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Decriminalization: Options and Evidence

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Executive Summary

A growing body of evidence suggests that decriminalization is an effective way to mitigate the harms of substance use and the policies and practices used to deal with it, especially those harms associated with criminal justice prosecution for simple possession. This policy brief reviews the various ways in which decriminalization of controlled substances is being interpreted and implemented internationally and in Canada.

Decriminalization is a policy strategy in which non-criminal penalties, such as fines, are available for designated activities, such as possession of small quantities of a controlled substance. It has been proposed as a way to reduce the harms associated with the opioid crisis. An understanding of decriminalization starts by recognizing that it is not a single approach, but a range of policies and practices.

This brief will inform policy makers, decision makers, analysts and advisors in the health, social and criminal justice sectors by:

- Defining key concepts;
- Illustrating examples of informal (de facto) and formal (de jure) applications of decriminalization, including harm reduction services, police diversion and national policy approaches;
- Identifying considerations for evaluation and monitoring of applied decriminalization approaches;
- Summarizing lessons learned from international and Canadian experience; and
- Proposing decriminalization options for application to the current Canadian context.

Key Findings

- Recognizing that substance use is a complex health issue with social, economic and public safety impacts is fundamental to developing comprehensive and effective responses.
- Decriminalization encompasses a range of policies and practices that can be tailored and combined to respond to particular contexts and to address specific objectives.
- The growing body of evidence on various approaches to decriminalization provides a valuable source of lessons learned to inform the development of policy and practice.
- Gaps in knowledge about the impact of decriminalization approaches need to be filled by conducting rigorous evaluations and making data and results accessible.

The Issue

Substance use patterns and prevalence, and its associated harms evolve over time. To address changing contexts, strategies to deal with substance use must change as well. The current Canadian context is marked by an opioid crisis, with deaths due to opioid overdose reaching unprecedented levels. The crisis highlights the need for agile and innovative responses informed by evidence.

Decriminalization is an evidence-based policy strategy to reduce the harms associated with the criminalization of illicit drugs. For those who use illicit drugs, these harms include criminal records, stigma, high-risk consumption patterns, overdose and the transmission of blood-borne disease. Decriminalization aims to decrease harm by removing mandatory criminal sanctions, often replacing them with responses that promote access to education and to harm reduction and treatment services. It is not a single approach or intervention; rather it describes a range of principles, policies and practices that can be implemented in various ways.

Background

Over the past few decades, various decriminalization strategies have been implemented both in Canada and in other countries, including Australia, the United States, Portugal and the Czech Republic. Decriminalization is receiving increased attention in Canada as a possible substance use strategy. Decriminalization measures are being considered to help address the opioid crisis, including the contamination of illicit drugs with fentanyl, and were earlier proposed as alternatives to legalizing non-medical cannabis.

Key Concepts

The regulation of controlled substances can take formal or informal approaches. It occurs across a continuum of categories from criminalization to decriminalization to legalization (see Figure 1).

Approaches

De facto approaches are implemented according to non-legislative or informal guidelines.

De jure approaches are reflected in formal policy and legislation.

Categories

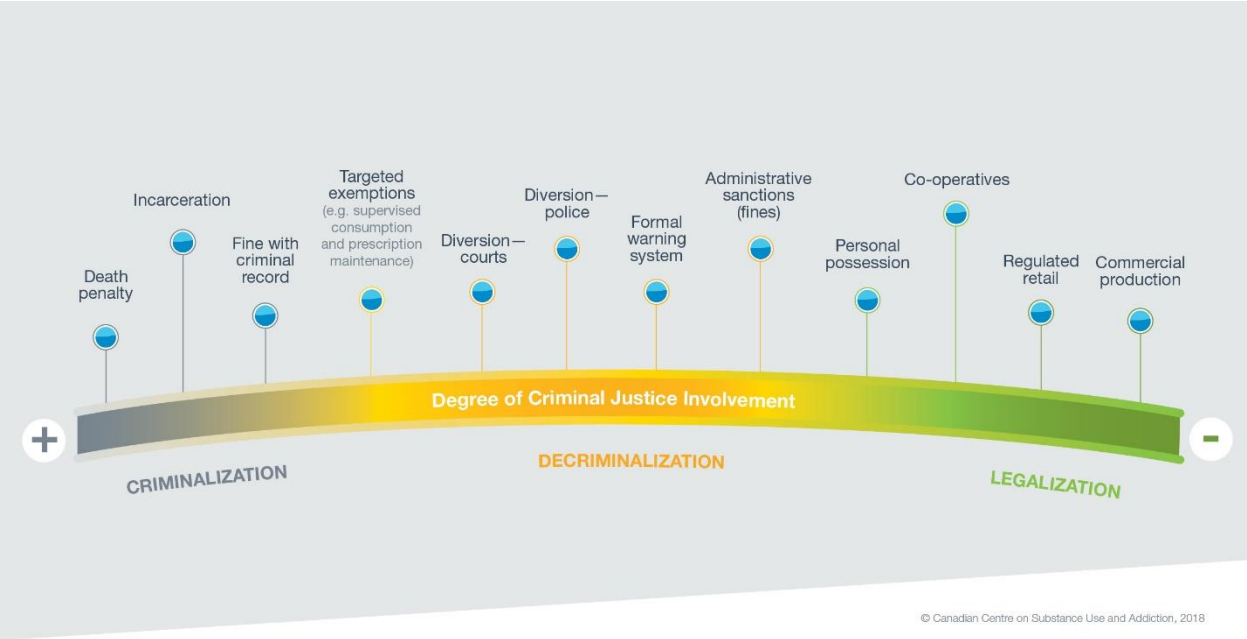
Criminalization: Production, distribution and possession of a controlled substance are subject to criminal sanctions, with conviction resulting in a criminal record.

Decriminalization: Non-criminal responses, such as fines and warnings, are available for designated activities, such as possession of small quantities of a controlled substance.

Legalization: Criminal sanctions are removed. Regulatory controls can still apply, as with alcohol and tobacco.

As shown in Figure 1, each broad category includes many options. Options within different approaches can be combined. For example, a country might practice de facto decriminalization of small quantities of cannabis and maintain de jure criminalization for other substances such as heroin, cocaine and amphetamines.

Figure 1: The Regulatory Continuum



Measuring Impact: Considerations and Limitations

The available evidence provides valuable guidance and lessons learned relevant to decriminalization. For example, population data indicate that rates of substance use are better predicted by regional trends rather than national regulations (European Monitoring Centre for Drugs and Drug Addiction, 2011). In fact, recent data from Europe indicate that countries with the highest rates of drug-related death tend to have more punitive approaches to drug use (European Monitoring Centre for Drugs and Drug Addiction, 2017a).

However, there are gaps in what we know, and in our ability to attribute causality versus association. To isolate and evaluate the effects of a specific policy or practice is a complex task. Decriminalization can have an impact on health, social and criminal justice sectors. External factors such as social norms, changes in drug supply, population demographics and police priorities strongly influence key indicators such as rates of use, number of deaths due to overdose or poisoning, and arrest rates. External factors can also affect the consistency or fidelity with which a policy or program is implemented.

The way that data is collected is another important consideration. To measure the impact of a new approach, data must be collected before and after it is implemented. However, many studies such as national prevalence surveys follow a pre-set schedule that might not coincide with policy change. Additional considerations for data collection include:

- Changes in the administration of a survey or in how questions are asked can limit the ability to compare results over time.
- Different indicators provide different value for measuring impact. For example, past-12-month substance use provides a better indication of behaviour change than lifetime use.

- Focusing on narrowly defined indicators might not capture broader impacts. For example, considering the cost of individual interventions such as heroin-assisted therapy only in terms of increased medical costs will miss overall health and social benefits (Home Office, 2014).
- It might not be possible to collect some data in a systematic way, or it might be available only through labour-intensive qualitative approaches such as interviews or file reviews (e.g., social functioning indicators, police and court records, and drug-related hospital admissions).
- Identifying meaningful control groups is challenging for both practical and ethical reasons.

These limitations must be recognized when reviewing evaluations of regulatory approaches, but they should not prevent drawing from the available evidence. It can provide valuable lessons learned to those making and implementing regulatory approaches. Existing gaps and limitations in the evidence provide guidance to those positioned to influence and improve data availability and collection.

International Experience

De jure criminalization remains the most common approach to regulating controlled substances. However, implementation of both de facto and de jure decriminalization is increasing. Legalization of cannabis is in place at the national level in Uruguay and the state level in the United States.

United Nations Conventions

Through the United Nations, Canada is signatory to three international drug control treaties.[1] The Single Convention on Narcotic Drugs requires that possession of scheduled substances be a punishable offence. The International Narcotics Control Board has reiterated the requirement for signatories to the Convention to maintain criminal penalties. The Convention **does** permit alternatives to conviction or punishment for individuals experiencing problematic substance use, providing some opportunity for innovative approaches outside the criminal justice system. A joint resolution by the World Health Organization and United Nations in fact calls for "reviewing and repealing punitive laws that have been proven to have negative health impacts. These include … drug use or possession of drugs for personal use …" (World Health Organization, 2017). There are formal mechanisms to resolve non-compliance with Convention requirements, including treaty reform, exemptions, withdrawal from the treaty and re-accession with reservations (Bewley-Taylor, Jelsma, Rolles, & Walshe, 2016).

Targeted Exemptions

Targeted exemptions include a range of programs for which there are specific exemptions from the application of criminal penalties. There is strong support for the use of targeted exemptions to reduce identified harms among certain populations. The following paragraphs discuss examples.

Supervised consumption sites provide a location where people can use drugs in a clean environment under the supervision of health professionals trained to provide emergency intervention. Attendees at legally sanctioned sites are not prosecuted for possessing or using a controlled substance within or in the immediate vicinity of the facility. This exemption can be either de facto, de jure or a combination of the two. For example, in Canada, exemption under Section 56 of the *Controlled Drugs and Substances Act* is a de jure policy used to exempt supervised consumption site staff who may have small amounts of controlled substances under their control as part of operations. De facto

1 The three international drug control treaties are the Single Convention on Narcotic Drugs 1961, as amended by the 1972 protocol; the Convention on Psychotropic Substances of 1971; and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.

practice applies through agreements with local police not to arrest those attending the site, unless there are aggravating circumstances such as violent behaviour.

The first supervised consumption site opened in Berne, Switzerland, in 1986. There are now over 100 operating, with the majority in Europe and one in Sydney, Australia. There is a large body of evidence illustrating the efficacy of supervised consumption sites in achieving a number of health and social objectives, especially when clients are offered access to integrated health and social services, including primary care, treatment and housing (Gaddis, et al., 2017).

The European Monitoring Centre for Drugs and Drug Addiction published *Drug Consumption Rooms: An Overview of Provision and Evidence* in 2017. Its summary of the results associated with supervised consumption sites includes:

- Increased contact with health and social services, including substance use treatment services, among marginalized clientele;
- Decreased drug-related litter;
- Decreased high-risk injection practice (e.g., re-using or sharing injection equipment); and
- Decreased injection in public.

Studies have not found any association of supervised consumption sites with increased criminal activity or with increased initiation or frequency of drug use.

Drug checking services analyze drugs in an effort to mitigate the risk of hazardous contaminants (e.g., fentanyl). Drug checking has been in place in Europe for over 25 years and there are now at least 31 services operating in 20 countries across Europe, the Americas and Australasia (Barratt, Kowalski, Maier, & Ritter, 2018). Services use a wide range of technologies and provide a variety of information from qualitative (presence/absence of a substance) to quantitative (levels of concentration and full make-up of a sample) (Harper, Powell, & Pij, 2017).

Drug checking services face legal conditions similar to supervised consumption sites, as staff provide equipment or handle small amounts of controlled substances as part of testing procedures. Some services operate under de jure policy, exempting staff from criminal prosecution. Some drug checking services in Europe operate under agreements specific to these services (e.g., Netherlands) or under broader harm reduction approaches that encompass these services (e.g., France) (Brunt, 2017). However, the majority operate under ambiguous legal conditions (see Sage & Michelow, 2016, Appendix B) and de facto agreements with local health and law enforcement agencies, which can limit the scope, funding and evaluation of the service.

Although no studies to date have assessed the health outcomes of drug checking in a systematic way, several recent evidence summaries (Leece, 2017; Kerr & Tupper, 2017; Brunt, 2017) suggest those who use drug checking services find them useful and that they can:

- Influence drug use risk behaviours (e.g., discarding drugs after unfavourable results, reducing the dose, using with others);
- Provide opportunities for brief intervention, education and referral to services;
- Help monitor the local drug supply and inform public health initiatives;
- Decrease the presence of contaminated drugs in the local market; and
- Be a key component of a comprehensive harm reduction strategy.

No studies have substantiated criticisms that drug checking provides a false sense of security or encourages drug use.

Prescription maintenance programs provide individuals with medically supervised access to controlled substances. In 1926, the United Kingdom's Rolleston Committee sanctioned the use of prescription heroin[2] for addiction where other treatments for addiction had failed (Wakeman, 2003). However, this option has not been in common use since the introduction of increased physician licensing requirements for heroin prescription in 1967 (Wakeman, 2003). Initially piloted in 1994 in Switzerland, heroin-assisted treatment in the form of supervised dosing has been implemented in the United Kingdom, Germany, Spain, the Netherlands, Canada and Denmark.

Results associated with participation in these programs include (see Ferri, Davoli, & Perucci, 2011; Strang, Groshkova, & Metrebian, 2012; Oviedo-Joekes, et al., 2016):

- Increased treatment retention for individuals who have not remained in methadone maintenance programs;
- Decreased illicit opioid use;
- Improved social function (e.g., reduced illegal sources of income, increased family engagement, housing stability);
- Decreased involvement in criminal activity; and
- Increased frequency of adverse events (i.e., overdose) in comparison with methadone.

Good Samaritan laws are legislation or policies that provide protection from arrest or prosecution for individuals who call for assistance or are present at the scene of an overdose. Most apply to the personal possession of illegal substances, while some also apply to drug paraphernalia or to breaches of supervision conditions. The objective of these policies is to remove the fear of criminal repercussions as a barrier to calling first responders. Several U.S. states, Canadian provinces and the Canadian federal government (in 2017) have passed Good Samaritan laws. There is limited data on their impact. Studies to date have identified the importance of ensuring there is an awareness and understanding of the laws among those likely to encounter an overdose situation and among police and other criminal justice professionals (Substance Abuse and Mental Health Services Administration, 2017; Banta-Green, Beletsky, Schoeppe, Coffin, & Kuszler, 2013).

De Facto Approaches: Police Diversion

Police diversion provides the option to use alternatives to criminal justice responses such as informal warnings, fines or referrals to treatment. Diversion can take place under police authority through outreach at point of arrest, under prosecutorial guidance or under judicial authority.[3] The further into the criminal justice process that diversion occurs, the greater the potential impact on the individual and cost to the system.

Under the Bristol **Drugs Education Programme (DEP)** in the United Kingdom, police can provide individuals caught possessing drugs with the option to attend a half-day drug education course. The program accepts people with criminal records; however, an individual can only participate once.

2 Most programs in fact use injectable diacetylmorphine, the active ingredient in heroin. A recent trial in Canada also supported the use of hydromorphone as non-inferior to diacetylmorphine (Oviedo-Joekes, et al., 2016).

3 Drug treatment courts are a popular form of court-monitored programming, particularly in the United States. This report will not address these courts for two primary reasons: One, the profile of the person charged with the offence determines eligibility rather than the offence; and, two, most provide an alternative to incarceration rather than actual diversion from the criminal justice system and in fact require a guilty plea and intensive court supervision (Department of Justice Canada, 2015).

Those who complete the course have their charges dropped. A pilot evaluation of the program indicated high rates of program uptake and an 80% completion rate among those offered participation (Luckwell, 2017). DEP partners also reported improved relationships among police, people who use drugs and community service agencies. However, the evaluation found some officers hesitated to apply the DEP to individuals using heroin or crack who are in fact program targets for the greatest impact in reducing criminal activity. It also found discrepancies in determining quantities for personal use versus intent to traffic (Luckwell, 2017).

Australia has numerous police diversion programs in place, including programs specific to cannabis and programs applicable more broadly to all illegal drugs. The diversion options usually have a therapeutic focus through assessment, education and treatment components, but also include warnings, confiscation and civil penalties. The Council of Australian Government-Illicit Drug Diversion Initiative, announced in 1999, supported evaluations of program development. This initiative provided a national framework, best practices to guide program development and federal funding for the expansion of treatment services (Hughes & Ritter, 2008).

Evaluations of Australian police diversion programs for cannabis have indicated they could increase the number of individuals involved in the criminal justice system, an effect known as “net widening” (Baker & Goh, 2004). Net widening was observed in the early cannabis expiation notice (CEN) schemes, which introduced non-criminal fines that police could process more quickly and easily than formal charges (Shanahan, Hughes, & McSweeney, 2016). For example, the number of CENs issued in South Australia increased from 10,282 in 1989–1990 to 18,015 in 1996–1997. During this time, the rate of expiation or payment of fines without criminal justice involvement averaged approximately 45%, while cases that proceeded to charges and criminal conviction averaged approximately 46% (Christie & Ali, 2000). Increased police training and changes to program requirements to provide greater flexibility in program completion have reduced the net-widening effect (Shanahan, Hughes, & McSweeney, 2016). A national review of 2012–2013 data, for example, found 91% of participants completed the program (including all ages and drug categories) (Australian Institute of Health and Welfare, 2014), and a review of the South Australian program from 2001–2011 (including only adults and drugs other than cannabis) found an average rate of 81% compliance (Milsteed, 2012).

Reviews have also found promising evidence about the impact of diversion programs on rates of re-offending. For example, a national sample of police diversion cases indicated that the majority of participants without prior offences did not commit further offences, and those with prior offences had reduced rates of offending after program participation (Payne, Kwiatkowski, & Wundersitz, 2008).

Additional lessons learned through evaluation of police diversion programs for possession of illicit drugs in Australia include the importance of effective referral to education or treatment, targeting interventions to levels of individual need, addressing the root causes of substance use, and developing appropriate eligibility criteria, especially with regard to threshold quantities (Hughes & Ritter, 2008; Hughes, Shanahan, Ritter, McDonald, & Gray-Weale, 2014).

The United Kingdom reclassified cannabis from a Class B to a Class C drug from 2004 to 2009, reducing the associated penalties but maintaining criminal sanctions. A police guidance was issued indicating that officers were to issue warnings rather than more formal cautions in cases of simple possession. These warnings did not result in a criminal record, but they did count toward police “cleared sanction” targets. Alignment with this guidance varied; for example, a study of four police services indicated a range of 22% to 42% use of warnings versus other sanctions (May, Duffy, Warburton, & Hough, 2007). Evaluation of police practice following the change in classification found an overall increase in police contacts associated with cannabis (i.e., net widening), but a decrease in the number of formal cautions (Shiner, 2015).

The **Law Enforcement Assisted Diversion** (LEAD) program originated in Seattle, Washington, in 2011. It is expanding to other states and is under consideration internationally. LEAD provides individuals suspected of low-level drug and prostitution crimes the opportunity to access comprehensive case management and community supports rather than proceed through the criminal justice system. Police present the diversion option to eligible participants following arrest but before booking charges. The program takes a harm reduction approach whereby abstinence is not a condition of participation.

Making conclusive statements about the impact of police diversion is complicated by the many variations in program structure, and the gaps and methodological challenges in evaluation data. Available research does indicate that police diversion programs, when compared to criminal charges, can reduce criminal justice system costs and reduce adverse social and economic consequences for the individual (Shanahan, Hughes, & McSweeney, 2016; Hughes & Ritter, 2008; Collins, Lonczak, & Clifasefi, 2015). The model and target population chosen for a police diversion program greatly impact the resources required to run it. Programs involving intensive case supervision and treatment, and targeting higher-need populations depend on the availability of harm reduction, treatment and social support programs in the community, and therefore require significant investment in health and social systems (Hughes & Ritter, 2008).

National De Facto Approaches

The **Netherlands**' *Opium Act Directive* (1976) is best known for introducing the regulated coffee-shop market. Although the *Directive* maintains criminal penalties, prosecutorial guidelines provide for the operation of cannabis coffee shops and decriminalize small amounts (up to 0.5 g or one pill) of other drugs. The objective of the Dutch policy was market separation to prevent those who used cannabis from moving into the use of more harmful drugs such as heroin. Research on the impacts of Dutch drug policy frequently focuses on cannabis. Although Dutch use of opioids, and notably drug-induced mortality rates, are well below European averages, use of cocaine, MDMA and amphetamines are comparatively high (European Monitoring Centre for Drugs and Drug Addiction, 2017b; United Nations Office on Drugs and Crime Statistics Online). The degree to which these trends are due to policy, which has remained relatively stable since 1976, rather than contextual trends, requires further exploration.

National De Jure Approaches

Several countries have passed legislation that formally removes criminal justice sanctions for certain drug-related offences. Approaches vary according to the type and quantity of substance, the nature of the eligible behaviour, and the associated type of sanction. The following examples illustrate this diversity, with sanctions ranging from warnings or small fines to mandatory treatment.[4]

In 2001, **Portugal's** *Law 30/2000* made the use of any illicit drug or possession of up to a ten-day supply of it an administrative rather than a criminal offence (Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências, 2000). This change was part of a comprehensive approach that included significant investment and capacity building in prevention, harm reduction, outreach, treatment and reintegration that began under the 1999 *National Strategy for the Fight Against Drugs*. An individual apprehended under this law receives a citation requiring an appearance before a Commission for the Dissuasion of Drug Addiction (CDT). CDTs are regional panels consisting of three members representing legal, health and social service perspectives. Their primary focus is to get those who are dependent on drugs into treatment (Goulao, 2016). CDTs are supported by multi-

4 For a more comprehensive overview of international approaches to decriminalization, see *A Quiet Revolution: Drug Decriminalisation Across the Globe* (2016) by Release.

disciplinary teams that review each case, assess the needs of the accused and determine an appropriate response. The responses available include dismissal with a warning, referral to health or social services (e.g., housing and employment supports), referral to substance use treatment, fines or community service. The majority of cases (83% in 2013) are suspended (Santos & Duarte, 2014).

The implementation of Portugal's national strategy was associated with reductions in the social harms of drug use, including use in public, the transmission of HIV/AIDS, lost productivity and demand on criminal justice resources (Goncalves, Lourenco, & Nogueira da Silva, 2015). HIV diagnoses attributed to injection drug use decreased from close to 1,800, or approximately 60% of new diagnoses in 1999, to 44, or 5% of new diagnoses in 2015 (Martins, 2016; European Monitoring Centre for Drugs and Drug Addiction, 2017a). Enhanced availability and coordination of harm reduction and treatment programs, and multidisciplinary services such as employment, welfare, health, prevention, law enforcement and education were essential to the strategy (Goulao, 2016). Although there were indications of an increase in rates of use after implementation of the strategy, these remained comparable to or lower than trends experienced in other European Union countries. Potential negative impacts such as a marked increase in use or expansion of the drug market have not been observed (Hughes & Stephens, 2010). Synthetic cost model analysis of the costs of opioids concluded that decriminalization did not result in lower prices, which would increase accessibility (Félix & Portugal, 2017).

The Czech Republic moved drug possession for personal use from a criminal to an administrative offence in 1990. Subsequent reforms in 1999 limited the scope of decriminalization by criminalizing amounts of drugs "greater than small"; leaving the police and courts to determine thresholds based on internal guidelines, which were generally quite restrictive, and the circumstances of the offence (Belackova & Stefunkova, 2017). In 2010, the government introduced defined quantities, which were generally more permissive than those informally established by police. In 2013, the Supreme Court replaced the quantities with comparable guidelines to inform case-by-base consideration based on quantity as well as other contextual factors (Mravcik, 2015). An evaluation of the 1999 policy change concluded that the shift toward greater criminalization was associated with increased social and enforcement costs. Although the timeframe for the evaluation was brief, there were no preliminary indications that it deterred drug use (Zabransky, Miovsky, Gajdosikoa, & Mraccik 2001).

Mexico's 2009 "narcomenudeo" reform mandated that individuals apprehended with small amounts of drugs be referred to health authorities rather than be arrested; after a third apprehension they would be required to enter treatment. Those apprehended receive a police record, but it states that "no penal action" was taken. However, implementation of these reforms has been limited (Eastwood, Fox, & Rosmarin, 2016). Research conducted in Tijuana indicated little to no police training or education to support the rollout of the new legislation, resulting in low levels of awareness of the law and threshold quantities (Arredondo, et al., 2017). The quantities qualifying for personal possession are also extremely low (5 g of cannabis; 0.5 g of cocaine, 50 mg of heroin), limiting the eligibility for participation as well as the impact of the reform (Mackey, Werb, Beletsky, Rangel, Arredondo, & Strathdee, 2014). Sanctions above these thresholds continue to include fines and prison sentences.

Legalization and Regulation

Uruguay is the only country to date to undertake full legalization of the non-medical use of a controlled substance. Legislation passed in 2013 allowed citizens to obtain cannabis through one of three ways: home production, licensed co-operatives or licensed pharmacies. Full implementation of the legal access framework has taken several years, with retail availability beginning in 2017. As of spring 2018, availability remains limited to a small number of pharmacies. Challenges to implementation included political de-prioritization, concern among citizens with the requirement to register their

chosen method of access with the state, delays in identifying state-authorized producers, and the refusal of banks to work with those selling cannabis due to international financial regulations and the status of cannabis as a prohibited substance internationally. There are not yet data available that bear on the health, economic and social impacts of cannabis legalization in Uruguay.

Status in Canada

Diversion is an integral part of the Canadian criminal justice system. The *Youth Criminal Justice Act* promotes the use of extra-judicial measures or responses outside the justice system, including informal warnings, formal cautions and referrals to community programs. The *Criminal Code* and *Controlled Drugs and Substances Act* permit the court to divert adults to an approved drug treatment program in order to avoid or reduce criminal penalties.

Several police services in Canada have adopted de facto police diversion approaches. Variations include informal de-prioritization of enforcing simple possession and referring or escorting individuals to local outreach or harm reduction services (Serr, M, personal communication, April 18, 2018).

Canada currently has a number of targeted exemptions in place. Two supervised consumption sites, InSite and the Dr. Peter Centre, have been operating in Vancouver for over ten years. *An Act to amend the Controlled Drugs and Substances Act and to make related amendments to other Acts* passed in May 2017, streamlined the application process for Section 56 exemptions for supervised consumption sites by reducing the number of conditions that applicants must meet from 26 to five. As a result, the number of supervised consumption sites in Canada is rapidly expanding, with twenty additional locations in operation as of April 2018.

There are limited drug-checking services currently available in Canada. These include onsite testing at events such as the Shambala music festival and targeted testing for fentanyl using test strips at supervised consumption and overdose prevention sites. Pilot study results from onsite testing conducted in November 2017 at two supervised consumption sites in Vancouver found that only 19% of substances purchased as opioids in fact contained the expected substance and 88% contained fentanyl (British Columbia Centre on Substance Use, 2018). In November 2017, the Minister of Health announced that Health Canada will authorize additional drug-checking services at supervised consumption sites. New programs will apply onsite technologies and for offsite analysis develop partnerships between frontline agencies and laboratories.

Canada passed the *Good Samaritan Drug Overdose Act* in May 2017. It provides an exemption from charges of simple possession and from charges concerning conditions related to pre-trial release, probation, conditional sentences or parole for individuals who call 911 for a drug overdose or are present when first responders arrive.

Canada's first heroin-assisted treatment program ran from 2005 to 2008 as the North American Opiate Medication Initiative. A follow-up study to assess long-term opioid maintenance began in 2011 (Oviedo-Joekes, et al., 2016). A small program continues to operate in Vancouver's Crosstown Clinic. In March 2018, the government removed restrictions on the prescription of diacetylmorphine (prescription-grade heroin) to allow doctors to prescribe and administer and nurse practitioners to administer the drug for opioid substitution purposes under Health Canada's Special Access Program outside of hospital settings. The regulatory changes came into effect in May 2018.

Implications for Policy and Practice

Experience with different approaches to decriminalization provides several key considerations that can guide the development of evidence-informed policy and practice. It is important to point out that there is no evidence to support an association between decriminalization and increased rates of use or other harms.

Continuity and integration of care increases positive health and social effects. One example is the co-location of health and addiction treatment services with supervised consumption sites (Gaddis, et al., 2017).

Community capacity is necessary to ensure the availability and interaction of health, enforcement and social programs needed to support police diversion that addresses individual risks and needs (Hughes, Shanahan, Ritter, McDonald, & Gray-Weale, 2014; Mackey, et al., 2014; Hughes & Ritter, 2008). Such programs include adequately resourced and accessible health promotion, harm reduction and treatment services.

Adopting broad or **flexible eligibility criteria,** for example with regard to criminal and substance use history, can maximize program reach and equity, especially for those who are harder to reach (Hughes & Ritter, 2008).

Threshold quantities that are set too low result in reduced impact by limiting eligibility (Hughes, Shanahan, Ritter, McDonald, & Gray-Weale, 2014). Thresholds provide clear guidance and support consistency of application, but providing some flexibility in these thresholds allows for other factors such as individual consumption levels to be taken into account (European Monitoring Centre for Drugs and Drug Addiction, 2003).

Diversion procedures that increase **administrative or resource requirements** on police without providing necessary support are likely to result in lower uptake and reduced impact (Mackey, et al., 2014).

Conversely, **net widening** occurs when there is an increase in the number of individuals caught up in criminal justice processes following the implementation of a diversion scheme. Net widening usually occurs when the diversion option is easily administered, when there are incentives for police to issue higher numbers of administrative sanctions (e.g., performance targets) and when there are criminal justice sanctions for non-compliance (Shiner, 2015; Hughes & Ritter, 2008).

Providing **clear communication** to both police and the public can reduce net widening by defining the objectives of diversion (i.e., reduced criminal justice involvement) and ensuring that those subject to diversion conditions are aware of the program requirements and the impacts of non-compliance (Hunter, 2001; Shanahan, Hughes, & McSweeney, 2016).

Clear guidelines and **ongoing training** for police are required to ensure both program implementation and fidelity (Belackova, Ritter, Shanahan, & Hughes, 2017; Luckwell, 2017). These supports for consistency in applying a program can also reduce the risk of inequitably applying it to minority groups, an unfortunate effect observed in some diversion programs in Australia (Hughes & Ritter, 2008; Baker & Goh, 2004).

Considering **legislative and regulatory context** is vital to ensuring successful implementation. As an illustration, New Zealand's *Psychoactive Substances Act* (2013) created a blanket prohibition on all new psychoactive substances, but provided the opportunity for producers and vendors of legal psychoactive substances to be licensed by the state if they could demonstrate that their products pose a low risk of harm. However, no substances have yet been approved and none are likely to be

approved because producers and vendors are unable to meet pre-market testing requirements after animal testing was banned but no suitable alternatives were identified (New Zealand Psychoactive Substances Regulatory Authority, 2017).

Finally, **people with lived experience** provide unique expertise and perspectives and should be meaningfully involved in developing policy and practice to address substance use (Canadian HIV/AIDS Legal Network, 2005; Belle-Isle, et al., 2016).

Knowledge Gaps

Many decriminalization initiatives have not been subject to rigorous evaluation, leaving many gaps in what we know about their health, social, economic and criminal justice impacts. The methodological limitations described earlier in this brief are responsible for some of these gaps.

There are also knowledge gaps about how to broaden or scale-up specific, targeted interventions. For example, heroin-assisted treatment has been limited to individuals with lengthy histories of use for whom alternative treatment approaches have not been successful; supervised injection sites have been limited to urban centres; and drug checking until recently focused on occasional use in nightlife settings. There is therefore a need to examine how interventions could be modified to suit different contexts. These contexts include both local and national considerations such as geography, population density, cultural and demographic diversity, substance use trends, legislative frameworks, law enforcement policies and practices, and, perhaps most importantly, the community, financial and administrative resources available to support implementation.

Options for Change

Substance use is a complex issue that cannot be resolved by any single change in policy or practice. This brief outlines a range of approaches that have been implemented in various ways and contexts. The constantly shifting nature of substance use and the illegal drug market requires timely, innovative and adaptive responses. The best solution for any given jurisdiction will be determined by a thorough consideration of contextual factors, including resources and readiness for change among decision makers and key stakeholders. Decision makers will need to determine whether adaptations to existing models are required to better reflect their own context and objectives.

Identifying a goal and clarifying objectives are preliminary steps in determining appropriate policy and practice. These steps include defining the problem to be solved and what progress will look like. Different objectives require different responses. For example, the Netherlands' approach to decriminalization was guided by the objective of separating the cannabis market from the market for other drugs perceived as more harmful. The Portuguese approach was driven by the objective of shifting the perception of drug use from a criminal issue to a health issue in order to address increasing rates of drug-related death and transmission of blood-borne viruses. Interventions targeted at reducing blood-borne virus transmission will focus on the context and equipment involved in use, whereas interventions targeting deaths due to contamination or unknown potency will focus on the drugs themselves, for example, by expanding controlled access to a regulated supply.

Situating any intervention within an evidence-informed continuum of prevention, harm reduction and treatment is fundamental to a public health approach. Rigorous data collection is needed to evaluate the success of decriminalization approaches. For instance, the impact of a controlled supply of drugs on contamination could be measured by collecting data on associated harms including rates of overdose or poisoning. Data collection and monitoring enable course corrections over time based on emerging evidence or changes in such external factors as trends in drug consumption.

De Jure Options

The most sweeping decriminalization option in Canada is to remove from the *Controlled Drugs and Substances Act* criminal penalties associated with certain drug-related offences such as possession. This option requires legislative change at the federal level, as well as changes at the provincial, territorial and municipal levels with regard to police, the courts, and, depending on the model, other health and social services. The evidence tells us that legislative change is only one part of a comprehensive approach that requires time and investment. In Portugal, for example, scale-up of prevention, treatment and harm reduction services began under the National Drugs Strategy two years before decriminalization.

The federal government can continue to scale up targeted exemptions under Section 56 of the *Controlled Drugs and Substances Act* to support harm reduction initiatives. These exemptions enable the government to respond in a timely way to identified priorities. Regulatory amendments under ministerial authority such as Section 56 exemptions can be implemented more quickly than legislative changes that require passing a bill through Parliament.

De Facto Options

National, provincial, territorial and municipal police forces have the authority to issue guidance or implement programs supporting the use of discretion to apply non-criminal justice alternatives to drug offences. De facto enforcement approaches can be implemented relatively quickly compared to de jure change. They can also be tailored to respond to local context. However, attention to training, administration and resourcing is essential to avoid net widening, ensure equity of application and provide a comprehensive community response.

Conclusion

The evidence is growing to support various approaches to decriminalization as effective ways to mitigate the harms of substance use and the policies and practices used to deal with it, especially those harms associated with criminal justice prosecution for simple possession. The evidence base needs to be improved by more consistently subjecting decriminalization to rigorous evaluation, and data and results need to be made accessible to analysts and policy makers.

Decriminalization is not a single model or approach. Many decriminalization options can be combined and tailored based on problem, context and resources. Substance use is a complex issue, touching public health and safety, social issues and the economy, and it requires a comprehensive approach. There is neither a single nor an immediate solution. Recognizing that substance use is a health rather than a criminal justice issue is a fundamental starting point for reform.

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