in 2022/23 of \$23.40, and a dispensed cost per prescription (DPMQ) in 2021/22 of \$49.88 and in 2022/23 of \$38.15. This DPMQ cost is the total cost charged to the person accessing PrEP. For PBS-subsidised medications, patients then pay a 'co-payment' for these medications. This 'co-payment' is lower for concession co-payments. Patients accessing medicines are also able to reach a safety net threshold, where once they reach a maximum price paid in a year they no longer pay the co-payment (if they were paying the concession rate) or they receive the reduced concession rate (if they are general patients) (<https://www.pbs.gov.au/info/healthpro/explanatory-notes/front/fee>). The possibility that this safety net cap was reached is not included in our estimates.

For medicines with an AEMP less than the DPMQ, the whole cost is borne by the patient, with pharmacies able to claim the difference between co-payment and DPMQ from the government

³⁹ Calculated using RBA Inflation calculator, which notes that total change in cost is 11.4 per cent, over 5 financial years from 2016/17 to 2021/22, at an average annual inflation rate of 2.2 per cent.
<https://www.rba.gov.au/calculator/financialYearDecimal.html>

(https://www.servicesaustralia.gov.au/about-pbs-for-pharmacists?context=22861&utm_id=9#a2). For medicines with higher AEMPs, the rest of the amount is subsidised by government.

As PrEP is an under co-payment medicine (i.e. the cost to the patient is higher than the cost of the medicine), the relevant cost to government is the difference between co-payment and DPMQ (Australian Institute of Health and Welfare, 2022a). The general co-payment in 2021 was \$41.30, in 2022 \$42.50, and was reduced in 2023 to \$30 (<https://www.pbs.gov.au/info/statistics/under-co-payment/ucp-data-report>). For our estimation purposes, we have used the 2022 general co-payment rate and DPMQ cost to estimate a cost to government per prescription filled of \$7.38 (DPMQ minus co-payment).

This figure was multiplied by the average number of prescriptions filled per person per year (Chidwick et al., 2022) to arrive at a cost per person per year to government of \$71.59. This results in an estimated cost of \$4,724 for PWID who are on PrEP. This is likely a substantial underestimate.

The total cost of HIV prevention, testing, and treatment for PWID is estimated to be \$20,188,167.

It is also worth noting that there are some complexities that attend PrEP for PWID, particularly around the relationship to NSPs (Read et al., 2019), cost-effectiveness, and potential coercive use (Gough, 2015; Heath Equity Matters, 2023).

Appendix 2: Activities by governments to proactively respond to illicit drugs

As noted by Ritter and McDonald (2008), a strength of the four pillars approach is the relative ease and consistency of assigning activities to domains. That means activities rarely sit across multiple domains. However, instances of activities that do not sit comfortably within one domain do exist (e.g. outreach programs which can include harm reduction activities such as blood-borne virus prevention advice while also aiming to improve access to treatment). In addition, the source of funding for some activities means we must reconsider where to classify the expenditure (e.g., drug courts, where some of the costs come clearly under law enforcement, but also have treatment related costs). This especially has consequences for the final breakdown of each domain's proportion of the whole, and the question of balance across domains. Details of where these items are costed are included in the third column of Table A1.

This initial mapping exercise came with the assumption (or hope, rather) that we would find a line item (i.e. labelled drug-related expenditure) for each activity and this would help us to calculate total expenditure for each domain and for overall drug policy expenditure. However, the function of the activity list had to be reconsidered as the costing of individual activities conflicted with 1) the availability of data on expenditure of public funds relevant to drugs, and 2) our approach to refining a consistent method to calculate expenditure. As such, the activity list was a tool for validation and verification to ensure we had not missed key funding. The activity list also gives further insight into the limitations and future areas of focus for drug expenditure studies.

Table A1: List of interventions/activities by domain, and by inclusion in total estimates

Activity	Description	What was costed in the drug budget?
Prevention		
School-based drug education (SBDE) programs	Programs within schools, aimed at preventing uptake of drug use, that use education, and/or skills-based approaches	Included in Prevention
Whole of community information, education	Broad information services, fact sheets, telephone lines for general public	Largely included within Prevention, consolidated under two items: Federal government general prevention and State and Territory governments general prevention.
Community-building / neighbourhood enhancement programs	Suburb/community renewal programs including physical improvements and provision of social programs, sports and recreation programs, jobs, education for whole of community	
Targeted media campaigns to at-risk groups	Social marketing campaigns to at-risk groups, e.g. overdose prevention campaigns	
Community/system-wide prevention programs, targeting youth	Multifaceted prevention that includes community, family and school components	
Mass media campaigns	Target whole of population; education and information	Federal campaigns are not costed separately. State/Territory general prevention expenditure is

Activity	Description	What was costed in the drug budget?
		estimated is calculated using and includes campaigns.
Infancy and early childhood programs for at-risk groups; At-risk family interventions; pre-natal programs	Antenatal programs, family interventions, parent education programs	Included in Prevention
Proactive classroom management and school policy	School programs and classroom management	Not able to be costed separate to SBDE costs
At-risk youth programs; Mentoring and peer support programs	Programs for at-risk youth e.g. truancy at schools, transition programs from primary to secondary school; mentoring programs for at-risk youths	Not included. (Proactive only if specific goal to reduce future drug use).
Treatment		
Specialist AOD treatment	Includes withdrawal, residential rehab, counselling, therapy, case management etc	Included in Treatment
Hospital-based AOD treatment	Admission for purposes of AOD treatment (withdrawal). Does not include incidental withdrawal in context of admission for another purpose.	Included in Treatment
Early and brief interventions in primary healthcare settings	Provided by GPs (screening and brief interventions). Includes motivational interviewing	Included in Treatment
Telephone information and counselling services	Provision of 24/7 information, advice and counselling services through the telephone – people who use drugs, family members, community members	Included in Treatment
Opioid Agonist Treatment	Pharmacotherapy maintenance program: methadone, buprenorphine, Long Acting Injectable Buprenorphine, etc	Included in Treatment
Naltrexone maintenance	Relapse prevention using opioid antagonist medication	Included in Treatment
In-custody withdrawal services	Prison-based withdrawal services	Not included
Drug driving programs	Drug driving offenders compulsory treatment/education	Not included
Drug education in prison; drug treatment in prison	Education programs to prevent or reduce likelihood of uptake of drugs; Various prison programs: withdrawal, relapse prevention and pharmacotherapy maintenance	Some costs for drug treatment (e.g. pharmacotherapy) in prison included in Treatment; Drug education in prisons not able to be costed
Family Treatment Services	Counselling and support programs for people affected by a family member's drug use or to support people seeking information about how to help family members receive treatment	Included in Treatment
Allied Health Services	Better Access, Medicare rebates to eligible recipients	Included in Treatment
Treatment associated with diversion, depenalisation, partial prohibition, and cautioning schemes	People referred via the police and criminal justice system into drug treatment	Included in Treatment. See also Appendix 14, Diversion
Parole programs, and other post-release programs	Drug treatment programs as part of parole order	Treatment components may be included in Treatment. Not

Activity	Description	What was costed in the drug budget?
		included in law enforcement (See Community corrections – assumptions and caveats)
Healthcare liaison services	e.g. Alcohol and Drug Consultation and Liaison Services	Included in Treatment
Involuntary treatment	Mandated treatment (e.g. via court order)	Treatment costs included in Treatment; Court costs included in Law Enforcement
Employee assistance programs	Assessment and treatment provided by workplaces	Excluded: not government funded
Real time prescription monitoring	Monitoring the prescribing and dispensing of controlled medicines to reduce misuse	Not included
Harm reduction		
Peer education	Various peer education programs for people who use drugs to reduce harm, improve treatment access etc.	Included in Harm Reduction, within peer-led drug user organisations
Needle Syringe Programs	Provision of clean injecting equipment, including needles, syringes, swabs, water	Included in Harm Reduction
Overdose prevention programs, incl Peer-administered naloxone	Improving witness responses, education on overdose prevention, training users in CPR, ambulance responses to overdose. Making naloxone available to injecting drug users to administer in overdose situations.	Included in Harm Reduction (Take-home naloxone only)
Drug checking	Voluntary submission of sample for drug testing	Excluded from main estimate. Details in Appendix 5
BBV prevention and education programs	Harm reduction programs aimed at reducing the risk of HIV and other blood borne viruses (hepatitis). Testing and counselling for blood borne viruses (as harm reduction intervention)	Excluded from main estimate. Details in Appendix 1
Harm reduction programs in prison	Provision of bleach	Not able to be costed, see Corrective Services - assumptions and caveats
Low aromatic fuel	OPAL fuel roll-out	Excluded from main estimate. Details in Appendix 12
Supervised Injecting facilities	Supervised room or service where injecting can occur without prosecution and in a safe environment	Included in Harm Reduction
Outreach programs	Programs targeting risk behaviours for blood borne viruses, but can also include outreach programs to improve access to treatment.	Included in Harm Reduction, within peer-led drug user organisations
Law enforcement		
Customs and border control	Seizures at the border (also known as interdiction)	Included in Law Enforcement
Routine policing against drugs	Local Area Commands routine policing against drug crimes. All drug-related police costs	Included in Law Enforcement
Court prosecutions for drug crimes	All the court costs associated with prosecuting drug crimes (across Magistrate, District, Supreme, High, and Children's courts)	Included in Law Enforcement
Legal expenses (Public Prosecutions and Legal Aid)	Costs associated with government prosecutions of drug crimes; and government funded defence of people accused of drug crimes	Included in Law Enforcement

Activity	Description	What was costed in the drug budget?
Drug squads	Dedicated units within state/territory police focussed just on drugs, intelligence-led policing, undercover operations, raids etc	Included in Law Enforcement within routine policing against drugs
Diversion: pre-trial, pre-sentence; post-sentence	Police and Court diversion; Treatment a condition of bail; Delay of sentence whilst treatment undertaken; Inclusion of treatment program within the sentencing options, deferred sentencing, non-custodial sentence with conditions	Excluded from main estimate. Details in Appendix 14
Clandestine laboratory detection and destruction	Mainly for methamphetamine - special teams to dismantle clandestine laboratories (within police)	Excluded from main estimate. Details in Appendix 10
Roadside drug testing	Roadside and/or random drug testing by police	Excluded from main estimate. Details in Appendix 8
Controls on precursor chemicals	In the case of heroin, particularly acetic anhydride. For methamphetamine, pseudoephedrine.	Excluded from main estimate. Details in Appendix 11
Drug Courts	Program of court-based interactions with treatment and support services for drug offenders	Some costs included in Law Enforcement (see Court prosecutions - assumptions and caveats) Treatment costs included in Treatment
Multi jurisdictions taskforces/partnerships	Coordinated actions between law enforcement agencies across jurisdictions	Not costed
Asset forfeiture against arrestees involved in drug related activities	Seizing assets of people convicted of drug crimes	Not costed
Corrective services	Prison costs and management of people in prisons	Included in Law Enforcement
Community corrections	Custodial and non-custodial orders in the community	Included in Law Enforcement
Civil remedies and third-party policing and drug nuisance abatement	Procedures and sanctions, specified by civil statutes and regulations, used to prevent or reduce criminal problems and incivilities; typically aim to persuade or coerce nonoffending third parties to take responsibility and action to prevent or end criminal or nuisance behaviour.	Not readily identifiable or able to be costed
Crop eradication and/or substitution (replacement) programs	Relevant for cannabis crops in Australia	Not able to be costed
Financial controls and monitoring; money laundering detection and prevention	Use of financial controls and surveillance to monitor financial activities and potential money laundering.	Not costed separately to border control activities
Restorative justice programs	Range of informal justice practices designed to require offenders to take responsibility for their wrongdoing and meet the needs of the victim(s), community	Excluded from main estimate. Details in Appendix 17
Medicinal market management	Security and management of medicinal crops (poppy and cannabis)	Excluded from main estimate. Details in Appendix 9
Community policing	Community-based crime prevention; proactive servicing as opposed to emergency response;	Not able to be costed.

Activity	Description	What was costed in the drug budget?
	public participation in the planning and supervision of police operations, and shifting of command responsibility to lower rank levels	

Appendix 3: Top-down vs. bottom-up approaches

Contemporary cost analysis methodologies describe four different approaches to cost-estimates: top-down gross-costing, top-down micro-costing, bottom-up gross-costing and bottom-up micro-costing (Tan et al., 2009). These are based on whether the cost components are highly aggregated or detailed (gross-costing vs micro-costing), and whether the relevant costs are valued by working your way down from comprehensive sources or working your way up by identifying direct resource use (top-down vs bottom-up) (Tan et al., 2009). Selection of the costing methodology should be driven by the research question, and the feasibility of accessing or collecting the necessary data (Špacírová et al., 2020). Our approach has been to collect top-down expenditure estimates for activities wherever possible. As part of our sensitivity analysis and triangulation efforts, we also collected bottom-up estimates for many activities. Finally, there are a few activities for which it was not possible to arrive at a top-down expenditure estimate. In those cases, we have used bottom-up only.

Within the prevention domain, we estimated four figures which each contribute to the total prevention estimate, three of them are top-down, one is bottom-up.

Within the treatment domain, we arrived at one overall top-down estimate that would include all drug-related treatment, except treatment in correctional facilities. In-custody treatment is broken down into three elements (pharmacotherapy, detoxification, and counselling) (See Appendix 4). We have also calculated two alternative bottom-up estimates to check our treatment figures. For cross-domain comparisons, we have chosen to use the overall top-down treatment estimate.

For law enforcement, the five main estimates are all top-down gross-cost estimates (customs, policing, courts, legal expenses, corrections), as bottom-up estimates were not feasible. The nature of our law enforcement cost estimates also guided our selection of top-down estimates for other domains, in order to arrive at a meaningful comparison with the estimated costs of the prevention and treatment domains.

However, we have no top-down estimates for the harm reduction domain. Our expenditure estimate for the harm reduction domain is based on a compilation of bottom-up cost estimates of individual harm reduction activities. This means that the validity of the comparisons between the prevention, treatment, and law enforcement domains with the harm reduction domain are poor, as top-down estimates are generally higher than bottom-up estimates. However, in the absence of any other data we have chosen to include these estimates. There remains utility in cross-domain comparisons despite the mixing of methodologies (Tan et al., 2009).

Table A2: Activities included in the drug budget, by methodology

	Top-down	Bottom-up	Notes
Prevention			
School based drug education	\$276,084,743		% of drug-related SBDE by total education expenditure
Federal government general prevention		\$13,651,723	Individual program costs (based on organisations financial reports)
State and Territory governments general prevention	\$66,723,077		Per capita average from WA and Vic spending

	Top-down	Bottom-up	Notes
Infancy and parental programs	\$12,458,711		% of DUD by spending on Intensive family support services and family support services
Treatment			
Drug treatment	\$1,300,201,062		% of drug treatment by total health expenditure
Harm reduction			
Needle and syringe programs		\$56,870,000	Unit cost of needle syringes distributed across delivery methods, CPI'd to 2021/22 values, then multiplied by number of needles distributed
Peer-led drug user organisations		\$9,525,626	Total individual organisation budgets, reduced to account for double counting
Take home naloxone		\$14,902,314	Based on cost estimates from trial program and applied to total number of NSPs providing THN programs
Supervised injecting rooms		\$8,599,600	Individual line item from financial report (multiplied to include both clinics/rooms)
Law enforcement			
Customs and border control	\$598,930,008		% of drug-related border activity by relevant Home Affairs budget
Routine policing against drugs	\$1,802,400,000		% of drug-related policing by total police budget
Court prosecutions	\$164,590,925		% of drug-related court activity, by court level, by total court costs.
Legal expenses – Public Prosecution	\$76,767,153		% of drug-related court activity by total public prosecution expenditure
Legal expenses - Legal Aid	\$67,081,704		% of drug-related court activity by total government-funded Legal Aid
Corrective services - Prisons	\$715,323,037		% of people in prisons with illicit drug offence as main offence by total prison expenditure
Community corrections	\$78,898,001		% of people with community corrections orders with illicit drug offence as main offence by total community corrections expenditure

Appendix 4: Drug treatment – Bottom up approach

To calculate a bottom-up estimate for drug treatment expenditure in 2021/22 we followed methods outlined by Ritter, Chalmers & Berends (2015) and Ritter et al. (2014), including supplementary methods papers provided. Each activity related to drug treatment was estimated using the methods outlined by these authors, except for specialist AOD treatment and OAT expenditure. Specialist AOD treatment was costed by Ritter et al. (2015) using information about funding amounts provided by state and territory health officials.]Without this information a different method was employed here - using an average cost of a non-residential episode of care and average cost of a residential episode of care (pharmacotherapy maintenance was costed separately) and applied these unit costs to the number of episodes of care where illicit drugs were the primary drug of concern. OAT expenditure followed the approach used in the previous report on Australian government expenditure on drug policy (Ritter et al., 2013).

Table A3: Drug treatment, bottom-up estimate

Activity	Total expenditure
Specialist AOD treatment	\$605,984,337
Hospital based treatment	\$75,804,424
OAT	\$126,227,726
In-custody treatment	\$61,070,941
PBS	\$137,713,820
Allied Health Services	\$74,439,000
Total	\$1,081,240,250

Specialist AOD treatment

This activity is related to drug treatment provided by publicly funded government and non-government AOD services. This activity relies on information reported to, and by, the AODTS-NMDS.

In 2021/22 the AODTS-NMDS, which reports on drug treatment provided by specialist AOD services, reported 224,712 closed episodes of care (AIHW, 2023a), excluding pharmacotherapy. The key variable to working out the expenditure of treatment for illicit drug use is finding the average cost of a closed episode of care. There are various sources reporting different costs, see Table A4.

Table A4: Costs of a closed episode of care for illicit drug use

Source	Costs	CPI 2021/22
Residential rehabilitation cost of an episode of care		
WA MH Commission 'The Plan'	\$11,768	\$12,865.93
NSW Health The NSW Alcohol and Drug Residential Rehabilitation Costing Study (2005)	\$4442	\$6,828.50
Average cost of residential rehabilitation episode of care		\$9,847.22
Non-residential rehabilitation cost of an episode of care		
WA MH Commission 'The Plan'	\$1,753	\$1,916.55
Government Drug Policy Expenditure in Australia 2009/10 (Ritter et al., 2013)	\$2388	\$3,092.87

Source	Costs	CPI 2021/22
NSW Health AOD Budget	\$7369.86 ⁴⁰	\$7369.86
Average cost of episode of care (excluding rehabilitation)	-	\$4,126.43

Using the unit cost of \$4126.43 for treatment types that are not rehabilitation or pharmacotherapy the following table gives a breakdown of the total expenditure for each state and territory.

Table A5: Cost of treatment (excluding residential rehabilitation and pharmacotherapy per state and territory)

	Cost per completed treatment episode	Number of episodes (illicit drug as principal drug of concern)	Total cost of illicit drug treatment
NSW	\$4,126.43	21980	\$90,698,931.40
Vic	\$4,126.43	57402	\$236,865,334.86
QLD	\$4,126.43	28783	\$118,771,034.69
WA	\$4,126.43	9806	\$40,463,772.58
SA	\$4,126.43	5286	\$21,812,308.98
Tas	\$4,126.43	1405	\$5,797,634.15
ACT	\$4,126.43	3682	\$15,193,515.26
NT	\$4,126.43	1832	\$7,559,619.76
S/T total	\$4,126.43	130176	\$537,162,151.68

The unit cost for an episode of care in residential rehabilitation is \$9,847.22. The following table shows the total expenditure for each state and territory in relation to rehabilitation for illicit drugs.

Table A6: Cost of residential rehabilitation treatment (per state and territory)

	Cost per completed treatment episode	Number of episodes (illicit drug as principal drug of concern)	Total cost of illicit drug treatment
NSW	\$9,847.22	2,743	\$27,010,910.75
Vic	\$9,847.22	1,334	\$13,136,184.81
QLD	\$9,847.22	1,453	\$14,308,003.40
WA	\$9,847.22	505	\$4,972,843.58
SA	\$9,847.22	106	\$1,043,804.79
Tas	\$9,847.22	367	\$3,613,927.91
ACT	\$9,847.22	228	\$2,245,165.02
NT	\$9,847.22	253	\$2,491,345.40
S/T total	\$9,847.22	6,989	\$68,822,185.64

⁴⁰ NSW Health announced their 2021/22 budget for AOD services to be \$330 million. Given there were 44,777 episodes of care in NSW during the same reporting period we divide \$330 million by 44,777 giving us an average of \$7369.86 per episode of care.

The total estimated expenditure for states and territories for all treatment types excluding pharmacotherapy is \$605,984,337.32.

The key assumption in this approach is that all treatment types, excluding residential rehabilitation, cost the same amount.

Hospital based treatment

Drug treatment in hospital relevant to this project include detoxification and withdrawal services and is based on activities that have been designed to proactively treat illicit drug use. As such, emergency department responses to illicit drug use are excluded from this expenditure.

Hospitals funding is activity based, and calculated using National Weighted Activity Units (NWAUs). NWAUs are calculated based on the number of hospital separations, which have allocated AR-DRG⁴¹ codes. The codes relevant to illicit drug treatment are:

- V61A Drug Intoxication and Withdrawal, Major Complexity
- V61B Drug Intoxication and Withdrawal, Minor Complexity
- V63Z Opioid Use and Dependence
- V64A Other Drug Use and Dependence, Major Complexity
- V64B Other Drug Use and Dependence, Minor Complexity

NWAUs are multiplied by the National Efficient Price (NEP) to determine the estimated government expenditure on hospitals.

Table A7: Calculations and expenditure associated with acute admissions related to illicit drug use disorders

	Estimate	Figure reference
NEP 2021-22	\$5,597	a
Separations 2021-22	9,972	b
NWAUs 2021-22	13,543.76	c
Estimated expenditure (a*c)	\$75,804,424.72 [^]	d
2021-22 average Commonwealth contribution	Approximately 31% ^{^^}	e
Estimated Commonwealth contribution (d*e)	\$23,473,006.40	f
Estimated state/territory contribution (d-f)	\$52,331,418.32	g

[^]less than previous budget as we have excluded alcohol

^{^^}based on ABS Government Finance Statistics 2021-22, Tables 130, 231-238, and Administrator of the National Health Funding Pool

Opioid Pharmacotherapy Treatment

The National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collects information about people currently accessing pharmacotherapy treatment (on snapshot day) (AIHW, 2023d). On a snapshot day in 2022, the NOPSAD reported there were 55,741 (2010 number was 46,078) people receiving pharmacotherapy treatment. Opioid dependence can be managed through treatment using agonist and antagonist pharmacotherapy. There are four medications available on the PBS that can be used for treatment. These include: Methadone, Buprenorphine, Buprenorphine-naloxone, Buprenorphine Long Acting Injectable (LAI). In 2019, Buprenorphine LAI was added to the PBS for

⁴¹ Australian Refined Diagnosis Related Groups

opioid maintenance treatment. Table A8 outlines the numbers of clients by state/territory and by drug type. In 2022, most clients resided in NSW (44.5%), followed by Victoria (27.2%) and Queensland (14.3%), which is the same trend as the previous 2009/10 'drug budget' (Ritter et al., 2013).

Table A8: Opioid pharmacotherapy clients, a snapshot day in June 2022

State/ Territory	Methadone	Buprenorphine	Buprenorphine-naloxone	Buprenorphine LAI	Total
NSW	13166	11617	n.a.	n.a.	24783
Vic	9318	682	3637	1516	15153
Qld	2523	684	3304	1450	7961
WA	1615	53	758	542	2968
SA	413	15	506	64	2972
Tas	263	69	269	128	729
NT	48	19	54	61	182
ACT	653	5	187	148	993
TOTAL	27999	13144	8715	3909	55741

There are three components of OAT expenditure: the cost of OAT medications, the cost of prescribing, and the cost of dispensing. To find the expenditure for this activity we had to find the separate costings for each of these components.

The cost of opioid pharmacotherapy medications is covered by the government under Section 100 of the National Health Act 1953 (Chalmers & Ritter, 2012) and is included as PBS expenditure (outlined below). This section calculates the two other components of OAT expenditure, prescribing and dispensing.

Costs of prescribing

To find the cost of prescribing opioid pharmacotherapy treatment we followed the top-down approach used in the previous budget. This approach sees the cost of prescribing as a proportion of all GP visits, given the requirement of people receiving this treatment to see a GP for prescriptions and monitoring.

Table A9: Opioid pharmacotherapy by general practitioners, numbers of cases and total visits, 2021/22

State	Patients	GP proportion*	Average visits**	Total GP visits associated with pharmacotherapy
NSW	24783	50.1%	12	148995.40
Vic	15153	91.6%	12	166561.78
QLD	7961	62.9%	12	60089.63
WA	2968	34.6%	12	12323.14
SA	2972	46.4%	12	16548.10

State	Patients	GP proportion*	Average visits**	Total GP visits associated with pharmacotherapy
Tas	729	54.6%	12	4776.41
ACT	993	47%	12	5600.52
NT	182	0.5%	12	10.92
Total	55741			414905.88

*Using 'Table S3 Clients receiving pharmacotherapy treatment on a snapshot day, by pharmacotherapy type and prescriber type, states and territories, 2005 to 2022' from NOPSAD 2022 data tables (AIHW 2023d)

**The number of average visits was used in the previous 'drug budget' based on an assumption by the authors (Ritter et al., 2013).

The estimated government expenditure on pharmacotherapy related GP visits for 2021/22 was \$17,855,209.79 (which equates to \$43.03 per visit).

Cost of dispensing

The third aspect of OAT expenditure to calculate is the cost of dispensing. However, prior to 2023 the government did not cover the dispensing cost of OAT. As such, government expenditure on OAT is calculated by bringing together the cost of medication and the cost of prescription.

The total government expenditure by the government on pharmacotherapy treatment was \$126,227,726.48

In-custody treatment

There are 3 components to calculating the total cost of treatment in prisons (Ritter et al., 2013). These include opioid maintenance therapy, detoxification and withdrawal services, and counselling services.

Opioid maintenance therapy in custody

On a snapshot day in 2022, 55,741 people were receiving pharmacotherapy treatment. Of this, 9.8% (5,481 people) were receiving treatment in a correctional facility. With the majority of people receiving buprenorphine (2,571), followed by methadone (1,818), buprenorphine LAI (731) and buprenorphine-naloxone (151). On the snapshot day, 5,100 people (9.1%) were being dosed in a correctional facility.

There are 2,982 prescribers nationally, of this 137 (4.6%) are reported as a correctional facility (AIHW, 2023d). Following the previous method, we need to CPI the average per prisoner cost of pharmacotherapy maintenance. Ritter et al. (2013) used an average cost of \$3,500 per prisoner. Indexed for 2021/22, this would be \$4,533.10. We then use this unit cost and apply it to the number of people receiving pharmacotherapy in a correctional facility (5,481) to get a total of \$24,845,921.10.

Detoxification and withdrawal services in custody

Moore's (2005) method for calculating this activity relied on expenditure figures reported in Black et al. (2004) for NSW, WA and ACT, which were \$5,554,000, \$2,680,200, and \$90,145, respectively. We indexed these figures for 2021/22: \$8,743,231.81, \$4,219,231.16, \$141,908.29, to estimate a total of \$13,104,371.26 for these three states. In 2022, these three states account for 47% of the national prison population. So, to find the total amount we need to increase the cost proportional to the total prison population, which generates a total of \$27,594,975.33.

Counselling services in custody

Moore (2005) estimated the expenditure for counselling services for the national population of prisoners to be \$5,300,000 in 2002/03. Indexing for 2021/22 the estimated expenditure is \$8,343,379.29.

Bringing together the estimates for each of these activities: \$24,845,921.10 + \$27,594,975.33 + \$8,343,379.29, we estimate the total government (state and territory) expenditure for in-custody treatment to be \$61,070,941.37.

These bottom-up estimates for in-custody treatment could be strengthened by sourcing the current cost of OTP taking into account differences in medication proportions; State/Territory withdrawal figures; and State/Territory differences in the provision of detoxification sources.

Pharmaceutical Benefits Scheme

Medications used in the treatment of opioid dependence are provided separately through the PBS' Section 100 Highly Specialised Drugs Program. As such, there is separate expenditure for this reported in the PBS' Expenditure and Prescriptions Report 2021/22. The total expenditure for the Opiate Dependence Treatment Program was \$108,372,516.69.

However, other medications related to the treatment of illicit drugs, other than medication for opioid use, are funded through the PBS. To estimate this cost, we estimate the proportion of the total PBS expenditure on medication related to illicit drugs using information from Bettering the Evaluation and Care of Health (BEACH) dataset⁴²(Ritter, Chalmers & Berends, 2015).

In 2021/22, the Pharmaceutical Benefits Scheme (PBS) total expenditure was \$14,670,651,822.⁴³ BEACH data estimated the percentage of total prescribed medications related to non-medicinal drug use disorder (non-opioid) as 0.2%. Applying 0.2% to the \$14,670,651,822 results in an estimate of \$29,341,303.64 spent by the PBS on medication for illicit drug treatment. When combined with the Opiate Treatment Program expenditure the total PBS medication estimate is \$137,713,820.33.

Allied health services

In 2021, 1,338,424 people accessed at least one Better Access treatment service.⁴⁴ The total number of treatment services provided was 7,275,153. This includes services provided by a GP. A previous method sought to exclude GPs because of the calculation of GP early intervention AOD services. However, we do not have this data. However, not all Better Access treatment services are for AOD use.

The previous authors of this method were given the proportion of people accessing these services for AOD from the Better Access team. The proportion for clinical and registered psychologists was 8% and 10% for GPs.

⁴² The BEACH study collected data from 1998 to 2016.

⁴³ As reported in the PBS' Expenditure and Prescriptions Report 2021/22

⁴⁴ "Appendix 1. 'Any Better Access treatment service' refers to a service provided under any of the following Better Access MBS items in Appendix 1: psychological therapy services delivered by clinical psychologists or focussed psychological strategies services delivered by GPs/other medical practitioners, psychologists, social workers and occupational therapists" (p. 35)

Table A10: Expenditure for allied health services illicit drug treatment

2021	Total benefits paid for BA treatment services	8% AOD related treatment	9% proportion for AOD related treatment	10% proportion for AOD related treatment
Expenditure for Better Access treatment services	\$827,100,000	\$66,168,000	\$74,439,000	\$82,710,000

Using the median of 9% we estimate that government expenditure for allied health treatment related to illicit drug use is \$74,439,000.

Appendix 5: Drug checking

Drug checking is a service offered to people who would like to test drugs that they have in their possession to ascertain the chemical composition of the drug. At a drug checking service, clients will be asked to fill in a short survey about the drug they are bringing in. They will then deposit a small sample of the drug, between 0.01mg to 0.1mg, for testing. On-site chemists will then test the samples. A health care worker will deliver the results to the client, including harm reduction advice. The service can also link the client to any other health care services or interventions they might need. There have been three trials of drug checking in Australia to date, all three in Canberra in the ACT. Two were on-site at a festival (2018 & 2019) and one is currently in operation (2022-2024), off-site at a central location. In Australia, these services have been offered for free to clients to date. CanTEST is funded by ACT Health. We obtained the cost of operation for the first six months of the CanTEST service (\$206,482) from the final evaluation report (Olsen et al., 2022), with the breakdown of costs as reported reproduced here:

Table A11: Operating costs, example drug checking service

Item	Description	Original Budget (ex GST)
Equipment	Drug checking equipment, drug safe & disposal system, IT and office equipment etc.	\$26,780
Analytic resources	FTIR spectrometer lease, software, UPLC-PDA consumables	\$18,250
Staffing & professional fees		\$89,850
Office expenses		\$1,250
Administration		\$12,602
Other expenses incl. insurance		\$57,750
Total		\$206,482

Appendix 6: BBV Organisation funding

Peer-led drug user organisations are included in our main estimates to reflect an investment in harm reduction work. BBV organisations likewise do harm reduction work relevant to PWUD, however, these have not been included in our main estimates. Similarly to the above section on BBV testing and treatment (Appendix 1), it is arguable whether expenditure represents a direct, proactive response to reduce drug harms or a consequential response to harms having accrued. A method estimating government expenditure relevant to illicit drug use is discussed below.

For BBV organisations, a proportion of the budget was derived to be drug-specific. Organisations included are: Hepatitis Australia (2022), Hepatitis SA (2022), Northern Territory AIDS and Hepatitis Council (NTAHC) (2022), Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM, 2022), Hepatitis ACT (acnc.gov.au), Hepatitis NSW (2022), LiverWELL (incorporating Hepatitis Vic) (2022), Hepatitis Qld (2022), Hepatitis WA (acnc.gov.au), Tasmanian Council on AIDS, Hepatitis & Related Diseases (TasCAHRD) (acnc.gov.au), and ACON (previously the AIDS Council of NSW) (ACON, 2022).

This proportion we used was calculated using recent figures on the estimated number of people with current hepatitis C (HCV) (117,800) (most recent figures available for end 2020 (Burnet Institute and Kirby Institute, 2022), recent estimates on the number of PWID in Australia (98,500 (Degenhardt et al., 2023, supplementary material)), and recent estimates on the prevalence of current HCV among PWID (16.1%, (The Kirby Institute, 2023) to derive an estimate of 13.5% of the total population in Australia with HCV who are PWID. Using the same method employed in our estimates for peer-led drug user organisation funding, we then reduced these figures by 24% to reflect the proportion of funding not double counted in other costs which may be reflected elsewhere (i.e. NSPs). This figure was then applied to the budgets of BBV organisations to derive an estimate of drug-specific, harm reduction focussed expenditure for 2021/22 of \$3,512,367, see Table A12.

Table A12: BBV organisation grant funding, 2021/22, by proportion of PWIDLHCV and excluding double counting (\$)

Organisation	Grant funding, 2021/22 (\$)	Proportion of current HCV who are PWID	Proportion of funding not double counted	Grant funding, 2021/22, by proportion of PWIDLHCV and excluding double counting (\$)
Hepatitis Aus	2,009,622	13.5%	76%	\$204,408.25
Hepatitis SA	1,894,386	13.5%	76%	\$192,687.05
NTAHC	2,481,152	13.5%	76%	\$252,369.82
Hepatitis ACT	643,440	13.5%	76%	\$ 65,447.36
Hepatitis NSW	2,089,400	13.5%	76%	\$212,522.85
Hepatitis Qld	1,015,553	13.5%	76%	\$ 103,296.75
LiverWELL	1,850,296	13.5%	76%	\$188,202.44
Hepatitis WA	1,386,226	13.5%	76%	\$140,999.67
TasCAHRD	798,556	13.5%	76%	\$81,224.94
ASHM	4,305,600	13.5%	76%	\$490,331.43
ACON	16,057,302	13.5%	76%	\$1,633,264.87
Total	34,531,533			\$3,512,367.12

*Overseas funding was subtracted. Note: Columns may not sum due to rounding

Appendix 7: Estimating government expenditure on Take Home Naloxone

Government spending associated with the Take Home Naloxone program comprises:

- The cost of the drug (a federal government expenditure)
- Fees associated with supply to and reimbursement of dispensing/providing the naloxone which varies by different providers (i.e., community pharmacies, LHD services, hospital pharmacies, AOD treatment services, NGOs, injecting centres etc.)
- The gap in costs of supply/reimbursement from the federal government payments which is covered by state and territory health departments
- Training, monitoring/oversight and infrastructure costs (by state and territory health departments)
- Other costs to consider

We detail each these components below:

The cost of the drug

There are 6 different products available, they include⁴⁵:

- Nyxoid
- Prenoxad
- Naloxone Juno
- Naloxone Hydrochloride (DBL)
- Naloxone SXP
- Nyxoid 1.8mg (UK) temporary S19A approval

The Program Rules provide the wholesale cost of each product (see Table A13).

Table A13: Naloxone supply fees: WA MHC and Wholesalers

Bulk Supply – 1 pack (excluding GST)	Product
\$34.36	Nyxoid
\$22.29	Prenoxad
\$20.56	Naloxone Juno
\$20.56	Naloxone Hydrochloride (DBL)
\$20.56	NALOXONE SXP
\$90.00	Nyxoid 1.8 mg (UK) temporary S19A approval

Source: Pharmacy Programs Administrator “Take Home Naloxone Program Rules”, Table 7-5 (p. 10)

Supply and reimbursement models

There are different fee arrangements depending on the category the provider comes under. There are two categories for providers. There are Approved Providers, which includes community pharmacies, hospital-based pharmacies, and approved medical practitioners. Providers in this category are reimbursed by the Pharmacy Programs Administrator for each unit of naloxone they dispense. The other category is Authorised Alternative Suppliers, which includes NGOs, AOD

⁴⁵ Each has product is costed differently and for different providers, this information is provided Pharmacy Programs Administrator’s *Take Home Naloxone Program Rules* (2024, pp. 8-10), <https://www.ppaonline.com.au/wp-content/uploads/2022/06/Take-Home-Naloxone-Program-Rules.pdf>

treatment services, injecting centres, and outreach services. Pharmaceutical wholesalers (or s94 hospitals or Western Australia Mental Health Commission) provide naloxone to these services, and they are not reimbursed for supplying individual units of naloxone.

The Pharmacy Programs Administrator's Take Home Naloxone Program Rules outline the different expenditure associated with ensuring services have a provision of naloxone to dispense (see Table A14).

Table A14: Naloxone individual supply fee structure by Service Provider Type

Service Provider Type	Fee Structure
Community (S90) Pharmacies	Dispensed Price for Maximum Quantity (DPMQ) (Approved manufacturer price (AEMP) + wholesale mark-up + Tier 1 admin, handling and infrastructure fee + dispensing fee)
Public Hospital (S94) Pharmacies	Price to Pharmacist (PtP) (AEMP + wholesale mark-up)
Private Hospital (S94) Pharmacies	PtP + 1.4% of PtP + dispensing fee
Approved Medical Practitioners (S92)	DPMQ
Authorised Alternative Suppliers	Nil

Source: Pharmacy Programs Administrator "Take Home Naloxone Program Rules", Table 7-1 (p. 7)

A costing exercise requires numerating how many units were distributed across all states and territories and the proportions of units dispensed by Approved Providers compared to the proportion of units supplied to Authorised Alternative Suppliers.

The gap covered by state and territory health departments

Despite the fee structure outlined above, the Commonwealth government's reimbursement to government health services for dispensing naloxone covers only part of the cost to these providers. This gap is covered up by state and territory health departments. For non-government health services, a gap is covered due to transport costs incurred by wholesalers and the small amount of product provided to Authorised Alternative Suppliers. The cost of the gap to state and territory health departments differs across jurisdictions.

State and territory health department infrastructure and resources

In addition to supplying the drug and reimbursement of fees, state and territory health departments provide training courses and have designed a credentialling process for providers. The infrastructure required for this includes course design and trainers' time and fees. The fees associated with these processes are also dependent on the type of provider who is being trained.

Other costs to consider

- Naloxone can also be supplied through a prescription from a doctor. This means there will be dispensing fees covered by the PBS that do not relate to the program but are still related to the government expenditure on naloxone.
- During COVID-19 Public Health Orders and restrictions the NSW Users and AIDS Association (NUAA) trialed a postal service of naloxone for people who were at risk of contracting COVID-19 and for those who were unable to visit services to access naloxone. This is not currently a government funded activity. However, as introduced harm reduction activities have always begun at a grassroots level and expanded to become recognised as activities that require government funding, this is a potential future government cost.

Appendix 8: Roadside drug testing

This is an activity that involves equipment, police time and laboratory costs. However, police time for this activity is already accounted for in the total expenditure on routine policing of illicit drugs. Laboratory costs are hard to determine. As such the estimate provided here is only the expenditure on equipment.

The Bureau of Infrastructure and Transport Research Economics provides information about Roadside drugs tests for each state and territory (data not available for NT).⁴⁶

There are multiple sources for the cost of roadside drug tests, they range between \$25.50 and \$35. Using a median cost, we estimate the cost of a test to be \$29. The below table shows a breakdown of costs for each state and territory. We estimate the total expenditure for all state and territories on roadside drug testing equipment to be \$11,639,063.00.

Table A15: Roadside drug testing expenditure

State/Territory	Number of tests in 2021	Cost of test (mid range)	Expenditure (mid range)
NSW	105,407	29	\$3,056,803.00
Victoria	163,764	29	\$4,749,156.00
QLD	57,749	29	\$1,674,721.00
WA	41,421	29	\$1,201,209.00
SA	27,814	29	\$806,606.00
Tasmania	4,384	29	\$127,136.00
NT*	0	29	\$-
ACT	808	29	\$23,432.00
TOTAL	401,347	29	\$11,639,063.00

⁴⁶

<https://app.powerbi.com/view?r=eyJrIjoiaZTAxY2EyOTAtYTdhMS00NTRiLWlONkM2U1ZDI0NzY0ZTU5IiwidCI6ImFhMjFiNiQwLWJhYzItNDU2ZC04NTA1LWYyY2MwN2Y1MTc4NCJ9>

Appendix 9: Medicinal crop management

Australia has substantial medicinal cannabis and poppy crops. Security for these crops is part of the licencing arrangements, and is the responsibility of growers. The Office of Drug Control (ODC) (in the Department of Health and Aged Care at the Federal level) is responsible for regulating and monitoring manufacture of controlled substances in Australia (Office of Drug Control, n.d.) These functions relate to compliance with International Drug Conventions and thus represent a law enforcement cost despite being primarily administrative.

The ODC cost recovery implementation statement notes that expenses for the medicinal cannabis program in 2021/22 were \$5,397,000 (Office of Drug Control, March 2023). A substantial portion (\$3,162,999) of this was recovered.

Tasmania is the primary producer of poppy crops in Australia. The Tasmanian Department of Natural Resources and Environment reports on crops and management (Department of Natural Resources and Environment Tasmania, 2023). The Poppy Advisory and Control Board (PACB) is the primary body responsible for licencing and compliance related to poppy crops. Total expenditure related to licences and harvests reported by the Department in 2021/22 was \$516,777 (Department of Natural Resources and Environment Tasmania, 2023).

Total costs for medicinal crop management in 2021/22 were estimated to be \$5,913,777.

Appendix 10: Clandestine Laboratory detection and destruction

Clandestine laboratories refer to sites of domestic illicit drug production. Their detection falls under routine policing activities for state and territory police. As such the cost of clandestine laboratory detection has been captured in the costs of routine policing. Most laboratories detected nationally are small-scale laboratories situated in residential areas, that are believed to cater to personal use and social supply (Australian Criminal Intelligence Commission, 2021). Illicit drug manufacture such as that associated with clandestine laboratory operations can have extensive damaging effects on the environment and health, through residual contamination (Newell et al., 2011). As the activity is illegal, producers often ignore conventional chemical manufacturing and handling good practices to evade detection (Newell et al., 2011). Production of drugs generates large quantities of waste, for some processes the ratio of waste to product is 10:1, i.e., for every 1kg of drug manufactured, 10kg of waste is also produced (Newell et al., 2011). As producers tend to avoid industrial waste facilities, waste products are often dumped on public lands, sewerage systems, industrial estates, national parks, and waterways (Newell et al., 2011). In all states and territories, property owners are responsible for the remediation of a clandestine laboratory site and any associated costs. With regards to pollution of public lands, pollution is an offence under state and territories environmental law. Our policies operate on the 'polluter pays' principle, meaning whoever was responsible for the original contamination needs to pay for the remediation. However, oftentimes the polluter is not found, and states absorb the costs.

We have produced two separate estimates for the cost of site remediation, one based on a bottom-up estimate, and the other based on a top-down estimate.

Bottom up: Experts have costed a clandestine laboratory site remediation as \$528,000 in 2019, adjusting for inflation the cost is \$567,903.61 per site in 2022 (Duffy, 2019). The Australian Criminal Intelligence Commission published the number of clandestine laboratory sites that were detected in each state and territory over ten years, the figures for 2018/19 are as follows (Australian Criminal Intelligence Commission, 2019):

Table A16: Number of clandestine laboratories detected (ACIC, 2019)

Year	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Total
2018/2019	59	91	81	58	14	1	2	2	308

We estimate that 5% of all of these sites are rural, based on the Australian Criminal Intelligence Commission estimate (Australian Criminal Intelligence Commission, 2021), this results in ~15.4 sites. We further estimate that of those, 21.6% of sites were slated for clean up in the same year, this results in ~3.33 sites. This estimate is based on details provided by the NSW Environment Protection Authority (EPA) who listed a breakdown of the total 'notified contaminate sites' for 2018-2020 as 139, 30 of which had been remediated, representing 21.6% of sites (NSW EPA, 2023). Therefore, using the bottom-up method we estimate that the total cost (for all states and territories) for associated site remediation was ($\$567,903.61 \times 3.33 =$) \$1,891,119.0213 in 2021-2022.

Top down: Two states, NSW and WA have published the costs they provide for remediating contaminated sites. In NSW, this funding is provided as a grant program for 'Contaminated land management' which funded in total \$1,228,820 in 2020-2021, when adjusted for inflation \$1,283,451.65 (NSW EPA, 2021). The government of WA listed 'Contaminated Site Remediation' as a budget item for 2022, funding \$1,300,000.00 towards this activity (Government of Western Australia,

2022). These budgets are for all sites. If we estimate that 4% are drug related, based on NSW EPA breakdown of sites (NSW EPA, 2023), we estimate that NSW expenditure on site remediation was $(\$1283,451.61 \times 0.04 =) \$51,338$ and WA's was $(\$1,300,000 \times 0.04 =) \$52,000$. To extrapolate the total spend of all states and territories based on this, we look to the percentage of clandestine laboratory sites found across the states that we used for the bottom up estimate (Australian Criminal Intelligence Commission, 2019), we see that NSW and WA sites amount to 24% of all sites, therefore total estimate is $((\$51,338 + \$52,000) / 0.24 =) \$430,575$.

We have higher confidence in our bottom-up estimate.

Table A17: Clandestine laboratory costs: bottom up and top down

Method	Estimate
Bottom-up	\$1,891,119
Top-down	\$430,575

Appendix 11: Control on precursor chemicals

Precursor chemicals are chemicals that can be used to manufacture psychoactive substances, some of which may be illicit or prohibited drugs. There are two parallel activities dedicated to the controls on precursor chemicals: 1) a permit system, 2) policing and border operations (included in the costings for policing and border control under the law enforcement section). The Office of Drug Control (ODC) is an agency that sits within the Department of Health and Aged Care. It maintains a 'list of controlled substances' and manages the permits and import licences for controlled substances. Permits and licenses are available for 12-24 months at a time. As the funding for the monitoring of the permits and licensing system is essentially the funding of a government agency, this activity falls under costs of 'regulation' and as such has not been included in the overall budget.

ODC has three bodies: Narcotics Control Section, Medicinal Cannabis Section and Monitoring and Compliance Section. In 2021-2022 the ODC completed 25 medicinal cannabis inspections (Department of Health, 2022c), and the Narcotics Control Section within processed 10,976 (Department of Health, 2023). We were not able to obtain the total number of infringements issued by the Narcotics Control Section in 2021/2022.

From a funding perspective, the ODC is part of the Health Products Regulation Group, (alongside the TGA). Their operating budget for 2021/2022 was \$172,026,000 (this included the Covid emergency response budget) (Department of Health, 2021). The ODC operating budget for 2020/2021 was \$28,085,000 (Department of Health, 2020). Taking the 2021 budget and adjusting for inflation comes to \$29,333,621 in 2021/2022.

Appendix 12: Low Aromatic Fuel

Low aromatic fuel is an unleaded petrol that was designed to discourage petrol sniffing by lowering the psychoactive component (National Indigenous Australians Agency, 2023). Low aromatic fuel was introduced to retail sites in certain communities in an ongoing fashion since 2005 (National Indigenous Australians Agency, 2023). The Australian government funded the cost of production of low aromatic fuel so that it could be sold at a similar price point to regular unleaded petrol (National Indigenous Australians Agency, 2023). Low aromatic fuel is widely available in Arnhem Land, Kakadu, Katherine, Tennant Creek, Central Australia, Goldfields. It is somewhat available in the Gulf of Carpentaria, Western Cape York, Kimberley and Darwin (National Indigenous Australians Agency, 2023). Whilst the 'roll out' is complete, the government subsidy of the production of the fuel is ongoing (National Indigenous Australians Agency, 2023). The subsidy has been funded through the Petrol Sniffing Strategy (Australian National Audit Office, 2015)). Projected funding allocated under the line item 'Subsidies – Petrol Sniffing Prevention Strategy' for the Portfolio of Prime Minister and Cabinet for 2021/2022 was \$190,000 (The Australian Government Department of the Prime Minister and Cabinet, 2021).

Appendix 13: Customs and border control estimates by Outcomes 1, 2 and 3

The Department of Home Affairs provides spending figures

- Outcome 1: includes national coordination, policy and strategy development, emergency management, and regional cooperation.
- Outcome 2: includes effective coordination and delivery of immigration and social cohesion policies and programs.
- Outcome 3: trade and travel facilitation, modernisation, effective customs, immigration, maritime and enforcement activities across the border community.

The challenge associated with using the Outcome budget estimates is that the reporting appears differently in the budget statements and the annual report. In the Department of Home Affairs 2020-2021 Annual Report – Drug Detections were reported under the category ‘Border Management’. In 2020-2021, the ABF recorded 58,916 drug detections, which translated into 23,131 kg in weight of illicit, prohibited, and restricted drugs and precursors. Figures do not include ABF’s Ocean Shield and Thaiyak (offshore patrol vessels). Outcomes 1, 2, and 3 are defined differently in this report. Outcome 1 is defined as national security, emergency management system, law enforcement, and border management, which includes managing the stay and departure of all non-citizens. Outcome 2 includes management of the visa, multicultural, and citizenship programs and provision of refugee and humanitarian assistance, and settlement and migrant services. Outcome 3 includes facilitation of the trade of goods to and from Australia, and collection of border revenue. Outcome 1 includes Border Enforcement and Border Management. Neither of these are well defined as Border Enforcement is not reported on in the same way as Border Management. A second option from which to derive total expenditure is to take the total Home Affairs budget. The Home Affairs budget from Budget Estimates for 2021/2022 was \$8,220,799,000. The budget allocated to Home Affairs from the Budget Paper no.4 is \$6,161,213,000.

The table below shows budget allocations sourced from the Home Affairs Portfolio Budget Statements for 2021/2022 and Parliament’s Budget Paper no.4: Agency Resourcing:

- Home Affairs Resource statement Budget estimates for 2021-2022 as of May 2021 were (Commonwealth of Australia, 2021b): \$147,438,000 for outcome 1, \$1,255,336,000 for outcome 2 and \$845,593,000 for outcome 3. The full budget for Home Affairs here (including appropriations) is \$7,512,424,000.
- Figures from the Budget Paper no.4: Agency Resourcing allocate ‘Agency Resourcing’ for 2021-2022 (Commonwealth of Australia, 2021a) as follows: \$521,682,000 to Outcome 1, \$2,248,848,000 to Outcome 2 and \$3,290,631,000 to Outcome 3. The full budget for Home Affairs here (including ‘equity injections’, assets, and liabilities) is \$6,161,213,000.

Table A18: Three different approaches to Home Affairs expenditure, by outcome

Outcome	Total	Source
Outcome 1 – Estimated actual	\$499,304,000	(Commonwealth of Australia, 2021b)
Outcome 3 – Estimated actual	\$2,904,933,000	(Commonwealth of Australia, 2021b)
Outcome 1 – Agency Resourcing	\$521,682,000	(Commonwealth of Australia, 2021a)

Outcome	Total	Source
Outcome 3 – Agency Resourcing	\$3,290,631,000	(Commonwealth of Australia, 2021a)
Outcome 1 – actual expenses	\$537,916,000	(Department of Home Affairs, 2022)
Outcome 3 – actual expenses	\$2,898,286,000	(Department of Home Affairs, 2022)

As a result of reporting differences, we are left with three possible total budgets to work with, consolidated in Table A19 below.

Table A19: Relevant Home Affairs expenditure from which to derive drug-related expenditure

Total budget	
\$3,436,202,000	Outcomes 1 and 3 expenditure (Actual expenditure)
\$3,404,237,000	Outcomes 1 and 3 estimate (Budget statement)
\$3,812,313,000	Outcomes 1 and 3 estimate (Agency resourcing)

We used the ‘actual expenses’ in our main estimates to reflect actual expenditure. Budget statement and agency resourcing figures would result in different final expenditure estimates.

Appendix 14: Diversion: Police diversion (pre-court), Court diversion (pre-trial, pre-sentence; post-sentence)

Diversion refers to the redirection of people charged or able to be charged with an illicit drug offence from conventional criminal justice (arrest, charge, imprisonment) into education and treatment (Hughes & Ritter, 2008). Diversion is one of the central elements of law enforcement responses to drug use and possession in Australia (Hughes et al., 2019). Diversion encompasses a range of programs and activities executed by police and courts that provide alternatives to arrest or sanction (Hughes et al., 2019). Diversion is often shaped by specific legislative conditions (e.g. threshold quantities) as well as cultural practices, including discrimination (particularly the case for programs that operate via discretion, see Teperski and Rahman, 2023).

Diversion programs have expanded and are resourced through federal and state/territory governments. All states/territories have court diversion programs (Hughes et al., 2019).

In the previous 'drug budget,' Ritter et al. (2013, pp. 21-22) noted that while some federal funds could be sourced for diversion programs, this would likely represent double-counting as diverted clients are registered within other costs already covered. They note, "Furthermore, tracking diversion funding is difficult, as although treatment support is most likely to be channelled through state health departments, police and other elements of the criminal justice system also incur diversion expenditure. This feature of the Australian system was highlighted by Hughes and Ritter (2008) who noted that diversion options 'were offered throughout all stages of the criminal justice system'. The costs of illicit drug-specific criminal justice costs are handled in a subsequent section. For these reasons, diversion expenditure was not separately estimated: it is subsumed within the drug treatment services and criminal justice costs."

Costs associated with persons diverted are captured in this updated budget within the drug treatment services and criminal justice costs.

Diversion includes police diversion (pre-court), and court diversion (bail-based programs, pre- and post-sentence programs) (Australian Institute of Health and Welfare, 2023b).

ACIC's IDDR 2020/21 (Australian Criminal Intelligence Commission, 2023b), discussed in Chapter 5, gives a proportion of 18% of national drug arrests being caution/diversion/or infringement, all of which are police diversion. Using the total number of arrests given in the IDDR 20/21, suggests there were as many as 25,312 instances of police caution/diversion/infringement in 2020/21.

Court diversion, as described by the Australian Institute of Health and Welfare, "occurs after a charge has been laid" (Australian Institute of Health and Welfare, 2023b).

Diversion programs occur at different stages throughout the criminal justice system (Hughes et al., 2019). In their broad study on diversion in Australia, Hughes et al include figures for aggregate movement of use/possess offenders through the Australian criminal justice system over the period 2010/11 to 2014/15. They show that:

- "There were on average 44,904 offenders detected with a principal offence of use/possession in any one year.
- 55.5% were diverted in the first instance by police away from court.

- 45.3% proceeded to court (including a small number of offenders – 0.8% – who failed to fulfil their diversion program requirements).
- 43.2% all detected offenders, or almost all (95%) offenders who proceed to court were found guilty and sentenced.
- Of those sentenced, most (96.3%) receive a non-custodial order e.g. a monetary order (63.8%). Conversely, 2.2% of all those sentenced received custody in a correctional institution (with a median sentence length of 4 months).” (Hughes et al., 2019, p.36).

Hughes et al., base this analysis on unpublished ABS data which allows for the disaggregation of use/possession offences, their method of proceeding by police (court and non-court action), and method of finalisation.

Appendix 15: Accounting for traffic and safety management in police expenditure figures

The police real expenditure estimates (Chapter 5, Routine policing against drugs) was adjusted down by 10% to account for traffic safety and management not otherwise reflected in police custody statistics (Moore, 2005). This reduction is to account for the difference in resource use attributed to traffic safety and management. Reports into costs of crime in Australia by Mayhew (2003) and updated by Rollings (2008) reduced overall expenditure by 30%. This figure is “without a particularly firm empirical base” and instead is taken with advice from the Australasian Centre for Policing Research (Mayhew, 2003, p. 69). In another update, Smith et al. (2014, p. 64) use New South Wales Police Force (NSWPF) estimates of 20% of police time spent on traffic and commuter services, then compares to figures from the UK putting figures for time spent dealing directly or indirectly with crime at 80-90%. These figures are then used by Smith et al. to allocate 80% of total cost of policing to crime in Australia. These estimates put traffic-related costs between 10 and 30% of total police budget.

We sought to improve the accuracy of this deduction to more accurately estimate policing costs. Smith et al. (2014) reference the 2011/12 NSWPF annual report to derive their 20% deduction. The 2011/12 report, however, gives a figure of 8.3% for staff deployment on traffic and commuter services. Other service groups are community support, criminal investigation, judicial support, and support functions. These figures are based on proportion of rostered hours. In the detailed financial statements, expenditure is given for four service groups (support functions are not included here). Focussing on the implications for proportion of budget to deduct, these detailed figures show that the traffic and commuter services service group accounts for 12% of rostered hours in 2011 and 11% in 2012 (NSW Police Force, 2012). The 8.3% for traffic and commuter services figure increases to 9.8% in 2011/12 (NSW Police Force, 2013), and 10.1% in 2013/14 (NSW Police Force, 2014). These same activity groups are described as ‘proportion of budget’ in 2014/15, where traffic and commuter services accounts for 11.5% of the NSWPF budget (NSW Police Force, 2015).

Some drug-related activity is captured in the traffic and community services group (traffic offences involving drugs). The final annual report to include these group breakdowns either by proportion of rostered hours or budget is 2015/16 gives the figure for traffic and commuter services as 11.1% (NSW Police Force, 2016). These figures consistently give the proportion of policing budget closer to 10%, rather than the higher 20%. 10% has been deducted in line with Moore (2005) and Ritter et al. (2013). As Shanahan (2011, p. 84) notes regarding attempts to accurately deduct proportion of time spent on traffic and safety management and community policing, it is unknown which of these or other methods are correct.

Appendix 16: Alternative estimates of court costs

We tested two other approaches to estimating court costs. One approach is another top-down option, where cases were weighted by defendant weeks (rather than average length of cases). We also calculated a more bottom-up approach, where data from the Report on Government Services on the average cost per case finalisation was applied to the number of cases in each court level. This cost-per-finalisation approach was adopted by Shanahan (2011) to estimate court costs for cannabis offences. We provide the details of both here.

Top-down costs - weighted by defendant weeks

Moore (2005) used the proportion of what he calls ‘defendant weeks’ spent on illicit drug court cases. Moore utilised median duration (mean duration was not available at that time) to derive relative duration of illicit drug related court activity. This was then used to modify the raw percentage of illicit drug offences for Higher and Magistrate court levels (similar to our approach in Chapter 5 using mean durations).

To estimate a figure for defendant weeks, we multiplied number of illicit drug cases at each duration by median weeks (e.g. cases less than 13 weeks were multiplied by 6.5 to estimate total weeks in court. The same method was used for all given durations: the number of cases at 13-25 weeks was multiplied by 19, the number of cases at 26-39 weeks was multiplied by 32.5, and the number of cases at 39-51 weeks was multiplied by 45. The number of cases at 52 + weeks was multiplied by 52).

This method weights cases at each duration. Total ‘defendant weeks’ was derived by adding together the results for each duration (i.e. 195 illicit drugs cases at less than 13 weeks was multiplied by 6.5 to get 1,267.5 weeks spent on these cases; 1,080 illicit drug cases at 13-25 weeks was multiplied by 19 to get 20,520 weeks spent on these cases, and so on, see table A20). The total sum for all ‘defendant weeks’ spent on illicit drug offences was then divided by total ‘defendant weeks’ of all offences across all court levels to derive a percentage of illicit drug cases, weighted by frequency and duration (rather than by average duration, as in our main estimate, Chapter 5). This results in higher percentages of court time related to illicit drugs at all court levels: 25.59% of Higher court activity spent on illicit drugs; 8.01% of Magistrates Courts activity; and 3.28% of Children’s Courts activity, see Table A20.

Table A20: Court cases: illicit drug cases, by court type, duration and ‘defendant weeks’

	# of cases	<13 weeks (%)	13-25 weeks (%)	26-39 weeks (%)	39-51 weeks (%)	52 & over weeks (%)	Total defendant weeks	Percent age of court activity (%)
Higher courts								
Guilty								
Illicit Drug Offences (IDO)	3,535	5.52	30.55	26.17	14.12	23.73		
All offences	13,433	6.36	27.91	23.67	13.75	28.30		

	# of cases	<13 weeks (%)	13-25 weeks (%)	26-39 weeks (%)	39-51 weeks (%)	52 & over weeks (%)	Total defendant weeks	Percent age of court activity (%)
Total defendant weeks, IDO		1,268	20,520	30,063	22,455	43,628	117,933	25.59
Total defendant weeks, all offences		5,551	71,231	103,318	83,115	197,704	460,919	
Magistrates Courts								
Guilty								
IDO	35,875	71.9	10.32	5.74	3.73	8.32		
All offences	396,785	64.11	13.92	7.91	4.67	9.39		
Total defendant weeks, IDO		167,687	70,338	66,885	60,210	155,168	520,288	8.01
Total defendant weeks, all offences		1,653,620	1,049,712	1,019,818	833,580	1,936,324	6,493,053	
Children's Courts								
Guilty								
IDO	726	68.32	16.67	5.51	4.27	5.65		
All offences	18,801	57.72	20.15	9.98	5.30	6.84		
Total defendant weeks, IDO		3,224	2,299	1,300	1,395	2,132	10,350	3.28
Total defendant weeks, all offences		70,532	71,991	61,003	44,865	66,820	315,210	

* columns may not sum due to rounding

An issue with both weighting methods (mean, in main estimate, and mode, given here) is the exclusion of length of acquitted cases, due to data limitations (see Chapter 5, court prosecutions - assumptions and caveats).

We have chosen to use our original percentage of court time spent on illicit drug offences weighted by mean duration to derive final expenditure estimates. As Higher Courts are the most expensive, the higher estimates when weighted by defendant weeks inflates total expenditure by around \$18 million. See Table A21, below, for comparisons between these two different top-down weighting methods (See also Chapter 8).

Table A21: Illicit drug court cases, by court type, average weighting, refined 'defendant week's weighting and total court related expenditure

	Illicit drug cases (acquitted and guilty) (%)	Illicit drug court cases, weighted by Average case duration (%)	Illicit drug court cases, weighted by 'defendant weeks' weighting (%)	Total court expenditure relating to illicit drug offences (weighted by mean duration)	Total court expenditure relating to illicit drug offences (weighted by 'defendant weeks')
Higher Courts	24.80	22.25	25.59	\$118,767,548	\$136,594,399
Magistrates Courts	8.87	7.50	8.01	\$44,409,402	\$47,456,721
Children's Courts	3.72	2.91	3.28	\$1,413,974	\$1,594,381
Total				\$164,590,924	\$185,645,502

Bottom-up approach: Cost per finalisation

An alternate method for estimating court expenditures is multiplying illicit drug related finalisations, by cost per finalisation. Cost per finalisation figures are given in the Report on Government Services (Productivity Commission, 2023c).

Court finalisations not weighted by duration (including transfers and cases withdrawn) are included in this costing approach. There was a total of 3,909 illicit drug offences finalised in higher courts, including acquittals, guilty findings, transfers, and withdrawals (Australian Bureau of Statistics, 2023b).

The number of finalised cases (see Law Enforcement chapter) is taken from the ABS (2023b), which aggregates Supreme and District courts finalisations into Higher Courts. The Report on Government Services gives a total number of finalisations for all criminal offences disaggregated by Supreme and District/County Courts (Productivity Commission, 2023c). These RoGS finalisation figures do not disaggregate by offence type and are much larger than the numbers given in the ABS data (i.e. total higher courts all offences, all finalisations, including transfers and withdrawals is 16,808 in the ABS (2023b) data, total finalisations appeal and non-appeal in Supreme and District/County courts is 29,211 in the RoGS data (Productivity Commission, 2023c)). Cost per finalisation is given in the RoGS data: Supreme \$25,292 per finalisation; District courts \$16,331 by finalisation (Productivity Commission, 2023c). In seeking to account for the large cost differences between Supreme and District courts, we sought to determine cases finalised in these different courts. In the absence of more accurate data, we worked out the percentage of Supreme Court cases and the percentage of District Court cases in the RoGS data: of the total 29,211 criminal finalisations, 5,336 (18.27%) were finalised in Supreme Courts and 23,875 (81.73%) in District Courts (Productivity Commission, 2023c). Applying these percentages to our primary ABS finalisations data by offence type (3,909 illicit drug cases) gives 714 Supreme Court cases, and 3,195 District Court Cases.

Multiplying these numbers by cost per finalisation in each court results in \$18,060,021 in Supreme Courts (714 illicit drug finalisations multiplied by \$25,292 cost per finalisation), and \$52,176,555 in District Courts (3,195 illicit drug finalisations multiplied by \$16,331 cost per finalisation). The total cost of illicit drug offences finalised in Higher courts (Supreme and District/County Courts) in 21/22

was estimated to be \$70,236,575.98. This bottom-up estimate does not include any weighting by duration of cases.

There was a total of 42,673 illicit drug offences finalised in Magistrates courts, including acquittals, guilty findings, transfers, and withdrawals (Australian Bureau of Statistics, 2023b). Cost per finalisation in Magistrates Courts was \$974 (Productivity Commission, 2023c). The total cost of illicit drug offences finalised in Magistrates courts in 21/22 was estimated to be \$41,563,502.

There was a total of 893 illicit drug offences finalised in Children's Courts, including acquittals, guilty findings, transfers, and withdrawals (Australian Bureau of Statistics, 2023b). Cost per finalisation in Children's courts was \$1,041 (Productivity Commission, 2023c). The total cost of illicit drug offences finalised in Children's courts in 21/22 was estimated to be \$929,613.

Comparing the three approaches to estimating court expenditure

Table A22: Top-down and bottom-up estimates, total court expenditure by court level

	Top-down #1 (total court expenditure divided by proportion of drug-related cases, weighted by mean length of case)	Top-down # 2 (total court expenditure divided by proportion of drug-related cases, weighted by length of case by defendant weeks)	Bottom-up (average cost per finalisation times number of cases)
Higher courts	\$118,767,548.18	\$136,594,399.77	\$70,236,575.98
Magistrates court	\$44,409,402.31	\$47,456,721.38	\$41,563,502.00
Childrens court	\$1,413,974.05	\$1,594,381.36	\$929,613.00
TOTAL	\$164,590,924.54	\$185,645,502.51	\$112,729,690.98

Appendix 17: Restorative justice

Restorative justice describes a range of justice practices designed to require offenders to take responsibility for their wrongdoing and meet the needs of the victim(s) and communities.

A 2014 Australian Institute of Criminology report describes the uses of restorative justice in Australia: “It can and has been employed at most points of contact with the criminal justice system. For example, it can be used by police to divert offenders away from court (eg youth conferencing), by courts as a sentencing outcome (eg referral to conferencing) or as a means of arriving at a sentence (eg circle and forum sentencing), or following release from prison (eg victim–offender mediation)” (Joudo Larsen, 2014, p. 5)

Restorative justice programs operate for youth (Australian Association for Restorative Justice, n.d.-b) and adults across Australia, although the use of programs for adults is still in the process of being established across jurisdictions (Australian Association for Restorative Justice, n.d.-a).

Group conferencing refers to a restorative justice program primarily used for young people who have committed crimes. The conference involves the young person, victim(s), families, police, and a youth justice agency officer (Productivity Commission, 2023e).

The more developed use of group conferencing for young people is reflected in the inclusion of group conferencing costs in the Report on Government Services on Youth Justice Services. These data are included under community services, and not under justice (where policing, court, and corrective services data are included).

This section focusses on the data available, which is available for group conferencing for youth. The total real recurrent expenditure on youth group conferences in 2021/22 was \$43,488,000 (Productivity Commission, 2023e). There were 6,850 concluded group conferences at a cost of \$6,348.58 each (Productivity Commission, 2023e).

To derive a drug-specific cost associated with group conferencing, we used ABS data related to criminal courts (Australian Bureau of Statistics, 2023b) to derive the proportion of total youth offenders with principal offence of illicit drug offences finalised guilty who were sentenced to other non-custodial orders (a category which does not include community supervision, work orders, or fines). This figure is 4.95%. This proportion was then applied to the total number of group conferences in Australia in 2021/22 to estimate 339 youth group conferences related to illicit drug offences. Using cost per concluded conference (\$6,348.58) (Productivity Commission, 2023e), we estimate that the cost of group conferences for youth, related to illicit drug offences in 2021/22 is \$2,153,856. This represents State/Territory expenditure.

Appendix 18: Previous Australian ‘drug budgets’, inclusion of ‘other’ category

The first (Moore, 2005) and second (Ritter et al., 2013) Australian ‘drug budgets’ included estimates for research and policy administration expenditure on illicit drugs. These estimates were classified as ‘other government expenditure’, i.e. funding not connected to one of the four domains.

We did not include research and policy administration expenditure in our 2021/22 estimate.

For the sake of comparison, we have used two approaches. For the first approach, we have removed Other funding from the 2002/03 and 2009/10 drug budgets for comparability. For the second approach, we applied CPI adjustment to the 2002/03 Other expenditure figure (\$18.4 million) and the 2009/10 figure (\$23.1 million). These are \$28.97 million and \$29.92 million respectively.⁴⁷ We have applied a rounded figure of \$30 million as Other (research and policy administration expenditure) for comparability.

These two approaches are given in Table A23, below. As can be seen, the estimate for Other expenditure is minor and does not unduly influence the overall proportions across domains.

Table A23: Proportion of expenditure on four domains, 2002/03, 2009/10, and 2021/22, including and excluding ‘Other’ expenditure

	2002/2003			2009/2010			2021/2022		
	\$ million [^]	% of spending	% of spending, excl. Other	\$ million ^{^^}	% of spending	% of spending, excl. Other	\$ million	% of spending (incl. Other: as a CPI adjustment (see text))	% of spending, excl. Other
Prevention	101.6	9.0%	9.1%	156.8	9.5%	9.7%	368.9	7.0%	7.0%
Treatment	229.2	20.2%	20.5%	361.8	22%	22.3%	1,300.2	24.6%	24.7%
Harm Reduction	44.8	4.0%	4.0%	36.1	2.2%	2.2%	89.9	1.7%	1.7%
Law Enforcement	740.4	65.3%	66.3%	1,068.4	64.9%	65.8%	3,503.9	66.2%	66.6%
Other	18.4	1.6%		23.1	1.4%		30*	0.6%	
Total (excl. Other)	1,116			1,623.1			5,263		
Total	1,134			1,646.1			5,293		

⁴⁷ The total change in cost reported by the RBA Inflation calculator (<https://www.rba.gov.au/calculator/financialYearDecimal.html>) from 2002/03 to 2021/22 is 57.4 per cent, over 19 financial years, at an average annual inflation rate of 2.4 per cent. From 2009/10 to 2021/22, change in cost is 29.5 per cent, over 12 financial years, at an average annual inflation rate of 2.2 per cent.

Columns may not sum due to rounding

[^] Moore included both direct and indirect government expenditure on illicit drugs. Ritter et al. (2013) took the direct figure only and removed social competency training from his figure for school drug education for comparability. We have taken the figure used which excludes social competency training and indirect funding for the bases of these comparisons.

^{^^} An addendum was published to the 2009/10 estimate which provided an updated calculation for law enforcement expenditure. The figure reported here is the 'new' figure at 70% of the original estimate. See Ritter et al., 2013 for details.

* CPI adjustment of previous estimates (\$30 million)

Appendix 19: Methodological improvements over previous Australian ‘drug budget’ estimates

We sought to streamline and improve the accuracy and comparability of our estimates across the four domains. Primarily, we prioritise top-down methods of estimation across the four domains. As discussed in Appendix 3, we have provided top-down estimates for all domains except harm reduction. One impact of this is that some items which were costed individually are now subsumed in a broader top-down estimate. This is the case for treatment. The previous drug budgets broke down treatment into constituent elements, including by funding source (state vs federal), hospital-based drug treatment, opioid pharmacotherapy treatment, and treatment in correctional facilities. The resulting approach used top-down and bottom-up (using unit costs) to derive final estimates. In the interests of maintaining comparability between domains, and particularly in response to the requirement to approach law enforcement expenditure using a top-down method due to data availability, we have used a top-down method to estimate total expenditure on treatment. The individual activities are not disaggregated in the main estimates. Despite this significant methodological change, it has not altered the resulting percentage contribution (at 24.7% for this year compared to 22% for the 2009/10 estimate, and 20.2% for 2002/03 estimate).

For our other top-down estimates, there were also differences in what was included. For example, to improve the accuracy of our prevention costs we included expenditure on infancy and parental support programs. These were not included in the previous drug budgets. Similarly, for the law enforcement domain, Moore included cost for the Australian Crime Commission, the Australian Institute of Criminology (AIC), and the management of legal poppy and hemp farms. The AIC, by comparison, was included in Ritter et al.’s section on research and policy administration, with the other items not costed. We have not included research and policy administration and so have not included costs associated with the crime commission or the AIC; costing estimates on medicinal cannabis and poppy are included in the appendices.

Our estimates for harm reduction also included items not costed previously. This is due to changes in harm reduction programs, primarily expansions (e.g. two medically supervised injecting centres, instead of one) and new inclusions (e.g. take home naloxone programs and peer-led drug user organisation (DUO) funding). The previous drug budget included funding for one DUO as part of research and policy administration. This has been included in our DUO estimate instead.

In some instances, the methodological difference is a refinement of the previous approach or approaches. These are detailed in each section of our main estimates. These differences have resulted, in some instances, in higher estimates. One reason for this is that higher proportions of illicit drug related activity are used to apportion illicit drug related expenditure using a top-down methodology. To demonstrate this, we can look at drug education hours and proportion of policing time spent on illicit drugs that leads to a higher overall estimate.

For drug education hours, Moore (2005, pp. 9-10) uses a Victorian Auditor General report from 2003 to estimate an average of 5.8 hours per year spent on drug-specific education. This was then used to determine a total proportion of classroom time that was multiplied by recurrent expenditure. We have retained this top-down approach (drug education hours used to derive a proportion of classroom time, multiplied by recurrent expenditure) but have updated the estimate of average hours per year spent on drug-specific expenditure with reference to more recent reports (see section

on school-based drug education). This results in a higher average hours spent at 7.264 hours. This is one factor contributing to our overall higher estimate.

For routine policing against illicit drugs, Ritter et al. (2013) used a 2011 study on NSW policing to derive an estimate of 5.9% of all incidents as illicit drug specific, excluding traffic related offences. These proportions were applied nationally. In this drug budget, we have refined this approach by using ABS data to provide a state-by-state breakdown of relative policing time spent on illicit drugs, excluding traffic offences. This resulted in a much higher estimate for all states, and a much higher national average of 13.8% (133.9% increase). We used state-based averages to derive final, more accurate expenditure estimates. If we applied the previous budget proportion of policing time (5.9%) to 2021/22 state police recurrent budget (minus 10% for traffic related policing, see section on routine policing), this results in an estimate of \$786.1 million. Our policing estimate is \$1,802.4 million, a 129% increase. Given the proportional increase of policing time and subsequent estimate, the higher proportion of policing time in our method contributes to the much higher estimate, suggesting that higher expenditure is a result of more policing time spent on illicit drugs.

