



International Approaches to Drug Law Reform



CRIME AND JUSTICE

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Summary of Key Points

Background and context

- Internationally, there is growing recognition of the harms that punitive drug policies cause, and a movement towards harm minimization and health efforts instead of traditional criminalization, law enforcement and abstinence based responses.
- There is a commitment in Scotland to reduce drug harms and the alarming recent growth of drug related deaths. However, the justice system's ability to reorient its approach towards people who use drugs is constrained by the current UK law, notwithstanding recent developments elsewhere in the UK, which illustrate the potential for localised innovation.
- This paper gives an overview of seven case studies in drug law reform approaches from five countries. It aims to support Scottish Government research and policy development regarding drug law and enforcement, and the work of the Drug Deaths Taskforce in identifying successful interventions and locating them within their legal and policing contexts.

Frameworks for Considering Law Reform

Harms

- Most drugs do not inherently cause large amounts of harm in and of themselves when used casually. Rather, the vast majority of drug harm arises from dependence.
- The hierarchy of harm is not well represented in most countries' classification laws. Data on harms in the UK make it clear that the present UK drug classification system does not correspond with the harm each substance causes.
- In particular, ecstasy and LSD are consistently ranked as two of the lowest harm drugs, despite being Class A drugs in most jurisdictions. Cannabis is also consistently ranked as less harmful than alcohol or tobacco, which are legal in most jurisdictions.

Risk Environment

- How the law is implemented and enforced can significantly impact the effectiveness of interventions.

- The risk environment can be thought of in terms of the physical, social, economic and policy contexts in which people use drugs. Both practical policing decisions (such as physical patrols), and bureaucratic structures (such as inter-agency referral pathways) can significantly influence people's decisions about drug use and service engagement, and public health outcomes.

What doesn't work?

- There is an emerging consensus that ineffective interventions for people who use drugs tend to be ones that:
 - are excessively punitive or involve excessively close monitoring
 - do not involve a rehabilitative element or build skills for the future
 - reinforce criminal identity
 - are implemented poorly
- a common failure of many interventions, whether psychoeducational, control-oriented or deterrence-oriented, is a failure to help people to gain the skills they need to manage situations differently in the future.

Case Studies

Seven case studies were selected for closer examination in this paper. The case studies were not selected systematically, but on the basis of recommendations and interest from experts within Scottish Government and

Australia

- The dominant strategy in Australia for many decades has been a policy of criminalising the use and supply of illicit drugs.
- Research on major policing crackdowns in Australia have generally found that such operations tend to make only modest impacts on supply and overall exacerbate harms rather than reduce them, by pushing drug use into more dangerous places, and more dangerous transport and consumption methods.
- In recent years, some reforms have occurred including:
 - Legal decriminalisation of cannabis possession in some States and Territories, replacing criminal sanctions with civil fines.
 - In other states, de facto reforms have taken place. These generally involve interventions such as diversionary cautions or referral to treatment. However, these schemes have strict

eligibility criteria which can exclude those who may need them most.

- In some places, police have supported harm minimisation interventions by, for example, limiting unwarranted patrols near needle exchanges.
- Evaluation of cannabis expiation schemes show some implementation problems, but have been effective at reducing enforcement costs without increasing consumption.
- Research has indicated that drug use in Australia is relatively stable over time and cannabis decriminalisation has not increased consumption. However, despite this, the number of civil penalties issued has continued to increase, suggesting that police propensity to detect and formally process cannabis possession may have increased due to the lower stakes of the civil penalty – an effect known as “net widening”.

Canada

- Canada has allowed medically prescribed cannabis since 2001, and in 2018 changed the law to create a fully legal, regulated market for recreational use.
- Retail cannabis is now available in all Canadian jurisdictions, with some states using government operated retailers and others using licensed private providers
- This change was motivated by a desire to not just decriminalise cannabis consumers, but to also remove production and revenue from criminal enterprise, giving the government both control over quality assurance, and the ability to collect tax on this previously black market.
- It is too early to confidently assess the change’s impact, however the data available suggest that:
 - After a small initial rise, reported consumption returned to pre-reform rates and has been relatively stable since.
 - Canadians report accessing significantly less cannabis directly from the illegal market.
- Vancouver also serves as an informative case study on harm minimisation for harder drugs. In 2003, Vancouver opened North America’s first supervised injection facility. It initially operated under a special exemption from Canada’s drug laws, and its legal status was affirmed by the Canadian Supreme Court in 2010.

- Vancouver police have adopted an organisation-wide policy that treats drug use as a public health issue and encourages police to use discretion and refer them to the safe injecting facility or other services.
- Since it began, there has never been a death at Vancouver's supervised injection facility. Extensive evaluation has indicated that the facility decreases risk of fatal overdose, improves service users' safe injecting practices, increases uptake of addiction treatment, and reduces public nuisance issues.
- There is also evidence that relationships between drug users and police have improved, police now regularly refer people to the safe injecting facility, and are more likely to view people who use drugs as needing protection.
- The supervised injecting facility has also served as an important first step for building further innovation, such as current work on heroin assisted treatment.

Denmark

- Since a law change in 2011, Denmark now has five supervised Drug Consumption Rooms (DCRs) across three municipalities.
- Overdose deaths in Denmark have been falling since consumption rooms were introduced. Evaluations indicate that DCR's have contributed to reducing the number of overdose deaths in the cities that have them. There is also evidence from the Copenhagen facility that crime, violence and publicly discarded syringes have all decreased in the area.
- Research has highlighted the important role consumption rooms have played in helping people access health, social and addiction services.
- Research on police attitudes also suggests that the advent of decriminalization zones around consumption rooms has caused more police to view drug users as people in need of police protection rather than as police targets.

The Netherlands

- Cannabis has been decriminalised for personal use since 1971. The current day 'coffee shop' model has developed through a dialogue between informal police tolerance policies and legislative/regulatory

reform.

- Today, coffee shops may sell cannabis as long as they are licensed and adhere to a range of regulations, including limits on the volume that can be traded, a minimum age of 18, and not selling alcohol or contributing to public nuisance.
- The consumer side of this model has been largely successful, and cannabis use in the Netherlands is about average for Europe despite its laws being significantly more liberal than most.
- However, because the law only permits and regulates small scale, consumer transactions, the cultivation and wholesale supply to coffee shops remains unregulated and criminal enterprise is significantly involved.
- For harder drugs, the Netherlands has developed a comprehensive health-based harm minimisation approach, with many of their most notable policy developments arising from informal or experimental practices that were subsequently codified by the government. Needle exchanges, safe injecting facilities and heroin assisted treatment are all examples of this.
- Research on the impact of a period of intensive policing crackdowns in the 1990s has consistently shown that such enforcement crackdowns contributed to moving drug scenes outdoors and into suburbs, increasing both the number of people involved and the degree of risk they faced.
- The Netherlands has very low rates of problematic drug use, and arrests for minor possession are extremely rare. Drug users in the Netherlands also tend to use safer practices (for example, a very low proportion of opiate users inject), and this has led to relatively high survival rates and longer life expectancy for people who use heroin in the Netherlands.
- Due to substantial investment in sheltered housing, integrated drug treatment, public mental health care, services for the homeless and criminal justice interventions, most problematic drug users now live in supported housing where they receive welfare and treatment.

Portugal

- In 2001 Portugal decriminalised the purchase, possession and use of all illicit drugs. The change went beyond depenalisation, which removes custodial sentencing, but did not amount to full legalisation, as the production, manufacture and large-scale distribution of illicit drugs remain a criminal offence.

- Low-level offenders are now dealt with administratively by informal “dissuasion commissions”. People found to suffer from addiction typically receive a suspended penalty in order to allow them to seek treatment. The commission may also impose fines or various personal restrictions on people’s drug use.
- The implementation of this model is supported by investment in a systematic approach to treatment, harm reduction and social reintegration across the country.
- Studies have generally found that the change did not significantly increase consumption or decrease drug prices. Moreover, research estimated that decriminalisation has decreased the social costs of drug use by 18%.
- Initially, decriminalisation had a clear direct impact on prison populations in Portugal, with substantially drops in the prison population and fewer incarcerated people reporting drug use. Incarceration rates began to rise again in 2008, although the profile of incarcerated offenders is now different and it is likely other external trends contributed to this.
- There is some evidence of “net-widening, similar to that seen in Australia, leading to increasingly low level offenders being brought before commissions. This is an important implementation lesson in ensuring laws are explicitly designed to prevent mission creep.

Key themes from the international literature

- Research on drug **criminalisation** generally indicates that criminal sanctions for drug use or possession tend to exacerbate harm or undermine efforts at harm minimisation, particularly around safe injecting and treatment access.
- Major policing crackdowns and enforcement operations tend to increase harms to people who use drugs. Research from a number of countries has shown that crackdowns are more likely to move drug dealing and usage geographically than to reduce them, incentivise more unsafe transport practices, and discourage people from carrying clean injecting equipment.
- Incarceration is associated with increased risk of drug death after release, while decriminalisation is associated with improved social integration and employment.

- Decriminalisation has also been shown to reduce the strain on justice systems.
- A large proportion of drug revenue is reinvested in other organised crime activities such as extortion, fraud, pornography, illegal poaching and weapons trafficking. Creating legitimate drug markets can help to divert income that perpetuates other crimes.
- Moreover, research indicates that decriminalisation does not lead to significant increases in drug use or other crimes.
- A growing number of countries have implemented **supervised injecting facilities** or drug consumption rooms. Such interventions have consistently been shown to:
 - Provide care in instances of overdose, preventing them from becoming fatal.
 - Improve service users' knowledge and practice of safe injecting practices.
 - Improve uptake of addiction treatment.
 - Provide healthcare for other issues, particularly injection-related infections, to drug users who may otherwise not access mainstream clinics.
- Research on **cannabis decriminalisation** consistently finds that decriminalisation does not significantly increase demand or consumption, but there is some evidence that liberalising cannabis laws causes some people to substitute away from higher harm drugs such as opioids or alcohol.
- In general, cannabis decriminalisation provides an opportunity to divert people away from the harms of the justice system. However, there is some evidence that making low level drug offence processing easier creates a "net-widening" effect that catches more people who might otherwise have benefited from police discretion. This pitfall should be guarded against in the design of any decriminalisation approach.
- Fully legal cannabis markets can be implemented and regulated in a number of different ways to reduce illegal trafficking and drug revenue supporting other criminal activities.
- Decriminalisation, diversion schemes, and the limited instances of legalisation suggest that similar benefits can be found for "**harder**" **drugs** than cannabis. Punitive enforcement is associated with increased crime, while less punitive approaches like diversion are associated with higher rates of treatment and safer injecting practices.

1. Purpose and context

This paper gives an overview of seven case studies in drug law reform approaches from five countries. It aims to support Scottish Government research and policy development regarding drug law and enforcement, and the work of the Drug Deaths Taskforce in identifying successful interventions and locating them within their legal and policing contexts. This is a research paper and represents the findings of the project only. It does not constitute a Scottish Government policy position.

Internationally, there is a growing recognition of the harms that punitive drug policies cause, and a movement towards harm minimisation efforts instead of traditional enforcement and abstinence based responses to drugs in the community. Reforms such as depenalization, decriminalization and even regulated legalization are increasingly common internationally, as are efforts to ensure policing and health priorities are better aligned. As Palmer noted in 2018: “during a period of arguably the most stringent prohibitionist enforcement in history, worldwide drug production has increased, drug consumption has increased, the number of new kinds of drugs has increased, drugs remain readily available to the consumer market, drug prices have decreased and the purity of street drugs has increased. If this is a recipe for success it is difficult to envisage a recipe for failure.” (Palmer 2018)

In Scotland, drug law is governed by the UK Misuse of Drugs Act 1971. There is a continuing commitment in Scotland to reduce drug harm, including addressing the rising number of drug related deaths. This has involved police engagement in harm reduction approaches, but the justice system’s ability to reorient it’s approach to people who use drugs is constrained within the current law.

The relationship between people who use drugs and the health and justice systems is complicated. Research from 2016 showed that 77% of people who died from overdose in Scotland had been in drug treatment, prison or police custody, or discharged from hospital in the six months prior to death (Barnsdale, 2018). Police officers are present at the scene of most overdoses (both fatal and non-fatal) if the emergency services are called, although the true number of non-fatal overdoses in Scotland is not known.

Moreover, commonly quoted drug death figures relate only to overdoses, not including other deaths related to drug use. Many of the wider harms of drug use are not measurable, but the overall extent of health harms and early death are indicated in Scottish Burden of Disease study, which showed that drug use disorder was the eighth most common cause of disease burden in Scotland in 2016. Of this burden, 60% was due to premature mortality and 40% to health loss caused by drug use disorders (NHS Health Scotland, 2016).

Drug treatment has been found to reduce costs. Research from 2010, found that the total social and economic cost of illicit drug use in Scotland is just under £3.56 billion (around £61,000 per problem drug user) per annum. Estimated costs of crime are reduced significantly for individuals in treatment (from £12,713 for individuals with no intervention in place; to £1,536 for those in treatment for more than one year) (Malloch, 2011).

In November 2019, the Scottish Affairs Committee made a number of recommendations including that the Misuse of Drugs Act be amended to allow a range of public health focused responses, and that the UK Government should move away from treating drugs as a Criminal Justice matter (House of Commons Scottish Affairs Committee, 2019). Similarly, The UK Parliament Health and Social Care Committee inquiry into drug use called for radical change to the drug policy and decriminalisation for the possession of small amounts of drugs for personal use (House of Commons Health and Social Care Committee, 2019).

The Scottish Government has now established the Drug Deaths Taskforce, in response to the almost unparalleled rise in annual overdose deaths in recent years. The Taskforce is examining the main causes of drug deaths, and will advise what changes, in practice or in the law, could help save lives. They are also considering the impact of the Misuse of Drugs Act on taking a public health approach to the drug deaths emergency, including proposals to provide harm reduction services, such as medically supervised overdose prevention rooms.

There are some examples of elsewhere in the UK where justice agencies are working with harm reduction services, although again these are all bounded by the Misuse of Drugs Act.

- As far back as 1988, a Police Order in England and Wales made it service policy that people who inject drugs should not be arrested for carrying injecting equipment in a public place (Monaghan & Bewley-Taylor, 2013).
- The Checkpoint scheme in Durham, England diverts certain people, including those with possession or minor dealing charges, into a four month long offender management programme with a navigator and support tailored to the individual, instead of prosecution. It has shown lower reoffending rates for those diverted from prosecution into rehabilitation.
- A pilot of the UK's first drug safety testing service at a music festival, involving a police negotiated 'tolerance zone' around the service in a large fixed tent in the festival's welfare area, took place in 2018 with paramedic and support services (Measham, 2019).

- Various naloxone pilots across the four nations of the UK.

With this context in mind, the remainder of this paper focuses on the international evidence. The next section lays out some frameworks for considering different options – the role harm plays in policy calculus, and the impact law and enforcement has on the risk environment for those who use drugs, and what is known about policies that don't work. The subsequent section provides case studies on reforms made in Australia, Canada, Denmark, The Netherlands and Portugal, and highlights some other international examples of note. The final section summarises key themes from the international literature, relating to criminalisation and harm reduction, supervised consumption rooms, cannabis-specific reforms, reforms specific to minimising the harms of harder drugs, and implementation issues.

2. Frameworks for considering law reform

'The policing of drug markets is usually conceptualised primarily as a matter of law enforcement – drug dealers and people who use drugs are breaking the law, and the role of the police is to reduce such law breaking. However, the wider purpose of policing is to ensure the safety of the community by reducing harms to its members' (Stevens, 2013).

2.1 The case for considering change

- There is much to be done to reduce drug harms in Scotland, but there are limits on how radically practice can change without changing the legislative framework. While regulation can be imperfect at achieving its objectives, the government has a wide range of policy options at its disposal which can be used to help mitigate risks outside of the criminal law.
- **There is no strong link between harsh penalties and the prevalence of drug use.** One might expect that countries that have the toughest penalties for drug use would also have the lowest levels of drug use. However, there is no obvious relationship between how prevalent drug use is and how aggressively the criminal law and other regulatory policies are applied. A study of the global prevalence of common recreational drugs concluded: "Globally, drug use is not distributed evenly and is not simply related to drug policy, since countries with stringent user-level illegal drug policies did not have lower levels of use than countries with liberal ones" (Degenhardt, 2008).
- **Some jurisdictions have created fully legal, regulated markets for some drugs**, although this is a relatively recent approach and there are only a small number of examples so far.
- **More common are jurisdictions that have undertaken some kind of decriminalisation**, the main options being:
 - Removal of use/possession from criminal law, irrespective of the amount possessed. This may be with a civil sanction or no action at all (a civil sanction might apply, for example, when a place of use restriction is breached, such as use in a public park).
 - Removal of use/possession from criminal law up to a certain threshold amount.
 - Removal of criminal penalties for eligible people or offences, up to a certain threshold amount (for example, a maximum number of cautions).

- Change in practice, without removal from the criminal law (de facto decriminalisation), although this raises issues in relation to the rule of law and potential bias in application.
- **However, these less ambitious reforms, such as instituting fines and other civil penalties, do not remove all of the costs associated with criminalisation:**
 - Even if characterised as noncriminal sanctions, civil fines and the associated administrative process can have significant punitive effects, which may be indistinguishable from the effects of court-imposed fines for criminal offences (Quilter & McNamara, 2019).
 - Reducing penalties for illicit drugs may result in net-widening if the lower threshold makes it more likely police will formally process people who may otherwise have benefited from discretion, as has been seen in parts of Australia. In the United Kingdom, when cannabis was reclassified as a lower-class drug and police were advised to warn and confiscate rather than arrest users, the number of convictions fell initially, but eventually returned to previous levels and the overall number of drug possession offences increased sharply with more formal warnings (Bryan, Del Bono, & Pudney, 2011).

2.2 Harms

Key Points

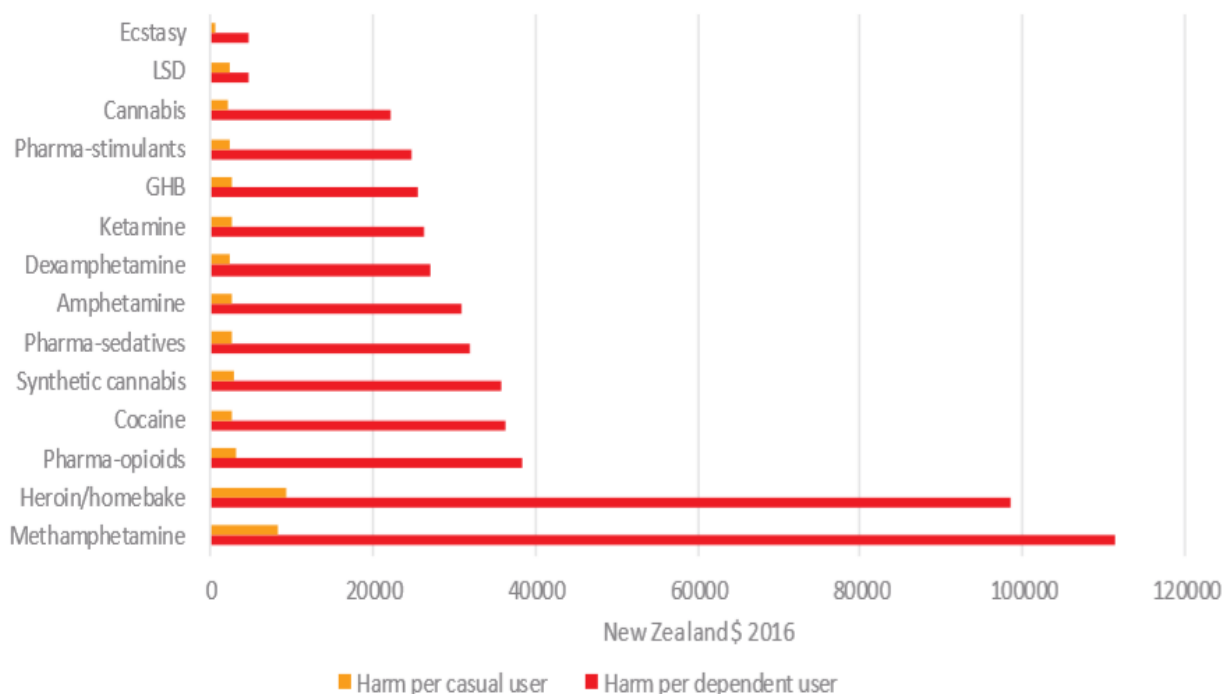
- Most drugs do not inherently cause large amounts of harm when used casually. Rather, the vast majority of harm arises from dependence.
- The hierarchy of harm is not well represented in most countries' classification laws – for example ecstasy and LSD are consistently ranked as two of the lowest harm drugs, but are class A drugs in most places.
- On the basis of data on harms in the UK, it is clear that the present UK drug classification system is not directly based on the harm each substance causes.

In setting policy goals, it is important to consider the magnitude and distribution of drug harms. Different drugs have different usage patterns and different impacts on people who use them, and (although all drugs are used in all segments of society) some predominate in particular groups.

- An illicit drug harm index developed for the New Zealand Ministry of Health estimated that the harms per drug user between casual and dependent users, and between substances, differ significantly (McFadden Consultancy, 2016). They considered individual harm through disability/death, and social harms including drug related violence, property crime, organised crime reinvestment in other crimes, harms to family and friends, tax avoidance, and legal/social intervention costs. The chart below shows their estimates of harm per casual user and per dependent user. It shows that:
 - **Most drugs do not inherently cause large amounts of harm when used casually. Rather, the vast majority of harm arises from dependence.**
 - **The hierarchy of harm is not well represented in most counties' classification laws – for example ecstasy and LSD are the two lowest harm drugs, but are typically class A drugs in most places.**

Other studies also consistently rank the relative harms of ecstasy and cannabis as lower than that of legal drugs (alcohol and tobacco) and other illicit drugs (such as heroin and cocaine) (for example: (Bonomo, et al., 2019) (van Amsterdam, Nutt, Phillips, & van den Brink, 2015)).

Figure G.3 New Zealand drug harm index, harm to and per user



- A British study in 2010 analysed data from a multicriteria decision analysis conference on drug harms. The harms were assessed according to a set of

16 criteria developed by the Advisory Council on the Misuse of Drugs (Nutt, King, & Phillips, 2010). The harms assessed were:

Harms to users

- Drug-specific mortality
- Drug-related mortality
- Drug-specific physical damage
- Dependency
- Drug-specific impairment of mental function
- Loss of tangibles
- Loss of relationships

Harms to others

- Physical or psychological injury
- Crime
- Environmental damage
- Family adversities
- International damage
- Economic cost
- Community

- Weighted scores provided ratings on harm to the individual, harm to society, and an overall harm score. These findings lend support to earlier work from both UK and Dutch expert committees on assessing drug harms. It concluded that **“on the basis of these data it is clear that the present UK drug classification system is not simply based on considerations of harm.”** The final ratings for all drugs considered are shown in the chart below:

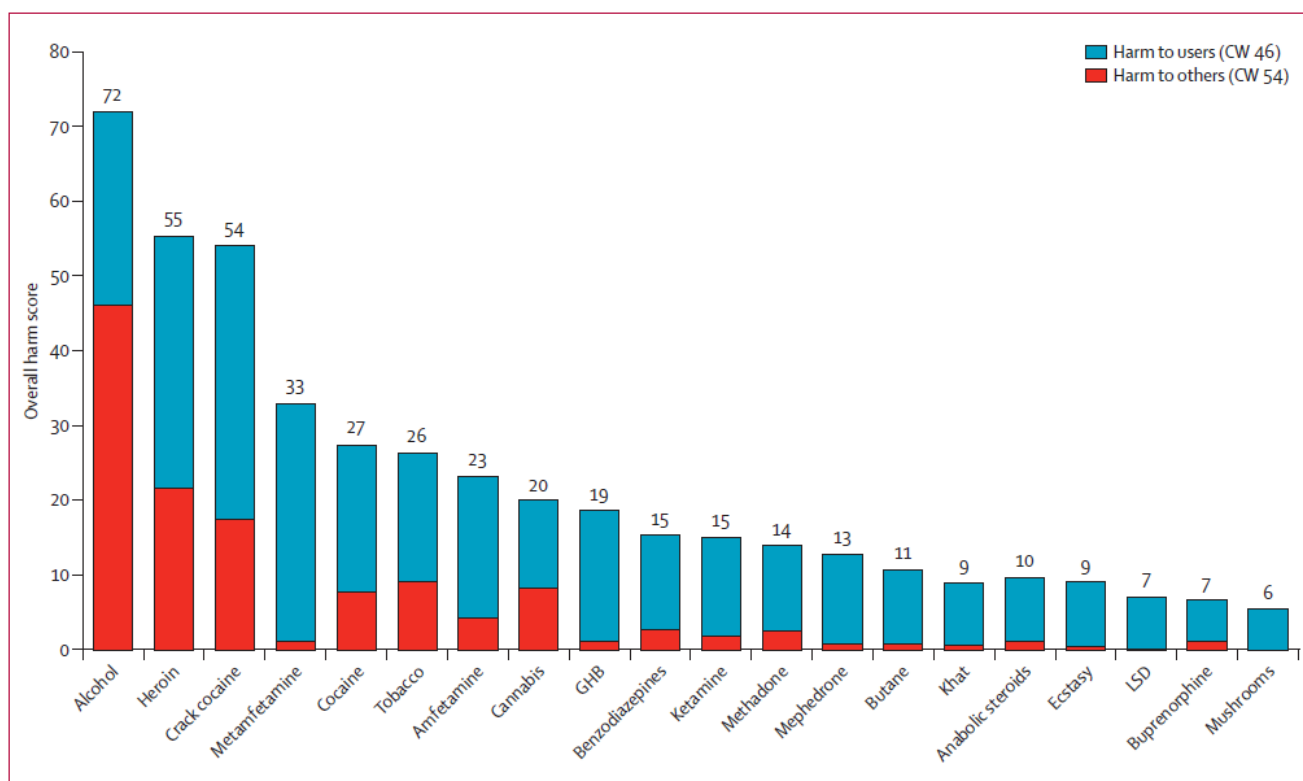


Figure 2: Drugs ordered by their overall harm scores, showing the separate contributions to the overall scores of harms to users and harm to others. The weights after normalisation (0–100) are shown in the key (cumulative in the sense of the sum of all the normalised weights for all the criteria to users, 46; and for all the criteria to others, 54). CW=cumulative weight. GHB=γ hydroxybutyric acid. LSD=lysergic acid diethylamide.

- **The economic harms of inefficient policies should also be considered.** Research by Transform Drug Policy Foundation (Rolles, 2009) considered four hypothetical scenarios, and estimated the benefits bringing all drugs in England and Wales under formal regulation. Their estimates for different scenarios are laid out below (estimates for FY 2003/4):

Change in number of drug users	Estimated benefits from regulation of all drugs in England and Wales, compared to prohibition
Decrease by 50%	£13.9 billion
No Change	£10.8 billion
Increase 50%	£7.7 billion
Increase 100%	£4.6 billion

The study concluded regulation was a more cost-effective approach than prohibition.

2.3 Risk environment

Key Points

- How the law is implemented and enforced can significantly impact the effectiveness of interventions.
- The risk environment for people who use drugs is influenced by many factors. Both practical policing decisions (such as physical patrols) and bureaucratic structures (such as inter-agency referral pathways) can significantly influence people's decisions about drug use and service engagement.

In addition to more accurately conceptualising drug use harms, the breadth of the law's implications (both intended and unintended) must be considered in terms of its contribution to the environment in which people view, buy and use drugs. The table below shows an example of the factors that influence the HIV risk environment, which has many overlaps with other drug harms.

Table 1 Simple model of HIV risk environment in the context of transition⁵

	Micro-environment	Macro-environment
Physical	Drug injecting sites Sex work sites Prisons and detention centres Refugee collecting and dispersal centres	Trade and trafficking routes (drugs, sex, humans) Labour mobility, urban and economic migration Geographical dispersal of population
Social	Peer and social norms Community attitudes Local policing practices Community health and welfare services	Social and cultural norms and values National and cultural identity and nationalism Gender and social inequalities Stigmatisation and marginalisation of social groups Civil society and societal infrastructure
Economic	Cost of living and health care Income generation Informal local economies Economic enterprise	Economic regulation and development Public and health service revenue and spend Employment norms and practices
Policy	Distribution of syringes Distribution of condoms City regulations	Policies governing trade, trafficking, and migration Laws governing drug use and syringe exchange Laws governing sex and consent Laws governing health, welfare, and citizen rights

Stevens et al note that “The outcomes of diversion will depend on relationships between policing systems and other agencies as well as the capacity of healthcare and welfare systems to provide effective treatment and to support social integration” (Price, Parkes, & Malloch, 2020).

The Ontario Treatment Network have written about the importance of appropriate policing responses in balancing the risk environment for drug users: “while macro- and meso-level laws and policies are intended to guide policing responses to drug and injection equipment possession and use, they do not necessarily align with policing behaviour enforced on the streets. Engaging police in harm reduction strategies may provide an opportunity to reduce the injection drug-associated harms while also reducing crime” (Rapid Response Service, 2016)

How the law is implemented and enforced can significantly impact the effectiveness of interventions. Ontario treatment network’s paper on engaging law enforcement in harm reduction programs for people who inject drugs found evidence to support the conclusions that:

- **Policing practices can hinder injection drug users’ access to sterile syringes**
- **Police targeting people who inject drugs can increase unsafe injecting behaviour**
- **Police presence can impact health outcomes for people who inject drugs**

- **Members of minority groups who inject drugs can be unequally targeted in enforcement.**
- Harm reduction can be supported by:
 - collaboration between the law enforcement and public health sectors;
 - encouraging police discretion with the law in encounters with people who inject drugs;
 - providing comprehensive harm reduction training for police officers;
 - limiting police presence surrounding harm reduction and health services used by people who inject drugs.

Public policy may be oriented towards harm reduction, and individual-level services may be available – but **the legal framework and the police who enforce it have substantial power to either encourage or deter their successful engagement.**

2.4 What doesn't work

Key Points

- The specific study of ineffective interventions and what doesn't work to reduce harms is a relatively new field, but a consensus is emerging that ineffective interventions tend to be ones that:
 - are excessively punitive or involve excessively close monitoring
 - do not involve a rehabilitative element or build skills for the future
 - reinforce criminal identity
 - are implemented poorly
- A common failure of many interventions, whether psychoeducational, control oriented or deterrence-oriented, is a failure to help people to gain the skills they need to manage situations differently in the future.

An ideal legal framework should create harmony rather than tension between the obligations and incentives law enforcement face, and those faced by health and social care providers. Where there is tension between legal enforcement and evidence-based interventions, substantial resource can be wasted on ineffective treatments, services that are never accessed by those who need them, or even interventions that increase rather than decrease people's risks of

harm. With that in mind, considering what does not work for those with drug dependency in the justice system is as important as what does work.

The field of specifically studying ineffective interventions is still young, but a number of quality review papers have begun to identify some of their common features:

- **Interventions that are excessively punitive or involve excessively close monitoring are likely to be ineffective**
 - MacKenzie and Farrington's (2015) and Lipsey and Cullen's (2007) systematic reviews both concluded that effective interventions for reducing reoffending were those that are rehabilitative and skills building (e.g., drug treatment and cognitive skills programs), while ineffective interventions were, on average, characterized by surveillance and control, including prison sentences, boot camps, and intensive community supervision.
 - Barnett and Howard (2018) review 21 systematic reviews on effective interventions for those either in prison or serving sentences in the community. It concluded that for those monitored in the community, increased supervision or surveillance without rehabilitative support may be ineffective. The authors note that neither ignition interlock interventions (for drink-driving) nor regular drug testing had any impact on recidivism as stand-alone strategies - consistent with a number of other rigorous evaluations of intensive supervision, surveillance and control based strategies, which have generally been unlikely to have a positive impact on reoffending for young adults or adults (Lipsey, 2009) (MacKenzie & Farrington, 2015).
 - Koehler et al's (2014) meta-analysis included three robust studies of drug testing orders, involving regular urine testing and increasing the likelihood of detecting use (two programmes included some form of psychosocial care as well). Analysis showed no significant effect on crime or substance abuse by participants, although the authors also noted that there may be some deterrent effect for specific sub-groups, for example, people whose drug use is less entrenched.
 - There is, broadly, a strong evidence base for the effectiveness of Opioid Maintenance Therapy (OMT) in reducing heroin use, drug injecting and drug driven crime. However, meta-analysis looking specifically at prison-based OMT for substance misuse, showed that although receiving OMT in prison did reduce illicit opiate use, findings on criminal recidivism were mixed, and studies reporting a positive impact on reoffending found that benefits were lost within 6 months (Hedrich, et al., 2011).
- **Interventions that do not involve a rehabilitative element, or do not build skills for the future are likely to be ineffective**

- Prendergast et al's (2013) meta-analysis of international drug treatment found that interventions that do not adhere to Risk-Need-Responsivity (RNR) principles (i.e., did not match level of treatment to level of risk of reoffending, did not target factors known to be associated with crime, and did not use multimodal, cognitive-behavioural approaches to treatment) were less effective in reducing reoffending, than those adhering to these principles. The authors concluded that, in general, drug treatment programs have a greater impact on drug outcomes than crime outcomes, but that the application of RNR principles increased the impact on crime outcomes.
- Barnett and Howard (2018) conclude that a common failure of many interventions, whether psychoeducational, control oriented or deterrence-oriented, is a failure to help people to gain skills needed to manage situations differently. They note that "Simply helping people to see the impact of their crimes, the consequences of their decisions or preventing them from engaging in certain behaviors for a limited amount of time, does not appear to help people change behavior in the long term. This is supported by behaviour change research more generally, which suggests that people need not only the motivation to change, but must be capable of that change (i.e., have the right knowledge and skills), and have the opportunity to enact that change" (Michie, van Stralen, & West, 2011).
- **Reinforcing criminal identity is likely to increase the risk of reoffending**
 - The recidivism literature shows that developing a prosocial, noncriminal identity is important to negotiating the hardships and setbacks associated with rebuilding one's life and reintegrating into the community following a conviction, while a criminal identity can lead people to feel "doomed to deviance" (Maruna, 2001). Barnett et al (2018) argue based on their systematic review that "it is possible that custodial sanctions, boot camps, mandatory treatment, and drug testing or intensive supervision may convey the message to some individuals that others believe they are highly likely to reoffend, or that a return to crime is almost inevitable".
- **Programmes that are not well implemented are unlikely to work**
 - Welsh and Rocque's review (2014) found that the majority of studies indicated that drug treatment programmes and specialist drug courts have a positive impact and demonstrably reduce reoffending. However, they also identified five evaluations that concluded the intervention under examination had not just been ineffective, but had harmed participants. In the author's view, this was most likely related to poor implementation and adherence to programme design.

3. Case Studies

3.1 Australia

Key Points

- The dominant strategy in Australia for many decades has been a policy of criminalising the use and supply of illicit drugs.
- In recent years, some reforms have occurred including:
 - Legal decriminalisation of cannabis possession in some States and Territories, which have replaced criminal sanctions with civil fines.
 - In other states, other forms of de facto reform have taken place. These generally involve interventions such as diversionary cautions or referral to treatment. However, these schemes have strict eligibility criteria and can exclude those who may need them most.
 - In some places, police have supported harm minimisation interventions by, for example, limited unwarranted patrols near needle exchanges.
- Research has indicated that drug use in Australia is relatively stable over time and cannabis decriminalisation has not increased consumption. However, over time the number of civil penalties issued has continued to increase, suggesting that police propensity to detect and formally process cannabis possession may have increased due to the lower stakes of the civil penalty – an effect known as “net widening”.

Background and model

Commonly used illicit drugs such as heroin, cannabis, opium and MDMA were legal in Australia in the first half of the 20th century. These drugs were gradually prohibited, but usage continued and in the 1960s, despite prohibition, drug use increased as the culture became more socially liberal (Gotsis, Angus, & Roth, 2016).

Drug policy in Australia is governed by a combination of federal laws and regulations, and the National Drug Strategy 2017–2026, which pursues “demand reduction, supply reduction and harm reduction”. **The dominant strategy for many decades has been a policy of criminalising the use and supply of illicit drugs.** Further control is devolved to states and territories, which also pass their own laws and policies.

The Queensland Government's Inquiry into Imprisonment and Recidivism (2020) notes that there is some inconsistency between evidence on harm and the scheduling of drugs in legislation – noting that ecstasy, a relatively low harm drug, is listed in schedule 1, while relatively high harm drugs like fentanyl, are in schedule 2.

In recent years, some reform has occurred in drug law and enforcement.

- Legal reform
 - South Australia, the Australian Capital Territory and the Northern Territory have decriminalised use and possession of cannabis, replacing criminal sanction with a system of civil fines.
 - No state or territory has undertaken legal reforms for illicit substances other than cannabis. Accordingly, many people do still appear in court for possession of small quantities of drugs.
 - No state or territory has implemented criminal law reforms legalising supply-side-related offences.

- Defacto reform
 - All jurisdictions that haven't legally decriminalised cannabis have undertaken some kind of de facto reform, including various forms of diversionary approaches such as cautions, provision of information, referral to treatment, compulsory treatment and compulsory education.
 - In most jurisdictions, these types of de facto reforms have also been extended to some other illicit drugs.
 - All de facto decriminalisation schemes have relatively strict eligibility requirements. Typically, these include to admit the offence, not have been detected by police more than once or twice, and carry only a particular quantity of drug (e.g. 2 grams or less). Anyone who does not meet the requirements (or has exceeded the low limits for past referrals) is processed through the usual court mechanism. Such eligibility requirements can exclude those most marginalised and/or those most in need of diversion into treatment and rehabilitation. De jure schemes have fewer eligibility restrictions which increases program access and equity.

De facto law enforcement reforms in relation to other harm minimisation approaches have also been implemented in some places. In 1988 the Commissioner of New South Wales Police discouraged police officers from making unwarranted patrols near needle and syringe exchange programmes, in order not to discourage drug users from attending. Other police forces subsequently introduced similar instructions (Monaghan & Bewley-Taylor, 2013).

De facto and de jure reforms in Australia are summarised in the table below:

Reform type and jurisdiction	Drugs	Scheme	Response/penalty	Number of referrals allowed	Response to non-compliance
De jure reforms					
ACT	Cannabis	Simple cannabis offence notice (SCON)	Fine	No limit	May result in criminal penalty
NT	Cannabis	Cannabis expiation scheme	Fine	No limit	Debt to state, may result in criminal prosecution
SA	Cannabis	Cannabis expiation notice (CEN)	Fine, but option to pay via community service	No limit	Reminder notice, additional fee, automatic criminal conviction
De facto reforms					
ACT	All illicit drugs	Police Early Diversion Program	Caution plus brief intervention	2 previous	May result in criminal penalty
NSW	Cannabis	Cannabis cautioning scheme	Caution plus information	1 previous	Recorded and court advised if subsequently reoffends
NT	Other illicit	NT Illicit Drug Pre-Court	Assessment and compulsory treatment	No limit	May result in criminal penalty
QLD	Cannabis	Police diversion program for minor offences	Assessment	1 previous	May result in criminal penalty
SA	Other illicit	SA Police Drug Diversion Initiative	Assessment and referral	No limit	May result in criminal penalty
TAS	All illicit drugs	Police diversion	Caution and brief intervention (for third offence, assessment and	3 previous in last 10 years	May result in criminal penalty

			compulsory treatment)		
VIC	Cannabis	Cannabis cautioning program	Caution and education, optional referral	1 previous	Nil
WA	Cannabis	Cannabis intervention requirement	Assessment and compulsory education	1 previous	May result in criminal penalty
WA	Other illicit	All drug diversion	Assessment and compulsory treatment	1 only	May result in criminal penalty

Reproduced from Hughes et al, 2016

Hughes et al (2016) concluded that although population drug use rates remain stable in Australia, the rates of drug use/possession detections are continuing to rise. This means more people who use drugs risk getting charged, convicted and imprisoned for minor quantities of drugs.

Outcomes and impact

The research on Australia's overarching prohibitionist approach is consistent in concluding that prohibition contributes to harm rather than minimising it. For example:

- The Queensland Government's Inquiry into Imprisonment and Recidivism (2020) concluded that "criminalisation has created significant costs and unintended harms. It helped to create an illegal market worth at least \$1.6 billion (with high levels of violence), made the quality of supply uncertain (resulting in increased morbidity and mortality), and impeded treatment of harmful use".
- Two studies have been done on the impact of police crackdowns in drug law enforcement.
 - Wan et al (2014) studied the impact of supplier arrests and seizures of heroin, cocaine and amphetamine-type substances over 10 years. They found no consistent effects between any of the supply reduction measures and police reports of theft, robbery and assault. The findings suggest that increases in seizures or supplier arrests indicate increased supply in the market making it easier to catch people, rather than signalling that a reduction should be expected. There was some evidence that 'very large-scale supply control operations do sometimes reduce the availability of illicit drugs for a period'.

- Earlier, Maher and Dixon (1999) looked at the impact of ostensibly successful crackdowns generating “respectable” arrest and conviction rates. However, the authors conclude that “crackdowns, whether carried out in the name of law enforcement or quality of life, push markets in directions which are highly undesirable.” They reported that much sale and consumption simply moved geographically, often to more dangerous locations, and that they adopted more dangerous transport methods, were less likely to carry clean injecting equipment, and increased other unsafe injection practices.
- Research comparing Australian jurisdictions with other countries has indicated that punitive approaches do not appear to impact consumption:
 - Martin et al (Martin, 2019) found that ecstasy, cocaine, methamphetamines and opioids are all significantly more expensive in Australia than in other countries, but conclude that this does not appear to be a deterrent, since drug use in Australia is relatively high. UNODC data suggest Australia has the second-highest prevalence of ecstasy use, the equal highest of cocaine, the fourth-highest of amphetamines and the fourth-highest of prescription opioids.
 - Degehardt et al. (2008) found that although the proportion of the Australian population imprisoned for drugs is substantially lower than in the US, “this does not appear to have deterred drug consumption—the United States consumes more illicit drugs per capita than Australia”

One possible explanation for this lack of deterrence is the low probability of getting caught. “About 90,000 drug offences are prosecuted each year in Australia while an estimated 2680 million drug offences are committed each year (2400 million cones, 40 million pills, 40 million hits, etc.) or about 1 prosecution per 30,000 offences; the cocaine rate is about one prosecution for every 110,000 lines of coke” (Jiggins, 2013).

Outcomes from cannabis expiation notice schemes seem to be mixed. Under this scheme, detected adult offenders can avoid prosecution by paying an expiation fee within a set timeframe. Penalties for single offences range from \$50 to \$150, but failure to pay expiation fees could lead to prosecution and the possibility of a conviction being recorded.

Evaluations of the scheme’s impact found:

- The proportion of cannabis offences cleared by payment is relatively low, at below 50%. Christie and Ali (2009) report that “one of the most common outcomes for offenders who do not clear their CENs by paying the expiation fees is prosecution with a conviction being recorded. This has occurred in a system that, it could be argued, was designed to remove or reduce that risk

of conviction. With many offenders not paying the fees, the absolute numbers of convictions being recorded for minor cannabis offences is probably greater than if the CEN system had not been introduced.”

- Over time, the number of CENs issued has continued to increase, but research shows that cannabis use has remained relatively stable, indicating that police propensity to detect and/or formally process these crimes has increased.
- Notwithstanding the problems above, the expiation approach has been cost-effective, reducing enforcement costs without leading to increased cannabis use. Eastwood et al (2016) also reviewed the analytical literature on decriminalisation’s impact on cannabis use in Australia. They found one study reporting a significant increase in cannabis use in states where it has been decriminalised, one study demonstrating a decrease in cannabis use after decriminalisation, and five studies showing that decriminalisation had no significant impact on the prevalence of cannabis use. They conclude that “Collectively, this would suggest that at the very least reform of the law and the ending of criminal sanctions for cannabis use has no or little impact on prevalence” (Eastwood, Fox, & Rosmarin, 2016)

3.2 Canada (cannabis legalisation)

Key Points

- Canada has allowed medically prescribed cannabis since 2001, and in 2018 the law was changed to create a fully legal, regulated market for recreational use.
- Retail cannabis is now available in all Canadian jurisdictions, with some states using government operated retailers and others using licensed private providers.
- This change was motivated by a desire to not just decriminalise cannabis consumers, but to also remove production and revenue from criminal enterprise, giving the government both control over quality assurance, and the ability to collect tax on this previously black market.
- It is too early to assess the change’s impact with high confidence, however, the data available suggest that:
 - After a small initial rise, reported consumption returned to pre-reform rates and has been relatively stable since.
 - Canadians report accessing significantly less cannabis directly from the illegal market.

Background and model

In 2018 the law in Canada was changed to create a fully legal, regulated market for recreational use.

Canada's longstanding cannabis prohibition was first significantly altered in 2001, when medically prescribed cannabis was legalised. Various unsuccessful attempts were made in the following years at both liberalising and tightening the law, until the Cannabis Act was passed in 2018, allowing the creation of a legal, regulated market for recreational use.

The Canadian Government emphasised three key goals for this reform:

- protecting public health
- protecting young people
- reducing criminality associated with the illegal market

Reducing criminality associated with the illegal market has a number of motivations. The Final Report of the government's Task Force on Cannabis Legalization and Regulation (2016) notes **concerns about the proceeds of the illegal cannabis trade enriching organized crime groups and funding other types of criminal activity, as well as the fact that criminalisation leaves potential tax revenue in the black economy** rather than with the government; "With decriminalization [as opposed to legalisation] the production, distribution and sale of cannabis remain criminal activities. Thus, individuals remain subject to the potential dangers of untested cannabis. Criminal organizations continue to play the role of producer, distributor and seller, thereby increasing risk, particularly to vulnerable populations."

The key features of the new recreational model in Canada are:

- Provincial devolution:
Historically, Canadian provinces have taken their own independent approaches to alcohol regulation, and a similar devolved principle was applied to cannabis. There are national minimum requirements – individuals must be 18 or over, and possession cannot exceed of 30 grams – but provinces may place their own further restrictions on possession, cultivation, sale and use. Provinces are responsible for developing their own retail system, which may be through physical stores and/or federal mail.
- Staged implementation:
In the first year, the Act only allowed for herbal cannabis and oils to be sold, with edibles and concentrates subject to separate regulations, and not going on sale until the following year (Government of Canada, 2019)
- Promotion and packaging regulation:
Products may be branded, but the law prohibits certain activities such as event sponsorship or marketing aimed at young people.

Outcomes and impact

Because this law change only occurred in 2018, and was implemented in phases, it is too early to robustly assess impact, but there is no evidence that the police have faced an increase in issues.

The Transform Drug Policy Foundation note in their one year review of the law that “it will inevitably take time for the new system to bed in and for emerging problems to be addressed”. Overall, they found that because cannabis regulation was devolved to provinces, “a ‘patchwork’ of regulatory models has now emerged across the country. **Some provinces have been more successful than others and many have experienced ‘teething’ issues during early implementation**”, referring to issues with both preparedness and implementation speed (Transform Drug Policy Foundation, 2019). Media coverage has noted specific public criticisms of some local implementation programmes, but no formal evaluations are yet available.

The details of regulation vary by province/territory (Government of Canada, 2020).

- The legal age is set at 19 in all but two provinces.
- All provinces allow people to grow cannabis at home for recreational use, except Quebec and Manitoba. Where it is allowed, growth is consistently limited to four plants per household.
- Retail cannabis is now available in all jurisdictions – eight using government operated retailers, and the remaining five licensing private operators. Online sales are government operated in all jurisdictions except Saskatchewan and Manitoba.
- States are about evenly divided between those that allow use in public and those that don’t. States that do generally have limitations in place similar to those that govern smoking tobacco in public.

Usage levels are a measure for considering public health implications, although the confluence of relevant factors is too complicated to robustly attribute causation to any single change. There is data available from the National Cannabis Survey, conducted by Statistics Canada from early 2018, although it must be treated with caution because:

- The law is too recent for trends to be clear yet, and we would expect to see a “novelty blip” at the point of change. The phased rollout further reduces comparability of quarterly results.
- People may have been less likely to disclose their use before law change.
- Prior to legalisation, some medical cannabis stores also sold recreationally illegally – this informal, quasi-legal grey market may have confused

respondents in some areas.

- Sales recorded for medical purposes in July 2019 were lower than in July 2018, suggesting that at least some of those who previously relied on medical documentation were now accessing cannabis on the legal recreational market (Government of Canada, 2019).

With these caveats in mind, usage figures can nonetheless be informative. Previous national survey data showed a long history of high levels of cannabis consumption in Canada, and use has been rising for the preceding 4-5 years across almost all age groups (Statistics Canada, 2019). The two waves of data available for analysis since the law change:

- suggest **use has remained relatively stable since the reform**: “After a small rise in the first quarter of 2019, reported consumption went back down to pre-October 2018 levels in the second quarter.
- indicate a **significant decrease in Canadians accessing cannabis directly from the illegal market** or from friends and family.
- may give some evidence that those who already consumed cannabis prior to regulation are consuming more. Data from the first quarter of 2019 indicates that the number of occasional users did increase slightly compared to the same quarter in 2018. This, too, could potentially be linked to a novelty ‘blip’ and changes in survey honesty following the law change.
- recorded an increase in first-time users in the first quarter of 2019, with over half of these individuals aged 45 or older.
- Indicate ongoing challenges in encouraging consumers with an established supply source towards the legal market – reporting that the average cost of a gram of legal cannabis was \$10.23 compared to \$5.59 for illegal cannabis (Statistics Canada, 2019).

There has been no formal analysis yet on the impact the law change has had on other crimes or drug driving. Media coverage has generally indicated that police have not faced an uptick in problems.¹

In terms of cannabis specific offences, police-reported cannabis crime had been declining for several years due to being a relatively low police priority. Between 2017 and 2018, when the law change was made, cannabis related offences fell 29% overall (although import/export offences rose 22%). Import/export offences

¹ See, for example:

<https://www.cbc.ca/news/canada/edmonton/cannabis-impaired-driving-update-2020-1.5449435>
<https://calgaryherald.com/cannabis/cannabis-news/cannabis-legalization/cannabis-legalization-has-had-little-impact-on-crime-disorder-city-police>

made up 21% of Cannabis Act offences in its first year, followed by possession of more than the maximum allowed (18%) (Statistics Canada, 2018).

3.3 Canada (Vancouver harm reduction)

Key Points

- In 2003, Vancouver opened North America's first supervised drug consumption facility. It initially operated under a special exemption from Canada's drug laws, and its legal status was affirmed by the Canadian Supreme Court in 2010.
- Vancouver police have adopted an organisation-wide policy that treats drug use as a public health issue and encourages police to use discretion and service referrals to achieve the best outcomes for people who use drugs.
- Since it began, there has never been a death at Vancouver's supervised injecting facility. Extensive evaluation has indicated that the facility decreases risk of fatal overdose, improves service users' safe injecting practices, increases uptake of addiction treatment, and reduces public nuisance issues.

Background and model

In 2003, Vancouver opened the first safe injecting facility in North America, called Insite, with a limited exemption from Canada's drug trafficking and possession laws to allow its operation. At the end of the three year pilot programme, the exemption was extended, but when the extension ended service users brought a court case which resulted in the British Columbia Court of Appeal ruling "While users do not use Insite directly to treat addiction, they receive services and assistance at Insite which reduce the risk of overdose that is a feature of their illness, they avoid risk of being infected or of infecting others by injection and they gain access to counselling and consultation that may lead to abstinence and rehabilitation. All of this is healthcare" (PHS Community Services Society v Canada (Attorney General), 2010). Ultimately, this was affirmed by the Supreme Court of Canada in 2010, who ruled that to "close Insite contravened the country's charter of rights by threatening the lives of injection drug users" (Small D. , 2012)

Vancouver now has an expanded harm minimisation approach across the city including multiple small scale injectable opioid programme sites, pilot drug checking service focusing on fentanyl in two sites with "legal authorizations for clients to be in possession of controlled substances and a clientele who regularly use opioids, stimulants, and other street drugs by injection" (Tupper, 2018) and projects to pilot automatic pill dispensing through secure atm-style machines intended to connect drug users easily to a clean, regulated supply (Fischer, 2018).

To support these programmes' success, the **Vancouver Police Department developed and implemented an organisation-wide drug policy that frames drug use as a public health issue and promotes police practices that encourage people who inject drugs to access harm reduction services.** (Landsberg, 2016). In particular, the policy encourages discretionary practices in street-level possession and use cases, and supports police referrals to safe injection facilities.

Outcomes and impact

Extensive evaluation has indicated that Vancouver's safe injecting facility decreases risk of fatal overdose, improves service users' safe injecting practices, increases uptake of addiction treatment, and reduces public nuisance issues. There is also evidence that relationships between drug users and police have improved, and that police now regularly refer people to the safe injecting facility.

A number of studies also shed light on the relationship between police and drug users in Vancouver:

- In 2001, prior to the reforms described above, a police exercise substantially increased police presence throughout the day in the vicinity of a Vancouver needle exchange. Researchers found that 27% fewer syringes were distributed in the first four weeks of the operation than in the four weeks prior (Wood, 2003). However, 9 years later, a qualitative study of policing practices in the neighbourhood where Insite is located during the 2010 Winter Olympic Games found that, despite higher police presence during this period, it did not reduce local drug users' access to health services or increase injection-related risk behaviour (Small W. , 2012).
- Police referral procedures have also played an important role. A 2008 study of Insite (De Beck, 2008), found that nearly 17 per cent of its clients reported being referred to the facility by police. In addition, the individuals the local police were referring to Insite were more likely to be engaged in sex work, to be frequent cocaine injectors, and to report discarding used syringes in public. By referring these particularly high-risk injection drug users to a health facility instead of a justice agency, local police help to reduce health harms.
- The authors also note that police referring injection drug users who are more likely to discard needles in public spaces to appropriate community services also serves to address public nuisance concerns.

Thanks in part to a major resource commitment when Insite was established to support robust data collection and research, the safe injecting facility has been extensively evaluated using cohort samples of drug users in Vancouver, administrative data and topic-specific surveys. Findings in this area can broadly be

grouped into those related to the impact on overdoses, access to treatment, injecting practices, crime/nuisance, and implementation and targeting.

- **Impact on overdoses**

- **A number of studies have consistently shown that Insite has helped to prevent overdose fatalities.** Although no overdose at Insite has ever resulted in death, nonfatal overdose is fairly common, with roughly 13 for every 10,000 injections (Milloy, 2008). In an 18-month study in 2004-5, 87% of overdoses were treated just with oxygen. The authors concluded overall that Insite plays a role in successfully managing overdoses among people who inject drugs, and it is also likely that Insite reduces the burden on emergency services that would otherwise respond to overdose events.
- Another study estimated how many non-fatal overdoses at Insite would have been fatal if they had happened in the community. The author's models suggest that between 8 and 51 deaths were averted in a four year period. The number of overdose deaths in the area had averaged about 35 over the preceding five years. The authors concluded that the care provided in the facility reduces the risk of death and improves public health in the area (Kerr, 2006).
- Some critics have suggested that supervised injecting facilities may actually lead to more overdoses, if the safe space makes people feel more comfortable with the risk of taking a higher dose. An evaluation surveying more than 1,000 Insite users over two years tested this theory, but found that those who were at Insite for the majority of their usage were not more likely to overdose than those who mostly used outside the service (Milloy, 2008).
- Qualitative research with 50 service users also supports these findings- people who used Insite reported that it addresses many of the environmental factors that drive the high rate of overdose among people who inject drugs. In particular, giving people the time to carefully and safely inject without rushing is noted as a key way in which InSite reduces overdose risk (Kerr, Small, Moore, & Wood, 2007).

- **Impact on access to treatment**

- The Canadian cohort study found that **attendance at Insite was associated with increased referral to addiction care centres, uptake of detox treatment and uptake of methadone maintenance** (Wood E. , 2006). Contact with Insite's addictions counsellor further significantly increased a person's chances of enrolling in detox.

- In the year after Insite opened, there was a 33% increase in detox service use, compared to the year prior. Moreover, Insite clients who entered detox were 1.6 times more likely to enroll in methadone treatment and 3.7 times more likely to enroll in other forms of addiction treatment. People who entered detox also visited Insite less frequently in the month after enrolling in detox services than in the month prior to enrolment (Wood, Tyndall, Zhang, Montaner, & Kerr, 2007).
- Criticism that safe injecting facilities may make people in recovery more likely to relapse was also tested in a study. However, no change was found in rates of relapse into injection drug use among former users in the year after Insite opened compared to the year before, and fewer people started binge drug use. The authors conclude that the facility's benefits have not been offset by negative effects on drug use patterns in the area (Kerr T. , 2006)
- People's access to other medical treatment also improved. A qualitative study of 50 service users found that nurses at InSite regularly provide care for injection-related infections and frequently connect drug users with off-site medical treatment by supplying referrals and arranging transportation. Service users reported that it was easier to get care for infections there than in conventional care settings because Insite nurses are experienced in working with drug users and because the facility is open late at night. Additionally, the authors note that if scaled this type of care has the potential to reduce emergency room use and hospitalization among local injection drug users (Small W. , 2008).

- **Impact on injecting practices**

A large number of studies have looked at Insite's impact on injecting practices. They have consistently found:

- Reduced needle sharing:

After adjustment for relevant socio-demographic and drug use characteristics, **use of the facility was associated with a marked reduction in syringe sharing** (Kerr T. , 2005) These findings are supported by earlier results suggesting that attendance at Insite appears to reduce syringe sharing specifically in HIV risk situations (HIV+ people lending needles or HIV- people borrowing them), and analysis of Insite data combined with a similar study in Spain concluded that regular safe injection facility users reduce their likelihood of sharing syringes by 69% (Molloy, 2009).

- Improved knowledge and practice of other safety measures:

The education provided at Insite has also been found to positively impact people's use of safe injecting practices. A study comparing those who consistently visited Insite (for 25% or more of their injections) and those who used the facility less consistently found that consistent Insite attenders were substantially more likely to use sterile water, swab injection sites, dispose of syringes safely, and cook or filter their drugs. They were also less likely to rush during injections or share syringes. The authors conclude that InSite is helping to reduce some of the health risks associated with unsafe injecting (Stolts, 2007).

A 2006 survey, (Petra, 2007) found that **75% of Insite Users reported injecting more safely as a result of visiting Insite.**

Qualitative research with 50 InSite clients supports these findings (Fast, 2008), with many people reporting that they did not know about the benefits of cleaning the skin with an alcohol swab prior to injecting, inserting the syringe bevel-side up, or other measures they could be taking to minimize health risks. Regular Insite users reported that they learned about these practices from nurses in a way that felt safe, supportive and unhurried. Importantly, study participants told researchers that the overall environment at **the facility encouraged them to adopt the safer practices and to make a habit of using them both within and outside of the facility.**

A small number of research participants did report that they had not received safer injecting education at the facility, indicating that Insite may not be meeting the educational needs of everyone who injects drugs there. Those people who use the facility often are more likely to interact regularly with nurses and receive educational messages that help protect health.

- Reduced public injecting:

A study of those Insite users who also continue to inject publicly was published in 2007. The results showed that those still injecting publicly were 3 times more likely to be homeless compared to other Insite users, and also 1.6 times more likely to require help injecting (a practice that is not permitted at Insite). People who continue to inject in public told researchers that the waiting times limit their use of the facility. The authors conclude that increasing availability through a program expansion may further help to reduce persistent risk behaviours and address community concerns about ongoing levels of public drug use, and that the restriction against assisting with injections at Insite may pose a barrier to use by some people who inject drugs (McKnight, et al., 2007).

Fairburn et al also note in their qualitative research that in many cases, the first time a woman uses an injection drug, someone else— usually an older male— injects the drug for her. By learning how to inject

themselves, women rely less on men and gain more control over the circumstances of their own drug use. They are then more likely to practise safer habits when injecting, such as using clean needles (Fairburn, Small, Shannon, Wood, & Kerr, 2008).

- **Impact on crime, nuisance and the community**

- **A rigorous quasi-experimental study found that the number of people injecting in public, number of publicly discarded syringes, and amount of injection related litter all declined significantly** in the 12 weeks after Insite opened, compared to the weeks before (Wood, et al., 2004).
- More broadly, crime rates in the year before Insite opened were compared with crime rates in the year after, using Police data on drug trafficking, assaults, robberies, vehicle break-ins, and thefts. Researchers found no statistically significant changes in rates of drug trafficking, assaults, or robberies, and a drop in vehicle break-ins and thefts. The results of this study provide evidence that Insite's presence has not contributed to an increase in drug-related crime in surrounding neighbourhoods.

- **Implementation and service user targeting**

- Due to its extensive evaluation, much can be learned about implementation and service user targeting from the Insite model.
- Multiple cohort and survey samples have shown that InSite is attracting those at highest risk, as is intended (Wood, et al., 2005) (Wood, et al., 2006). The researchers concluded that the facility was successfully attracting:
 - people who are at elevated risk of blood-borne disease or infection
 - people at elevated risk of overdose
 - people who were using publicly or unsafely disposing of syringes
 - Marginalised people including homeless people, sex workers, younger people and indigenous people.
- A survey of over 1000 service users also identifies some of the most common obstacles to using the service. These were most frequently travel time to Insite, the facility's limited operating hours, and the waiting time to use the facility (Petrar, 2007).

3.4 Denmark

Key Points

- Since a law change in 2011, Denmark now has five Drug Consumption Rooms across three municipalities.
- Overdose deaths in Denmark have been falling since consumption rooms were introduced. Evaluations indicate that DCR's have reduced the number of overdose deaths in the cities that have them.
- There is also evidence from evaluations of the Copenhagen facility that crime, violence and publicly discarded syringes have all decreased in the area.
- Research has highlighted the important role consumption rooms have played in helping people access health, social and addiction services.
- Research on police attitudes also suggests that the advent of decriminalization zones around consumption rooms has caused more police to view drug users as people in need of police protection rather than as police targets.

Background and model

Denmark has pursued harm-reduction policies such as opioid substitution treatment (OST) and needle exchange programmes for many years, but politicians and health authorities initially opposed drug consumption rooms (Ministry of the Interior and Health, 2003) (Ministry of the Interior and Health, 2010). However, in 2011, in an act of civil disobedience, Danish NGOs started two mobile drug consumption rooms in retired ambulances, staffed by volunteer nurses and doctors (Ege, 2012), and the next year Denmark passed legislation to allow municipalities to establish drug consumption rooms.

The amendment to Denmark's law on psychedelic substances had three stated intentions:

- to reduce the number of overdose deaths,
- to improve life situations for people who use drugs by connecting them to the healthcare system, treatment facilities and social services,
- to reduce the nuisance of public drug taking to surrounding neighbourhoods (Ministry of Health and Prevention, 2011).

The bill amending the law provides that “**within the vicinity of the DCRs, police will not prosecute people who are over the age of 18 years, who possess drugs for their own use, and who have a prolonged use of and addiction to illicit drugs**” This can be seen as a form of de facto decriminalisation of drug use, since possession remains an offence, but in practice the law is not fully enforced.

The key features of the Danish DCR model are summarised here from Keppel et al (2019):

- Consumption rooms follow two delivery models:
 - Integrated units, typically part of a shelter with additional services such as counselling, laundry and shower facilities, or a health clinic.
 - Mobile unit, with relatively limited space, primarily only functioning as a hygienic, safe place for injecting.
- DCRs are financed by the municipalities and managed by NGOs².
- All DCRs are staffed with registered nurses or nursing aides, who work in a team alongside social workers and social educators. All staff members have advanced first aid training and are trained in the effects and side effects of the most commonly consumed drugs, but no additional formal training is required to work at a DCR. The healthcare professionals are mainly responsible for intervention and treatment in cases of severe intoxication.
- To access DCRs, clients must:
 - register, create an alias that will be used for future entry, and agree to house rules.
 - accept that staff will intervene if they overdose
 - indicate at every entry what drug they plan to consume
 - not be a minor or pregnant
 - not deal or trade within the facility
 - no client is allowed to provide assistance to peers

In addition to providing safe, clean space for consumption, DCRs also provide information on drug ingredients and potency, refer clients to a variety of treatment and health services, and may also issue clients with Naloxone. The staff address barriers to care for injection-related injuries, provide low-threshold nursing attention on site, and connect with off-site medical service (Small, Wood, Lloyd-Smith, Tyndall, & Kerr, 2008).

Outcomes and impact

There are now five DCRs, spread across three municipalities in Denmark, all of them in permanent locations with integrated services except for one mobile unit in Copenhagen. By 2016, within five years of the law change, there were 3600 service users registered at DCRs (Toth, Tegner, Lauridsen, & Kappel, 2016).

² Except for the one mobile DCR, which is directly financed and run by the Municipality of Copenhagen.

The Danish ministerial evaluation of DCRs is not available in English, but Kappel et al (2016) report that it indicates “**DCRs in Denmark has had an effect on reducing the number of deaths by overdose in the cities that have implemented the DCR programme**”. Although we cannot confidently attribute causation, it is noteworthy that Denmark’s overdose deaths peaked in 2011, the year the DCRs commenced, and have been declining since. Other impacts have been reported in the media – news articles (such as Boffey, 2013 and Busby, 2018) on the Copenhagen DCRs have reported that:

- Year on year, burglaries in the wider area are down by about 3%, theft from vehicles and violence down about 5%, and possession of weapons also down.
- Up to 10,000 syringes used to be picked up off the streets of Vesterbro every week before the room opened. Since the launch of the room, the quantity of drug paraphernalia collected from gutters, playgrounds, stairwells and doorways in the area has halved.

Their research concluded that the “humanizing approach of DCR staff, combined with the provision of facilities and tools for drug consumption, appear to promote a sentiment of social acceptance among DCR clients” and noted that this was consistent with other studies of DCRs (eg (Rance & Fraser, 2011)). They further found that the approach empowered the DCR clients towards feeling more “like citizens rather than scummy junkies”, and concluded that this empowerment is in fact “the most important feature of DCRs... which ultimately paves the way for both the successful prevention of overdoses, as well as for steering clients towards utilizing both social and health services, including drug rehabilitation facilities.”

Fieldwork for Kappel et al’s study also observed that the trust forged between the staff and clients was evidenced in their willingness to heed staff’s advice on being cautious with their intake, and attribute this as a success of the service. They also note that DCRs appear to function as bridges to other health and social services, including drug treatment, but that it is difficult to measure impact because people use aliases to access the DCR, and are then need to follow up the referral themselves.

The model is also reported to have had an impact on policing practices. According to qualitative research by Kammersgaard (2019) “decriminalization zones that were established with the DCRs in 2012 enabled the police to abstain from traditional drug law enforcement techniques that focus on use reduction through punishment and the confiscation of illegal substances. Instead the police were able to direct their attention to the wider harm experienced by people who use drugs”. Kammersgaard further suggests **that this policy change led to police viewing people who use drugs primarily as people in need of police protection rather than as offenders who pose a threat to their community.**

3.5 Netherlands (cannabis 'coffee shop' market)

Key Points

- Cannabis has been decriminalised for personal use since 1971. The current day 'coffee shop' model has developed through a dialogue between informal police tolerance policies and legislative/regulatory reform.
- Today, coffee shops may sell cannabis as long as they are licensed and adhere to a range of regulations, including limits on the volume that can be traded, a minimum age of 18, and not selling alcohol or contributing to public nuisance.
- The consumer side of this model has been largely successful, and cannabis use in the Netherlands is about average for Europe despite its laws being significantly more liberal than most.
- However, because the law only permits and regulates small scale, consumer transactions, the cultivation and wholesale supply to coffee shops remains unregulated and criminal enterprise is significantly involved.

Background and model

In the early 1970s, two government committees on drug law (Hulsman, 1971 and Baan, 1972) recommended attempting to separate cannabis from the wider drug scene, to reduce the extent to which young people who experimented with cannabis were exposed to more harmful substances.

Since 1971, cannabis has been decriminalised for personal use, and the Ministry of Health has had primary responsibility for drug policy. A further law change in 1977 sanctioned tolerant policing practices that had emerged as informal policy in the previous decade, giving authorities the ability to creatively interpret the new legislation in their local areas. Public prosecutors subsequently deprioritised small scale cannabis offences, focusing almost exclusively on large operations and harder drugs (De Kort, 1995).

'Coffee shops', where people could buy cannabis more or less free from the risk police enforcement, emerged as an unintended consequence of this change, and the Government responded with restraint, applying a pre-existing but informal set of tolerance criteria: that coffee shops must only sell small quantities, and not serve young people, advertise or cause nuisance. However, due to this unclear legal status, enforcement was inconsistent, with some places raided while others were tolerated (De Kort, 1995).

The number of coffee shops continued to grow and eventually in 1991 formal regulation was brought in which:

- Set a minimum age of 18
- Decreased the maximum transaction amount to 5 grams per person per day
- Limited daily trade to 500g

These regulations have been strengthened over time, for example tightening restrictions on premises licensees, and giving local municipalities the power to close down coffee shop's deemed to cause a public nuisance.

In 2012, the government piloted a new approach, known as the 'weed club pass'. This required coffee shops to operate on a small membership-only model, and only residents of the Netherlands could become members (Aanwijzing Opiumwet, 2012) (although, as discussed below, this was not successful and the pilot has not been rolled out more widely).

Outcomes and impact

There is no evidence that the relatively free availability of cannabis has led to substantial increases in consumption. **Despite having significantly more liberal laws than its neighbours, cannabis use in the Netherlands is on par with the European average** (Grund & Breeksema, 2017).

However, while the consumer side of the coffee shop model has been largely successful, important lessons can be drawn from the Netherlands' experience of what is termed the "back door problem". The regulated coffee shop model means sales of small quantities (ie, retail to consumers – the 'front door') is exempt from prosecution, but cultivating larger quantities for supply (ie, wholesale supply to coffee shops – the 'back door') remains illegal (De Kort, 1995). This came about, according to former Prime Minister Van Agt, because 'there was no parliamentary majority for decriminalising the supply of cannabis or other drugs in 1976, and the Dutch government did not want to risk diplomatic or economic problems with neighbouring countries and the international community'.

The compromise reached gave consumers safe access in regulated environments, certainly lowering harms to them, but the vast majority of research agrees that **the fact cultivation and supply to coffee shops is not regulated is the main source of the negative side effects currently seen in the Netherlands**, particularly the involvement of organised crime and the lack of quality control. Investment in criminal enforcement has not been effective at removing these problems. At the same time, the Dutch government has felt limited in their ability to regulate the back door because of the potential diplomatic and economic consequences (Grund & Breeksema, 2017).

Through the 1990s and early 2000s periodic police crackdowns on suppliers and home growers had the unanticipated consequence of significantly increasing criminal organisations' involvement in cannabis cultivation (Belackova, Maalste, Zabransky, & Grund, 2015). This problem has arguably been exacerbated by the

fact that the Ministry of Health has primary responsibility for drug policy, and do not see this type of commercial regulation or criminal law enforcement as their role.

The 2012 pilot in southern provinces, of clubs restricted to small memberships of only Dutch residents, was not found to be very successful. Much of the evaluation literature is not available in English, but Grund and Breeksema summarise it: “Nuisance from street drug sales and feelings of lack of security increased (SSC Onderzoek en Informatie, 2012). Local consumers refused to register at coffee shops, citing privacy concerns (Wouters and Korf, 2011; Nijkamp and Bieleman, 2012) and many regulars abandoned the shops, resorting to illegal markets instead (Maalsté and Hebben, 2012).” Consequently, soon after the pilot was introduced, the requirement that shops be limited-membership only was abolished, while the requirement to only serve Dutch residents was devolved to local municipalities, many of which do not enforce it (Opstelten, 2012).

3.6 Netherlands (harm minimisation)

Key Points

- The Netherlands has developed a comprehensive health-based harm minimisation approach, with many of their most notable policy developments arising from informal or experimental practices that were subsequently codified by the government. Needle exchanges, safe injecting facilities and heroin assisted treatment are all examples of this.
- The Netherlands has very low rates of problem drug use, and arrests for minor possession are extremely rare.
- Drug users in the Netherlands also tend to use safer practices (for example, a very low proportion of opiate users inject), and this has led to relatively high survival rates and longer life expectancy for people who use heroin in the Netherlands.
- Due to substantial investment in sheltered housing, integrated drug treatment, public mental health care, services for the homeless and criminal justice interventions, most problematic drug users now live in supported housing where they receive welfare and treatment.

Background and model

The Netherlands tried unsuccessfully to dismantle the organised crime groups importing heroin in the 1970s and 80s, but its prevalence continued to grow. As street level policing crack downs drove heroin dealing indoors, many local municipalities supported tolerating these so-called “street addresses” as a way of keeping drug-related nuisance off the streets.

In some cities, the police, drug services, urban planners, and neighbourhood organisations actively collaborated with dealers and proprietors of street addresses, with an unwritten understanding that they would be tolerated as long as they sold only consumer amounts and did not advertise, cause nuisance or serve young people. This lasted until a crackdown in the 1990s closed street addresses again, causing the heroin and crack cocaine market and users to return to the streets (Grund & Breeksema, 2017).

The Netherlands has developed a comprehensive health-based harm minimisation approach, with the most notable policy developments coming out of informal or experimental practices that were subsequently codified by the government. For example:

- Needle distribution began informally in the 1970s, and continued to grow through grass roots organising, until official needle and syringe exchange programmes were introduced (Blok, 2008) (Grund, et al., 1992). By 2012 there were 150 needle exchange programmes in the Netherlands. (EMCDDA, 2012).
- As early as 1974, off-the-record drug injection rooms were available in two Amsterdam drop-in centres, and one in a church basement in Rotterdam began in 1982 (Blok, 2008). These activist projects laid the groundwork for the official safe consumption facilities that opened in most large Dutch cities 1995. By 2012 there were 37 drug consumption rooms across the country, targeting injectors and smokers (Schatz & Nougier, 2012)(EMCDDA, 2012).
- Heroin Assisted Treatment was introduced in 1996 as a scientific trial and, after a favourable evaluation, was registered as a legal medication for 'chronic, treatment-resistant heroin-dependent patients' in 2006 (Blanken, et al., 2010) (Fischer, et al., 2007).

An official agreement with the public prosecution service ensures that anyone possessing illicit drugs at an official drug-testing service will not be arrested or prosecuted (EMCDDA, 2017)

Outcomes and impact

The largely tolerant, harm-minimisation focussed approach to drugs in the Netherlands has not given rise to high prevalence.

- The Netherlands has the lowest level of problem drug use in the EU (Van Laar & Van Ooyen-Houben, 2009)
- The overall prevalence of drug use in the general population is below the EU and USA averages(EMCDDA, 2012; Van Laar et al., 2014).

Arrests and criminal records for use or minor possession are extremely rare in the Netherlands compared to other European states (3 per 1,000 users, compared to 44 per 1,000 users in Austria) (Room, 2008).

The research also indicates a number of other ways in which Dutch drug policy has contributed to reducing harms. Notably, the **Netherlands has one of the lowest**

rates of injecting amongst opiate users – only about 7% of all people in treatment for heroin dependence were or are injecting users. This has served to reduce Dutch opiate and crack cocaine users' risks of both overdose and HIV, which has contributed to relatively high survival rates of people who use heroin (Grund & Breeksema, 2017). Treatment for heroin dependence increasingly includes elements of geriatric care, and the EMCDDA recently complimented the Netherlands for pioneering senior citizens homes for the aging group of heroin consumers (EMCDDA, 2015).

The Netherlands also provides important lessons in the unintended consequences of intensive law enforcement. Research suggests that both of the major policing crackdowns attempted in the last 50 years led to increasing harms:

- Schreuder and Broex (1998) found that policing crackdowns in the 70s did not stop the escalation in heroin. Instead, they argue that along with other environmental trends, stringent policing contributed to pushing street scenes out of the city centre, diffusing heroin into more working-class neighbourhoods.
- A large body of research suggests that **as street addresses were closed by a crackdown in the 90s, drug users were pushed into a much less favourable risk environment**. Without the protective environment and social control of the street addresses, people smoking cocaine in the streets became increasingly prone to its negative side effects, and the street market scene became larger, more volatile, and more harmful to the people in it (Blanken, Barendregt, & Zuidmulder, 1999).

Finally, the success of the Dutch approach has relied on **government investing significant resources in a comprehensive and integrated harm reduction, treatment and social support system** targeting people with drug problems, the homeless and chronic psychiatric patients (Grund & Breeksema, Drug Policy in the Netherlands, 2017). Since 2006, coordinated investments have been made in:

- sheltered housing
- integrated drug treatment
- public mental health care
- services for the homeless, and
- criminal justice interventions

Consequently, most problematic street drug users now live in sheltered or supported housing where they receive welfare, medical care and tailored drug treatment, or consume their drugs in on-site drug consumption rooms (Schatz, Schiffer, & Kools, 2010). Those who continue to cause nuisance or engage in crime are subjected to various criminal justice interventions, including compulsory treatment and other forensic psychiatric interventions (Van Laar, 2015)

3.7 Portugal

Key Points

- In 2001, following expert medical and social strategic advice, Portugal decriminalised the purchase, possession and use of all illicit drugs.
- The change went beyond depenalisation, which removes custodial sentencing, but did not amount to full legalisation, as the production, manufacture and large-scale distribution of illicit drugs remain a criminal offence.
- Studies have generally found that the change did not significantly increase consumption or drug prices. Moreover, analysis estimates that decriminalisation has decreased the social costs of drug use by 18%.
- Initially, decriminalisation had a clear direct impact on prison populations in Portugal, with fewer people incarcerated and fewer incarcerated people reporting drug use. Incarceration rates began to rise again in 2008, although the profile of incarcerated offenders is now different and it is likely other external trends contributed to this.
- There is some evidence of “net-widening” leading to increasingly low level offenders being brought before commissions. This is an important implementation lesson in ensuring laws are explicitly designed to prevent mission creep.

Background and model

At the end of the 1990s, Portugal was noted for high rates of problematic drug use and heroin market. This led to significant increases in infectious diseases, particularly HIV and AIDS, and drug related deaths with a peak of 369 in 1999 (Hughes & Stevens, 2010) (Van Het Loo & Van Beusekom, 2002).

In 1998 the Commission for a National Anti-Drug Strategy brought together legal, medical, and social professionals and recommended that decriminalisation of drug use and possession would allow the government to focus on prevention, harm reduction, treatment, and helping people to maintain their social connections (Domoslawski, 2011). Law enforcement and health experts viewed criminalisation as part of the problem rather than the solution because people with addictions were deterred from seeking treatment by the stigma of criminalisation (Hughes and Stevens, 2010).

In 2001, Portugal decriminalised the purchase, possession and use of all illicit drugs. The change went beyond depenalisation, which removes custodial sentencing as an option for low-level drug offenders, but did not amount to legalisation, as **the production, manufacture and large-scale distribution of illicit drugs remain a criminal offence.**

- Low-level offenders are now dealt with administratively by an informal 'Dissuasion Commission', which determines an appropriate non-custodial sanction. The Commission's work regionally, and their purpose is not to punish the offender but to encourage treatment and rehabilitation.
- The commission determine whether the person suffers from addiction or not, and then choose from a range of consequences.
- If the person suffers from addiction, commission is not able to mandate treatment but can suspend a penalty on the condition that an offender agrees to get treatment.
- Commissions may also impose fines or restrictions (from one month to three years) on people, depending on a range of factors including the type of drug, whether it was used in public, and how often the person uses.
- The Commissions come under the Ministry of Health rather than Ministry of Justice and include a treatment professional, social worker and lawyer, and are supported by a range of agencies such as treatment, health, employment, child protection, social services and schools.

Investments in drug treatment, harm reduction and social reintegration were also expanded at the same time. Crucially, **the Government moved away from providing harm reduction interventions on a small scale based on local risk reduction and short-term aid, to a systematic approach across the whole country** (Leite, 2019).

Outcomes and impact

In 2017, 11,329 people were involved in commissions, a new high watermark and an 80% increase over the period of a decade. In 2017, around 10% of those before commissions were classed as addicts (SICAD, 2019). For those classed as addicts, the most common ruling is a suspension to allow the perpetrator to undertake treatment. For those not considered addicted, the majority receive a provisional suspension. **Between 2007 and 2012, only 4-6% appeared before a commission again**, and 88% of those only registered one relapse in a year (SICAD, 2013).

Studies have generally found little impact on usage or drug prices:

- **Reviews of the Portuguese experience of decriminalising all drugs have not found evidence of an increase in drug use** (Greenwald, 2009) (Hughes & Stevens, 2010) Depending on the study examined, there was either no increase or only a very small increase in adult drug usage.

- In line with this, Felix and Portugal (2017) found that prices for cocaine and opiates did not decrease following decriminalization. They conclude that “drug decriminalization seems to have caused no harm through lower illicit drugs prices, which would lead to higher drug usage and dependence. This evidence contrasts with the commonly held belief that drug decriminalization would necessarily lead to a dramatic increase in usage rates.

Studies have indicated a number of benefits in terms of drug harms and costs:

- An ex-post analysis of Portugal's decriminalisation of all drugs estimated that **the total social cost of drug use decreased 18 per cent** (Goncalves, Lourenco, & Nogueira da Silva, 2015). This was mainly driven by reductions in indirect health costs (29 per cent), non-health related indirect costs (24 per cent) and non-health related direct costs including the criminal justice system (17 per cent). There was an increase in direct health costs of 9 per cent associated with providing prevention, treatment and harm reduction services.
- Greenwald (2009) and Hughes & Stevens (2010) drew similar conclusions. “The reforms did lead to a reduction in drug-related harms (both problematic drug use and youth drug use declined), and criminal justice system costs: While small increases in drug use were reported by Portuguese adults, the regional context of this trend suggests that they were not produced solely by the 2001 decriminalization. We would argue that they are less important than the major reductions seen in opiate-related deaths and infections, as well as reductions in young people’s drug use. The Portuguese evidence suggests that combining the removal of criminal penalties with the use of alternative therapeutic responses to dependent drug users offers several advantages. It can reduce the burden of drug law enforcement on the criminal justice system, while also reducing problematic drug use.” (Hughes & Stevens 2010, p.1018)
- An economic analysis of the effects concluded that **the Portuguese approach was not harmful and contributed to a reduction in seizures of heroin and cocaine, number of drug offences, drug-related deaths and the incidence of HIV among drug addicts** (Felix, Portugal, & Tavares, 2017).
- Opioid substitution treatments and injecting rooms have been tried in many jurisdictions and these approaches have been associated with reduced overdose hospitalisations and deaths, public injecting and discarding of needles (EMCDDA 2018).

Initially at least, it was possible to discern a direct impact of decriminalisation on incarceration rates in Portugal. **Between 2000 and 2008 there was a fall in the imprisonment rate from 126 per 100,000 to 102**, and the number of offenders who reported using heroin before entering prison also fell from 27 per cent in 2001 to 13 per cent in 2007 (Hughes and Stevens, 2010). **Since 2008,**

however, there has been a notable rise in imprisonment again, and rates are now comparable to those before the reform. Again, the extant English language literature does not seem to offer an explanation for this trend, although the Council of Europe report on European prisons 2005-2015 indicates that during that period, at least, the proportion of prisoners sentenced for assault and battery as well as for sexual offences increased, while the proportion serving sentences for homicide, robbery, theft and drug offences decreased. It may therefore be that other trends in some combination of crime, detection, enforcement and sentencing have contributed to re-filling Portugal's prisons with a different profile of offender.

The Portuguese experience offers a number of important implementation lessons:

- Laqueur (2014) highlights the way in which **Commissions are increasingly being required to deal with younger, non-addicted people for cannabis-related offences**, which amounted to 76% of cases in 2009, and notes that such cases create a strain on scarce resources. This gradual increase in young, non-addicted people coming before commissions for small amounts of cannabis appears to be a similar phenomenon to the “net widening” effect seen in Australian cannabis expiation schemes, and underscores the need to consider ways to prevent this mission-creep in law enforcement, such as explicitly excluding certain substances or groups from enforcement measures, or by fully legalising and regulating trade.
- Strain on resources has also been identified by others as a factor impeding the work of the Commissions (Pinto, 2010) . An evaluation of the 2008-2013 action plan identified that a lack of quorum was responsible for delays in the system (SICAD, 2013; Laqueur, 2014). Pinto also highlighted that people being referred for treatment were often already undergoing treatment.

4. Other international examples of note

- **Uruguay** is the first country in the world to create a legal, regulated market for adult cannabis use with the explicit goal of undermining the illegal drug market and severing cannabis revenue from those who also sell harder drugs. The law allows people to grow their own cannabis, purchase it commercially, and join a cannabis club that cultivates and distributes to members (Leite, 2019)
- **Mexico:** In 2009, Mexican Federal Government enacted "narcomenudeo" reforms decriminalizing possession of small amounts of drugs, delegating prosecution of retail drug sales to the state courts, and mandating treatment diversion for habitual drug users. There is not a large body of evaluative work on the impact of this change. Two studies from Tijuana are informative, but impacts on a wider range of health and social outcomes, and in other parts of the country, are not known:
 - A mixed methods study in Tijuana found that "Narratives underscored the law's irrelevance to PWID; 699 (98%) saw police practice as generally inconsistent with formal law. Instead of treatment diversion, police encounters were associated with risk behaviors, including syringe sharing" (Beletsky, et al., 2015).
 - A study that looked at policing practice in Tijuana found that the change did not appear to have significantly shifted drug law enforcement practices, and other factors, such as electoral cycles, were more strongly associated with arrest volumes (Arredondo, et al., 2018).
- **Germany's** Federal Constitutional Court ruled in 1994 that drug addiction is not a crime, and neither is possession of small amounts for personal use, although production, distribution and acquisition remain illegal. Threshold quantities for the decriminalisation of personal possession have been defined by the courts over time. In 2000 a new narcotic law was passed to allow safe injecting facilities. German research into heroin-assisted treatment in the 2000s yielded positive results, and heroin-assisted treatment has been part of mandatory health insurance there since 2009.
- **USA:** There is a growing trend amongst US states towards liberalising state drug laws, despite tension with the federal law characterised by the war on drugs.
 - Recreational cannabis is now legal in fifteen states, and ballot measures have also been used to ease restrictions on harder drugs in some. Most notably, in the 2020 US election Oregon decriminalised personal possession of small quantities of drugs including cocaine, heroin, methamphetamines and psychedelics.

- Most drug law reforms in the US are relatively recent and their impact cannot be fully assessed yet, but the following findings are available from those jurisdictions that were relatively early reformers:
 - **Cannabis**
 - Cannabis decriminalization showed improvements in risk areas for teenagers, declines in possession arrests, and reduction in illegal markets in 5 states, but true public health effects of cannabis legalisation cannot yet be assessed, because it has only been implemented within the past 5 years and cannabis remains illegal under US federal law (Hall & Lynskey, 2016) (Hall et al., 2019)
 - Law reform in **California** has also enabled automatic expungement of past marijuana convictions and an estimated 218,000 individuals are due to benefit as a result.
 - Colorado: the contraband cannabis industry still flourishes in Colorado (Stuart, 2014) and Washington (Kleiman et al., 2015). The Washington data showed that more than a year after legalization, illegal sources still accounted for an estimated 28% of cannabis sold in the state.
 - FBI data from Colorado and Washington show that crime clearance rates — the frequency of crimes being solved by police — increased for both violent and property crimes after legalization (Makin, et al., 2018).
 - Oakland, California and Massachusetts have both considered social equity for people and communities disproportionately impacted by cannabis law enforcement in the design of their legalisation programmes. In Oakland, half of the licenses to grow and distribute cannabis are reserved for people who earn less than 80% of the average income, have been charged with a cannabis offense in the last 20 years, or have lived for a decade or more in a neighbourhood with disproportionately high cannabis arrests. There is a similar programme in Massachusetts. Elsewhere, state taxes ensure a portion of the revenue generated from legal sales is allocated back into such disproportionately impacted communities (Nicol, 2019).
 - National: In a national survey of US students, Palamar et al. (2014) found that 10% of non-using students intended to use cannabis if made legal, and that 18% of users expected to increase their use upon legalization of the drug (Palamar, Ompad, & Petkova, 2014).

▪ Other drugs

- By 2015, 30 states had Naloxone programmes, covering 654 police departments. Rando et al, found that following these police officer Naloxone programs, the number of opioid overdose deaths decreased (Rando, Broering, Olson, Marco, & Evans, 2015).
- A process evaluation of Seattle’s Law Enforcement Assisted Diversion (LEAD) programme, a pre-booking diversion scheme for narcotics and sex work charges, highlighted the importance of ensuring reforms are implemented and supported by front line police. They found examples in Seattle’s programme where officers were reluctant to divert people who use drugs through LEAD because they felt the programmes ‘enabled’ addiction. Beckett emphasises the importance of ensuring buy-in from all levels of police forces, not just the leadership (Beckett, 2014).
- Many studies in the US have looked at the costs and benefits of treatment programmes.
 - A California study of treatment outcomes found a benefit to cost ratio of 7 to 1, largely attributable to reductions in subsequent criminal activity (Ettner, et al., 2005).
 - A literature review of 18 benefit-cost studies found that benefits exceeded costs, with benefit–cost ratios of 1.6 to 26 (Cartwright, 2000).
 - A Minnesota study found benefit–cost ratios for treatment and recovery services of between 2.4 and 16.1. For prevention and early intervention services, the study found benefit–cost ratios of 0.2 to 20.4 (Merrick et al. 2017).

5. Summary of key themes

5.1 Overview of criminalisation and harm minimisation

Research on drug criminalisation generally indicates that criminal sanctions for drug use or possession tend to exacerbate harm or undermine efforts at harm minimisation. For example:

- Injection safety:
Studies looking at barriers to using a new needle for every injection in large, diverse urban settings have consistently found that fear of law enforcement encounters is associated with people:
 - Sharing syringe and injection equipment (Wagner, 2010) (Wagner, Simon-Freeman, & Bluthenthal, 2013) (Bluthenthal, 1999) (Wood, 2017) (Pollini, 2008) (Flath, 2017)
 - not accessing new needles, from reduced exchange program participation (Wood, 2017) (Beletsky, 2014) (Bluthenthal, 1997) (Davis, 2005)
 - feeling reluctant to carry new needles (Flath, 2017) (Sarang, Rhodes, & Platt, 2008) (Grund, 1995)

- Treatment access:
When evidence-based and delivered well, treatment is known to be a cost effective means of reducing drug harms.
 - A 2015 study in England used estimates of opioid use in the general population, the extent of treatment provision, and the number of deaths related to opioid use, to develop a counterfactual model which estimated that treatment prevented 880 excess opioid-related deaths each year between 2008 and 2011 (White, et al., 2015).
 - Evidence from the US looking at the cost-benefit ratios of treatment programmes consistently show that their benefits reflect a large return on investment. A study of California treatment outcomes found a benefit to cost ratio of 7 to 1, largely attributed to reductions in subsequent criminal activity (Ettner, et al., 2005). This is consistent with an earlier literature review of 18 benefit-cost studies, which found that benefits exceeded costs, with benefit–cost ratios of 1.6 to 26 (Cartwright, 2000).

Considering this, it is important to ask what impact prohibition has on treatment engagement. An international survey of drug users found that those from countries with a strong prohibition-based drug policy reported a far greater propensity to seek help following the introduction of more permissive policies (Benfer, et al., 2018). The main reason for the change in help-seeking behaviour cited was the reduced fear of criminal sanctions.

- Incarceration:
A meta-analysis of studies from six countries found that after imprisonment, drug users were at three to eight times more risk of drug-related death in the

first two weeks after release, and remained elevated for a further two weeks (Merrall, et al., 2010).

- **Justice system strain:**
Decriminalisation reduces the demands on the criminal justice system, through less demand on police, courts and prisons. For example, total law enforcement costs in California dropped from \$17 million in the first half of 1975 (before decriminalisation) to \$4.4 million in the first half of 1976 (after decriminalisation). Such savings can contribute towards replacing criminal intervention with well-resourced social and treatment intervention instead.

Additionally, research from New Zealand estimated that more than half of the revenue from all drug trafficking is reinvested in criminal activity, and that around 20-28% of this funds other organised crime activities such as extortion, fraud, pornography, illegal poaching and weapons trafficking (McFadden Consultancy, 2016).

- **Social integration:**
Decriminalisation improves employment prospects and relationships with significant others for those detected with drugs, and evidence from a number of countries shows that decriminalisation can lead to improved social outcomes. For example, individuals who avoid a criminal record are less likely to drop out of school early, be sacked or to be denied a job. They are also less likely to have fights with their partners, family or friends or to be evicted from their accommodation as a result of their police encounter (Drug Policy Modelling Programme, 2016).

Moreover, research indicates that decriminalisation does not lead to significant increases in drug use or other crimes (Babor, et al., 2010).

- Decriminalisation has no or very small effects on rates of drug use. Research from across the globe has consistently found that decriminalisation is not associated with significant increases in drug use.
- In instances where just cannabis has been decriminalised it has not led to increases in use of other drugs such as ecstasy or heroin.
- Research has shown that decriminalisation does not lead to increases in crime through perceptions of weaker laws. People who do not receive a criminal record are much less likely to engage in future crime or have subsequent contact with the criminal justice system, even when previous offending history is taken into account. There is also no evidence that decriminalisation will lead to other types of crime, such as supply or drug-related crime.

Within a legalised system, there are different purchaser/end-user regulatory options including, for example, age and place of use restrictions like those

that most jurisdictions currently use for alcohol. From least to most strict, these options include:

<p>Unlicensed sales model</p>	<p>Regulation focuses on standard product descriptions and labelling. Where appropriate, food and beverage legislation (dealing with packaging, sell by dates, ingredients etc.) may be adopted.</p>
<p>Licensed premises model</p>	<p>Licensee is responsible for restricting sales on the basis of age, intoxication and hours of opening. Licence infringements may be sanctioned by a sliding scale of fines, loss of licence, or even criminal penalties. Licensees can be held partially or wholly liable for how their customers behave, similar to the licensed premises model applying to the on-premises sale of alcohol. Various controls exist over the venue and (in particular) the licensee.</p>
<p>Licensed sales model</p>	<p>May put various combinations of regulatory controls in place to manage the vendor, the supply outlet, the product and the purchaser. These controls may be supported by changes to police, customs, trading standards, and health and safety policies and practices, similar to the off-premises sale of alcohol.</p>
<p>Pharmacy sales model</p>	<p>Pharmacists are trained and licensed to dispense prescriptions, although they cannot write them. They can also sell certain generally lower risk medical drugs from behind the counter of licensed pharmacy venues, usually with conditions such as buyer age, level of intoxication, quantity requested, or case-specific concerns relating to potential misuse. Pharmacists are overseen by regulatory legislation, managed by various agencies and are subject to a clearly defined enforcement infrastructure.</p>
<p>Prescription model</p>	<p>The most tightly controlled and enforced drug supply model - drugs are prescribed to a user by a qualified and licensed medical practitioner, and dispensed by either a licensed practitioner or pharmacist from a licensed pharmacy or other designated outlet. The process is controlled by a range of legislation, regulatory structures and enforcement bodies, which guide, oversee and police the prescribing doctors and dispensing pharmacists. They also help determine which drugs are available, in what form, where, and under what criteria.</p>

summarised from Rolles, 2010

One negative consequence of decriminalisation that has been reported in research from Australia is ‘net widening’. Net widening occurs when more people are sanctioned after a reform than before, due to the greater ease with which police can process minor drug offences. The extent of this depends on the specific choice of policy design and how the reform is implemented (for example, whether the consequences for non-compliance are more severe than the original offence; the extent of police discretion) (Bryan, Del Bono, & Pudney, 2011).

5.2 Drug consumption rooms

To reduce harm and prevent overdoses, many countries including Denmark, Switzerland, Germany, Spain, Norway, Australia and Canada have established drug consumption rooms or safe injecting facilities over the last 30 years .

Drug consumption rooms are typically professionally supervised healthcare facilities where drug users can use drugs in safer and more hygienic conditions. As of 2018 there were over 90 DCRs in over 60 cities across 10 different countries, with several more jurisdictions working towards them (EMCDAA, 2018).

A growing body of scientific evidence shows that consumption rooms have an impact on both improving health and reducing death by overdose among clients who use these facilities (Bravo, De la Fuente, Brugal, Barrio, & Domingo-Salvany, 2009) (DeBeck, et al., 2011) (Kinnard, Howe, Kerr, & Marshall, 2011). For people who use drugs, unsafe drug intake often involves unhygienic or incorrect injecting, which cause both injury and infection. A systematic review found that supervised consumption at a facility reduces the risk of fatal overdose and disease transmission (Pardo, Caulkins, & Kilmer, 2018).

Several qualitative studies highlight the benefits of DCRs, noting that they can address various contextual risks associated with public injecting by:

- enabling safer injection practices (Kerr, Small, Moore, & Wood, 2007),
- providing refuge from street-based crime (Fairburn, Small, Shannon, Wood, & Kerr, 2008),
- mediating and facilitating access to healthcare and social resources (McNeil & Small, 2014) and
- delivering education regarding safer injection practices which is more likely to be accepted among clients than it would be from other sources (Fast, 2008).

However, as noted above regarding criminalisation, the success of these services relies on people’s willingness to engage with them. Fear of apprehension by the law can be a significant deterrent to accessing services, so to be effective, DCRs should be accompanied by support from policing to ensure service users are not criminalised, and that police actively refer people who use drugs to the service.

Evidence on consumption rooms’ impact at a population level is sparse, but some evidence from ecological studies suggests that, where coverage is

adequate, drug consumption rooms may contribute to reducing drug-related deaths at city level (Poschadel, Hoyer, Schnitzler, & Schreckenberger, 2003) (Marshall, Milloy, Wood, Montaner, & Kerr, 2011). A study in Sydney showed that there were fewer emergency service call-outs related to overdoses at the times the safe injecting site was open (Salmon, Van Beek, Kaldor, & Maher, 2010).

5.3 Cannabis law reform

For decades, research on the impact of cannabis decriminalization has shown that, in a variety of jurisdictions in Australia, Europe, Canada and the United States, **decriminalization does not cause a significant increase in consumer demand or ease of access.**

- Data from four Canadian cities showed that under prohibition, cannabis users generally, even in times of easy access, moderate their cannabis use such that it does not interfere with their lives or lead to adverse health consequences. These patterns appear to continue under decriminalization (Duff, et al., 2012).
- The literature on depenalisation of cannabis possession in various states of the United States, the Netherlands, Portugal and Australian states finds that reducing penalties has either no or only small effects on prevalence of use (Home Office, 2014) (Hughes, 2016) (MacCoun, 2010).
- Bryan et al (2013) found there was no evidence that decriminalisation of limited cultivation in South Australia and Alaska substantially changed consumption.
- At the same time, decriminalization decreases related social problems (such as criminal records and their impact for people) as well as enforcement and judicial costs (see, for example: (Single, 1989) (Lenton, et al., 2000) (Room, 2008).

In relation to young people specifically, a recent review of 38 countries shows no significant increase in cannabis use amongst adolescents living in liberalised states (Stevens, 2019). Consistent with the results of previous researchers, the most comprehensive empirical study to date found:

- there was no evidence that the legalization of medical marijuana encourages marijuana use among youth.
- Moreover, the estimates showed that marijuana use among youth may actually decline after legalization for recreational purposes (Anderson, Hansen, Rees, & Sabia, 2019).
- Some of the evidence suggests legalisation may reduce underage consumption in some instances, due to fewer illegal suppliers.

There is also some evidence that liberalising cannabis laws causes some people to substitute away from higher harm drugs such as opioids or alcohol. In US states that have legalised medicinal cannabis, there is early evidence of some people substituting from opioids to cannabis, and lower attendant health burdens:

- death certificate analysis showed that states with medical cannabis laws had lower opioid analgesic overdose mortality rates compared with states without such laws (Bachhuber, Saloner, & Cunningham, 2014).
- This persisted when excluding intentional overdose deaths (ie, suicide), suggesting that medical cannabis laws are associated with lower opioid analgesic overdose mortality among individuals using opioid analgesics for medical indications.
- Similarly, the association between medical cannabis laws and lower opioid analgesic overdose mortality rates persisted when including all deaths related to heroin, even if no opioid analgesic was present, indicating that lower rates of opioid analgesic overdose mortality were not offset by higher rates of heroin overdose mortality (Bachhuber, Saloner, & Cunningham, 2014).
- A study of substance use trends amongst US college students in the ten years ending 2018 found that recreational cannabis legalisation was linked to decreased binge drinking among students age 21 and older. Recreational marijuana legalisation was also associated with increased sedative misuse among minors (Alley, Kerr, & Bae, 2020).
- Dragone et al. (2019) estimated that cannabis legalisation increased cannabis consumption by about 2.5 percentage points, a decrease in alcohol consumption of 2 points and a decrease in other drug consumption of about 0.5 points. This change in consumption was associated with a change in criminal behaviour, with reductions in rape of between 15 and 30 per cent and theft of between 10 and 20 per cent.
- In their review of the evidence Anderson and Rees (2014) find that "studies based on clearly defined natural experiments generally support the hypothesis that marijuana and alcohol are substitutes." Increasing the drinking age seems to result in more marijuana consumption, for instance, and pot smoking drops off sharply at age 21, "suggesting that young adults treat alcohol and marijuana as substitutes." This supports other findings that legalizing marijuana for medical use has been associated with a drop in beer sales and a decrease in heavy drinking.
- Earlier research found that enacting medical marijuana laws is associated with a 13 percent drop in traffic fatalities. They posit that this effect is likely due to a combination of the fact that marijuana impairs driving ability much less dramatically than alcohol does, and the fact that alcohol is more likely to

be consumed outside the home, resulting in more driving under its influence (Anderson, Hansen, & Rees, 2013).

There is some evidence that prohibition of cannabis has led to the advent of synthetic cannabinoids, which have been formulated to mimic the effects of natural cannabis but have much greater harms. The incentive for this innovation arises because of their benefits in a prohibited market place: “They are easy to purchase, relatively inexpensive, produce a more potent high and don’t emit the typical marijuana scent. And, they are much harder to detect in the urine or blood than marijuana. Legalisation is likely to shift users from synthetic cannabis back to natural cannabis. Regulation would also reduce contamination of natural cannabis” (White C. , 2018).

- In 2013 alone, 150 new cannabinoids were identified and these new synthetic drugs have been linked to poisonings, hospitalisations and deaths. Serious illnesses due to cannabis are exceedingly rare, while those due to synthetic cannabinoid use are becoming more common, and clusters of synthetic cannabinoid overdose are associated with the newest drugs (Bannister et al. 2015).
- A recent study of Australian drug harms (Bonomo, et al., 2019) ranked the harm to users from synthetic cannabis as more than twice that from natural cannabis. An American study estimated synthetic cannabinoids were 30 times more likely to harm the user (White, 2017).

There is less in the published literature on implementation issues, but it is worth noting that several health policy organizations in Canada and abroad have warned against the perils that industry lobbying may present for protecting the public’s health in cannabis law reform. One proposal for mitigating this issue is for a legal market to be operated by the state:

- “A not-for-profit cannabis authority would maintain a singular mission of protecting the public’s health. It would serve this mission by supplying safe product to serve only the existing demand for cannabis. There would be no intent, or provision of incentive or encouragement of any kind to increase use among cannabis users or to induce nonusers to start using cannabis. Given the primacy of a public health mission, a long-term objective might actually be to reduce use by individuals and prevalence in the general population. The Authority would provide and promote evidence-based information on the low-risk use of cannabis, and actually encourage and support people who wanted to stop or reduce their cannabis use” (De Vallaer, 2017).

5.4 Reform for other drugs

As experience of significant law reform regarding harder drugs than cannabis is relatively recent and not yet widespread, there is less research evidence available to draw from. However, **the overall trend of the literature on drug law**

enforcement consistently indicates that increases in punitive or prohibitionist approaches are generally associated with increased harms and, conversely, that many harms can be ameliorated when the law, and/or its enforcement, is relaxed.

- Studies using data from Florida, New York and Portugal consistently show that escalations in drug enforcement are accompanied by property and violent crime rates increasing, relative to what they would have been (Benson, 2009).
- Effectively removing mandatory minimum sentences for people convicted of a range of felony drug charges, and increasing eligibility for diversion to treatment led to a 35 percent rise in the rate of diversion of eligible defendants to treatment in New York. Although the use of diversion varied significantly among the city's five boroughs, it was associated with reduced recidivism rates, and cut racial disparities in half (Parsons, et al., 2015).

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7. ANNEX: TABLE OF REFORMS

Jurisdiction	Year	Reform
Colorado	2012	Legalised possession and supply of cannabis
Washington	2012	Legalised possession and supply of cannabis
Oregon	2014	Legalised possession and supply of cannabis. Decriminalised possession of other drugs.
Alaska	2014	Legalised possession and supply of cannabis
California	2018	Legalised possession and supply of cannabis
Nevada	2016	Legalised possession and supply of cannabis
Massachusetts	2016	Legalised possession and supply of cannabis
Maine	2016	Legalised possession and supply of cannabis
Michigan	2018	Legalised possession and supply of cannabis
Illinois	2019	Legalised possession and supply of cannabis
Washington DC	2015	Legalised possession and supply of cannabis
Guam	2019	Legalised possession and supply of cannabis
15 other US states		Decriminalised use/possession of cannabis
Canada	2018	Legalised possession and supply of cannabis. Medically supervised heroin injecting.
Uruguay	2013	Legalised possession and supply of cannabis
Bolivia	2009	Legalised supply and possession of coca
Spain	2001	Legalised consumption, growing and cannabis social clubs, but commercial production and sale remain illegal.

Netherlands	1974	Retail but not wholesale cannabis sales 'de facto' allowed through outlets. Possession of small quantities of other drugs (eg half a gram of cocaine) is generally unenforced. Medically supervised heroin injecting.
Chile	2005	All private drug use/possession is unpunished. Thresholds between trafficking and personal use determined by a judge.
Croatia	2012	All drug use/ possession decriminalised. Drug use itself is not regulated by the law, but administrative regulations apply for public usage.
Czech Republic	2009	All drug use/possession decriminalised, but financial fines can apply.
Mexico	2009	All drug use/possession decriminalised, however quantities are ambiguous. In 2018 the Supreme Court ruled a ban on the use of cannabis was unconstitutional.
Peru	2003	Possession of small quantities of cannabis, cocaine, opium and MDMA are not punishable. However, police practices may not always reflect this.
Portugal	2001	All drug use/ possession decriminalised
Costa Rica		Use/possession of cannabis de facto decriminalised
Ecuador		Decriminalised use/possession of cannabis
Estonia		Decriminalised use/possession of cannabis
France	2018	Depenalised use/possession of cannabis to 200 euro fine
Georgia	2018	Legal possession and consumption, but not sale, of cannabis through a constitutional court decision
Germany		Authorities not required to prosecute possession of minor amounts
India		Illegal but exceptions are made for selling and consuming bhang
Jamaica	2015	Decriminalised use/possession of cannabis. Legalised use for religious purposes

Luxembourg	2001	Decriminalised use/possession of cannabis
Paraguay	1988	Decriminalised use/possession of cannabis
South Africa	2018	A constitutional court decision legalised cannabis consumption by adults in private places
Switzerland	1990s	Decriminalised use/possession of cannabis. Medically supervised heroin injecting.
UK		Medically supervised heroin injecting.

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	Date	Changes
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