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Innovative Courses of Action Pertaining to "Illicit" Psychoactive Substances

Québec

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List of initialisms and acronyms

AQPSUD	*Association québécoise pour la promotion de la santé des personnes utilisatrices de drogues*
BOCSAR	Bureau of Crime Statistics and Research (Australia)
CACP	Canadian Association of Chiefs of Police
CCIC	The Canadian Consortium for the Investigation of Cannabinoids
CCSA	Canadian Centre on Substance Abuse
CDSA	Controlled Drugs and Substances Act
CDT	Commissions for the dissuasion of drug addiction
CIHECH	Collaborative Initiative to Help End Chronic Homelessness
CSC	Correctional Service Canada
CSEDP	Crack smoking equipment distribution program
CTS	Cannabis ticketing scheme
DCPP	Director of Criminal and Penal Prosecutions
DESC	Downtown Emergency Service Center
DTC	Drug treatment court
DU	Drug user
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EPOPMN	Education program for overdose prevention and management with naloxone
FDA	Food and Drugs Act
IDU	Injection drug user
IEAC	Injection equipment access centre
INSPQ	*Institut national de santé publique du Québec*
MESS	*Ministère de l’Emploi et de la Solidarité sociale*
MJQ	*Ministère de la Justice du Québec*
MSP	*Ministère de la Sécurité publique du Québec*
MSSS	*Ministère de la Santé et des Services sociaux du Québec*
NAOMI	North American Opiate Medication Initiative
NPO	Non-profit organization
PHAC	Public Health Agency of Canada
PPSAFE	Program for prevention and substance analysis in festive environments
PSEP	Prison syringe exchange program
ROEACH	Reaching Out and Engaging to Achieve Consumer Health
SCS	Supervised consumption service
SEP	Syringe exchange program
SIS	Supervised injection service
SLITSS	*Service de lutte contre les infections transmissibles sexuellement et par le sang*
STBBIs	Sexually transmitted and blood-borne infections

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Highlights

Background

This report is the result of a mandate from the Ministère de la Santé et des Services sociaux (MSSS) [Québec’s ministry of health and social services] to produce a knowledge synthesis focused on nine courses of action which pertain to “illicit” psychoactive substances and which have not been implemented, or have been implemented only on a limited scale or as a pilot project in Québec.

The nine courses of action are:

- Education programs for overdose prevention and management with naloxone;
- Supervised consumption services;
- Prison syringe exchange programs;
- Low-threshold housing programs;
- Crack smoking equipment distribution programs;
- Programs for prevention and substance analysis in festive environments;
- Commissions for the dissuasion of drug addiction;
- Cannabis ticketing schemes;
- Drug treatment courts.

These interventions have the potential to amplify the beneficial effects and to reduce the negative effects of our current system for controlling what are referred to as illicit psychoactive substances.

For each course of action, the analysis covers six dimensions:

- A description of the intervention;
- The logic of action and objectives;
- Precedents and institutional endorsement outside Québec;
- The evaluations of their effectiveness;
- Legal aspects; and
- Some implications regarding the intervention in the Québec context.

Key messages

The analysis presented is not intended to provide conclusive responses to the issues tied to the use of illicit psychoactive substances, but rather to inform the much needed discussion about this subject.

Within the context of the federal legal system, Québec authorities possess a margin of manoeuvre sufficient to permit the introduction of most of these interventions. Moreover, most of these interventions have already been implemented in Québec or elsewhere in Canada.

Cannabis ticketing schemes are the exception, because they would likely require the establishment of a new regulation by the federal government.

In the case of commissions for the dissuasion of drug addiction, it seems that a closely related intervention could be implemented, within the framework of the current *Program to deal non-judicially with certain criminal offences committed by adults.* In this case, they would have to be introduced without the legislative change that accompanied their introduction in Portugal (the repeal of criminal penalties for possession of all currently illicit drugs), as this falls within the federal government’s authority.

The potential of these interventions was evaluated assuming their addition to the current system. If the resources used to implement the interventions being considered are instead drawn from resources currently devoted to other interventions, the expected benefits must be re-assessed.

Furthermore, within Québec there exists a knowledge gap concerning certain aspects of drug use. This lack of knowledge deprives us of the means of evaluating several potential forms of intervention that might be more efficient, effective or cost-effective. This synthesis proposes a few avenues for addressing this problem.

Summary

The INSPQ has produced a synthesis of the literature concerning certain interventions related to drug use. These interventions were selected in part because they have not yet been implemented, or have been implemented only as a pilot project or on a small scale in Québec, and also because they have been implemented elsewhere in the country, in the United States of America, in countries within the European Union or in Australia. The underlying objective of this mandate was to explore ways to enhance the positive effects and mitigate the negative effects of the current system for controlling “illicit” psychoactive substances.

The analysis presented is not intended to provide conclusive responses to the issues tied to the use of illicit psychoactive substances, but rather to inform the much needed discussion about this subject. In addition, the analysis opens a path toward new work that could be carried out, particularly in the area of cannabis regulation, in order to prepare Québec authorities to make informed decisions, given a context where significant changes are looming on the horizon.

Presented here is a review of evaluations that takes into consideration the strengths and methodological limitations of each. The review consists of a set of statements that it seems reasonable to affirm based on the synthesis of the literature that was carried out. The statements are qualified by the words likely and possibly. Likely signifies that a statement can be considered more veracious than competing statements, based on the “preponderance of evidence” found in the evaluations. Possibly signifies that the “preponderance of evidence” indicates that the statement is plausible, but that more evaluations are needed before this statement can be considered more veracious than competing statements.

Education programs for overdose prevention and management with naloxone (EPOPMNs)

The evaluations demonstrate that the implementation of EPOPMNs likely tended to:

- enable a significant portion of program participants to use naloxone during overdose events;
- reduce or have a neutral effect on the frequency of recourse to emergency services by the persons who intervened;
- enable participants to acquire and maintain adequate skills for managing overdoses with naloxone and reduce the frequency of harmful interventions;
- reduce or have a neutral effect on drug use and overdose risk behaviour;
- reduce mortality from opioid overdoses;
- be cost effective.

Furthermore, the evaluations demonstrate that the implementation of EPOPMNs possibly tended to:

- reduce morbidity from overdoses.

Supervised consumption services (SCSs)

The evaluations demonstrate that the implementation of SCSs likely tended to:

- allow a particularly vulnerable segment of injection drug users (IDUs) to be reached;
- reduce certain at-risk practices for sexually transmitted and blood-borne infections (STBBIs);
- reduce overdose mortality in IDU populations;
- increase access to various social and health services (detoxification and rehabilitation services, primary care, etc.) for users;
- improve or have a neutral effect on some aspects of public order (discarded syringes, consumption in public places);
- reduce recourse to pre-hospital services in the surrounding area;
- be cost-effective.Furthermore, the evaluations demonstrate that the implementation of SCSs possibly tended to:
- reduce the incidence of STBBIs.

Prison syringe exchange programs (PSEPs)

The evaluations demonstrate that the implementation of PSEPs likely tended to:

- have a neutral effect on, or reduce the amount of drug use;
- have a neutral effect on the use of injection as a mode of consumption;
- reduce needle sharing.

Furthermore, the evaluations demonstrate that the implementation of PSEPs possibly tended to:

- reduce the incidence of STBBIs among IDU inmates;
- increase the use of prison health care services by drug user (DU) inmates;
- have a neutral effect on, or improve, safety, safety conditions and perceived safety in correctional facilities.

Low threshold housing programs (LTAHPs)

The evaluations demonstrate that the implementation of LTAHPs likely tended to:

- stabilize the housing situation of difficult to accommodate and treat DUs, more successfully than regular high threshold of accessibility housing;
- produce divergent effects (increase, stabilize, reduce) on the use of specific social and health care services, within an overall context of apparent stability or with a slight decrease in the intensity of support;
- have a neutral effect on psychiatric symptoms and have a neutral effect on, or reduce, consumption of psychoactive substances by participants;
- improve the perception of DUs of their own mental health and their social situations;
- reduce the police and penal sanctions to which DUs are subject.

Crack smoking equipment distribution programs (CSEDPs)

The evaluations demonstrate that the implementation of CSEDPs likely tended to:

- allow a new segment of vulnerable DUs to be reached or provide sterile equipment for a mode of consumption adopted by IDUs already participating in a syringe exchange program (SEP);

Furthermore, the evaluations demonstrate that the implementation of CSEDPs possibly tended to:

- produce divergent effects (neutral, positive and negative) on various specific at-risk practices, within an overall context of apparent stability;
- have a neutral effect on drug use patterns, except perhaps for reducing polydrug use and heroin consumption;
- have a neutral effect on the overall health status of participants;
- have a neutral effect on the frequency and location of in-public consumption by inhalation or injection.

Programs for prevention and substance analysis in festive environments (PPSAFEs)

The evaluations demonstrate that the implementation of PPSAFEs likely tended to:

- allow a segment of the DU population to be reached that does not access regular harm reduction services;
- provide information of limited quality on the nature of analyzed substances when so-called presumptive detection technologies were used *in situ*.

Furthermore, the evaluations demonstrate that the implementation of PPSAFEs possibly tended to:

- allow DUs with particularly risky consumption practices to be reached;
- allow DUs to acquire knowledge about safe consumption practices;
- produce a neutral effect on, or reduce, at-risk consumption practices;
- prompt a switch to the consumption of other substances;
- delay the initiation of consumption.

Commissions for the dissuasion of drug addiction (CDTs)

The evaluations demonstrate that the implementation of CDTs in Portugal likely tended to:

- allow for the administrative sanction and the social and health management of DUs who previously were criminally sanctioned, without increasing the total number of DUs sanctioned;
- contribute to an increase in the use of rehabilitation services;
- contribute to an increase in the number of persons arrested for “trafficking” and in the volume of drugs seized;
- contribute to an increase in the number of homicides linked to the illicit drug market.

Furthermore, the evaluations demonstrate that the implementation of CDTs in Portugal possibly tended to:

- have little or no effect on population consumption patterns;
- contribute to a decrease in the number of IDUs;
- contribute to a decrease in the number of DUs and IDUs incarcerated, and in the amount of drug use in prisons;
- contribute to a decrease in the number of DUs struggling with addiction problems;
- contribute to a reduction in the incidence of STBBIs.

Cannabis ticketing schemes (CTSs)

The evaluations demonstrate that the implementation of CTSs likely tended to:

- have a neutral effect on cannabis consumption patterns;
- limit the consequences for people sanctioned through ticketing, as compared with those sanctioned criminally;
- increase confusion about the legal status of cannabis;
- be applied inconsistently from one region to another;
- increase the over-representation of Indigenous persons in cannabis-related “drug cases”;
- decrease the number of DUs processed through the criminal system;
- increase the total number of persons sanctioned for possession either through the criminal system or through ticketing.

Drug treatment courts (DTCs)

The evaluations demonstrate that the implementation of DTCs likely tended to:

- reduce recidivism among participants, whether new arrests or reconvictions are being considered.

Furthermore, the evaluations demonstrate that the implementation of DTCs possibly tended to:

- have a neutral effect on, or reduce, drug consumption and addiction among participants;
- improve various dimensions of participants’ social lives.

Conclusion

It appears to be fully within the legal jurisdiction of Québec authorities to implement these interventions or closely-related interventions, with the exception of cannabis ticketing schemes, which would require an amendment to the federal regulatory framework. The implementation of such a regime, moreover, would probably signal an end to the *Program to deal non-judicially with certain criminal offences committed by adults*. This program, which to our knowledge is unique in Canada, has in each recent year allowed over 2,000 Québec residents to be spared criminal charges for simple cannabis possession and, likely, to avoid the consequences linked to court action (difficulties obtaining employment, travelling abroad, etc.). Québec authorities thus have an interest in closely following any process leading to the implementation of a Canadian CTS.

With regard to the *Program to deal non-judicially with certain criminal offences committed by adults*, it seems that its expansion, accompanied by certain modifications, could result in a mechanism of action similar to the Portuguese commissions for the dissuasion of drug addiction.

Finally, it seems that many of these interventions would make it possible to reach new segments of the DU population, such as persons who use drugs in festive environments, those who smoke crack, or those who are “difficult to house and treat.” Contemplating the possibility of implementing one or another of these interventions involves establishing intervention priorities and balancing financial trade-offs, a process which a review of evaluations such as this one can only partially illuminate.

1 Introduction

A few years ago, in response to a request from the MSSS, the INSPQ proposed organizing a symposium to clarify public health issues specifically related to illicit psychoactive substances and their current control system. Some principal findings emerged from this symposium. First, it appears that certain uses of these substances have apparent advantages. However, many also have significant impacts at the population level, and these impacts require a response from public health authorities.

In a similar vein, the prohibitive system through which we principally seek to mitigate these impacts has some apparent benefits. However, on some levels this system seems fairly ineffective, even exacerbating or itself generating certain social and public health problems. Thus, it was determined that it would be beneficial for public health authorities to perform a careful analysis to produce a clear understanding of these difficulties and to identify adequate responses. Moreover, some jurisdictions have developed avenues of intervention which appear to carry benefits for public health. It seems worthwhile to undertake to further explore these avenues of intervention and to analyze their implications in the Québec context.

Thus, this knowledge synthesis focuses on a series of interventions that have the potential to amplify the beneficial effects and to reduce the negative effects of our current system for controlling what are referred to as illicit psychoactive substances. These interventions were selected because they have not been implemented or have been implemented only on a small scale or as a pilot project in Québec. Table 1 summarizes the situation.

Since work began on producing this synthesis, new publication rules have been enacted at the INSPQ. Henceforth, reports and advisories from the INSPQ must be produced in versions of 1, 3 and 25 pages. These formats are thought to be a means of enabling the INSPQ’s target audiences to make greater use of the knowledge produced. To comply with the new rules, several sections in the long version of this report were withdrawn, in whole or in part, from this version. Thus, the long version includes a section detailing the methodological framework of this synthesis. It also includes a section describing the Québec public policy framework and an analysis of the margin of manoeuvre allowing Québec public health authorities to introduce innovations within the context of the Canadian legal framework governing "illicit” psychoactive drugs. Following from the work presented here, we propose, in the conclusion of the long version of this report, some avenues for strategic public health actions that it would be desirable to undertake.

Note:

The author of this document is not a lawyer. The legal considerations developed in this synthesis cannot in any way be regarded as constituting legal advice. Organizations wishing to implement any one of these interventions should obtain legal advice to ensure the legality of their project.

Table 1 Comparison of services and programs offered in 2015

Jurisdiction/ intervention	Québec	Canada – outside Québec	United States of America	European Union
Education programs for overdose prevention and management with naloxone	Pilot project under development	X	X	X
Supervised consumption services		X		X
Low threshold housing programs		X	X	X
Programs for prevention and substance analysis in festive environments		X	X	X
Prison syringe exchange program				X
Crack smoking equipment distribution programs	X	X		X
Commissions for the dissuasion of drug addiction				Portugal
Cannabis ticketing schemes			X	X
Drug treatment courts	Pilot project underway	X	X	X

2 The courses of action

The overview of each course of action includes six subsections:

- Description of the intervention
- Logic of action and objectives
- Precedents and institutional endorsement outside Québec
- Review of the evaluations
- Legal aspects
- The intervention in the Québec context

In the review of the evaluations presented, we will qualify as “likely” or “possible” certain statements that may be made based on the evaluations reviewed. A statement will be qualified as “likely” if we consider, without major reservations, that the preponderance of evidence weighs in its favour, when compared with potentially competing statements. A statement will be qualified as “possible” if we consider, with significant reservations, that the preponderance of evidence still weighs in its favour, when compared to potentially competing statements.

The following criteria influenced the decision to qualify statements in one way or the other:

- The number of evaluations
- The diversity of places covered by evaluations and of their authors
- The congruency of results among evaluations
- The congruency of results with the intervention’s posited logic of action
- The congruency of results with knowledge about risk and protective factors
- The statistical significance of tests and the reported confidence intervals.

2.1 Education programs for overdose prevention and management with naloxone (EPOPMNs)

2.1.1 Description

The concept of EPOPMNs refers to the provision of education about how to safely consume opioids and manage opioid overdose events using naloxone. These are programs aimed at drug users (DUs) or their relatives and include the distribution of naloxone and the equipment required to administer it to such persons.

Naloxone is a substance that is antagonistic to opioid receptors.[1] Naloxone acts by blocking opioid receptors from binding with the active agents of opioids. The administration of naloxone is part of normal intervention protocol in cases of overdose in many para-hospital practice environments and in hospitals in the West. In some jurisdictions, the decision has been made to authorize and equip non-professionals, such as drug users or their relatives, to administer it.

2.1.2 Logic of action and objectives

The most commonly identified objective is a reduction in overdose mortality. In at least one case, a reduction in overdose morbidity was set as an objective. The underlying logic of these interventions is that preventive education can reduce overdose incidence. Through education about managing overdoses with naloxone and distribution of the antidote to drug users or their relatives, it is hoped that the likelihood of intervention will be increased and that the quality of interventions involving this antidote will be improved.

2.1.3 Precedents and institutional endorsement outside Québec

The first EPOPMNs were apparently launched in the United Kingdom and in Germany in the 1990s. In the United States, 150 programs were initiated in 19 states between 1999 and 2010 (82). The first EPOPMN in Canada was established by the Edmonton Street Outreach Program, a peer helper program. In 2011, Toronto Public Health was the first public health organization to implement an EPOPMN. In 2012, the Ottawa Public Health Branch and the British Columbia Centre for Disease Control established EPOPMNs - in the latter case on a provincial scale.[2]

Furthermore, it should be noted that this type of program is identified as an advisable course of action or "best practice" by several organizations, such as CATIE[3] (13), the European Monitoring Centre for Drugs and Drug Addiction[4] and the Centers for Disease Control and Prevention in the United States of America (14).

2.1.4 The evaluations

The evaluations demonstrate that the implementation of EPOPMNs likely tended to:

- enable a significant portion of program participants to use naloxone during overdose events (75; 30; 38; 70; 80; 20; 81; 26; 88; 6; 21; 4);
- reduce or have a neutral effect on the frequency of recourse to emergency services by the persons who intervened (89; 88; 26);
- enable participants to acquire and maintain adequate skills for managing overdoses with naloxone and reduce the frequency of harmful interventions(88; 55);reduce or have a neutral effect on drug use and overdose risk behaviour (75; 54; 88);
- reduce mortality from opioid overdoses (89; 1; 54);
- be cost effective (17).

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1 When they do not cause death, overdoses can cause other damage including: neurological problems due to a prolonged lack of oxygen, the destruction of skeletal muscle cells (rhabdomyolysis), edemas and other pulmonary complications. Moreover, the more quickly intervention aimed at reversing the overdose occurs, the more limited will be the incidence or severity of its effects. Furthermore, a full recovery is possible if oxygen is restored before permanent damage to organs results (43).

2 Retrieved on December 17, 2013 from: http://towardtheheart.com/naloxone/

3 CATIE: Canada's source for HIV and hepatitis C information.

4 Retrieved on June 1, 2015 from: http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=11UK02&tab=objectives

Furthermore, the evaluations demonstrate that the implementation of EPOPMNs possibly tended to:

- reduce the incidence and severity of overdose-related morbidity.

2.1.5 Legal aspects

The administration of naloxone has proven effective at relieving respiratory distress and carries a low risk of complications. Consequently, the legal context surrounding implementation of such programs seems fairly risk free. This risk would be further reduced if naloxone distribution and training protocols were established to ensure that interventions are carried out in the most appropriate manner.

Furthermore, there are precedents for the administration of medication by non-professionals or first responders, including epinephrine (Epipen™) and glucagon administration (43). Moreover, naloxone seems to be safer and to have fewer unwanted side effects than epinephrine and glucagon (54). To maximize the potential for intervention and the use of pre-hospital emergency services, we might also wish to introduce so-called "911 Good Samaritan" laws (such as the *911 Good Samaritan Drug Overdose Law*).

Methodological quality of evaluations. Firstly, it is worth noting that the effects of EPOPMNs on morbidity from overdoses were not examined.

Some other limitations (such as the use of observational investigation and self-reported data) are relevant to numerous interventions covered in this report. Their significance will be weighed in a concluding section of this report entitled "cross-cutting methodological issues."

2.1.6 The intervention in the Québec context

Since work began on the present study, the *Urgences-Santé* corporation has decided to equip some of its intervention teams with naloxone. In addition, the MSSS has authorized the launching of an EPOPMN pilot project in Montréal. These changes have been introduced concurrent to an increase in the number of deaths from opioid overdose on the island of Montréal and to a longer-term trend toward an increase in mortality due to opioid overdose within Québec overall (29).

It would, furthermore, be salient to develop an epidemiological portrait of mortality and morbidity tied to overdoses. Such a portrait would, in particular, allow for assessment of the relative strengths and limitations of a number of organizations which could be mobilized to offer EPOPMNs to DUs and their relatives: non-profit organizations (NPOs), clinics, hospital centres, correctional facilities, etc.

2.2 Supervised consumption services (SCSs)

2.2.1 Description

The concept of supervised consumption services refers to the practice of qualified personnel supervising drug use by injection or inhalation in a location designed for this purpose. The personnel are able to respond to emergency situations, such as overdose events. Many other services, such as education about safe consumption or referral to detoxification and rehabilitation services, are offered in parallel, although in a manner that varies from one service site to another (62).

Two main organizational models can be distinguished. On the one hand, new spaces can be specifically designed to provide this type of service. In such cases, the terms "consumption rooms" or "supervised injection sites" (for places reserved for those injecting drugs) are often used, even when other services are also offered *in situ*. On the other hand, supervised consumption services can be integrated into an existing service environment. These services are generally provided in fixed locations; however, authorities in Barcelona have set up a mobile unit that criss-crosses the city offering these services. Finally, when services are provided for both injection and inhalation, separate rooms are set up.

2.2.2 Logic of action and objectives

The overall aim of SCSs is always two-faceted: they seek to improve both public health and public safety. The main mechanism of action of supervised consumption services is the relocation of public drug use to a protected and supervised location. It is this relocation which makes it possible to carry out a number of actions with relatively precise objectives.

2.2.3 Precedents and institutional endorsement outside Québec

Informal services were likely offered earlier, but the first publicly authorized SCS was inaugurated in Bern (Switzerland) in 1986 (37). Formal SCSs were established following the emergence of the HIV/AIDS epidemic among IDU populations. Today, there are estimated to be over 90 publicly authorized SCSs in the world. The majority are located in European cities (Germany, Spain, Luxembourg, Norway, the Netherlands, and Switzerland), but there are also some in Australia and Canada.

The two supervised injection sites (SISs) in Canada are located in Vancouver. The first to have offered these services, in 2002, is located in the Dr. Peter Centre, a health centre caring for people living with HIV/AIDS. The other, the Insite supervised injection site, opened its doors in 2003. There are not yet any service sites in this country that allow inhalation as a mode of consumption, although a room has already been set up at Insite and some have called for a pilot project.

2.2.4 The evaluations

The evaluations demonstrate that the implementation of SCSs likely tended to:

- allow a particularly vulnerable segment of IDUs to be reached (62);
- reduce certain at-risk practices for STBBIs (62; 19);
- reduce overdose mortality in IDU populations (62; 53);
- increase access to various social and health services (detoxification and rehabilitation services, primary care, etc.) for users (62);
- improve or have a neutral effect on some aspects of public order (discarded syringes, consumption in public places) (62);
- reduce recourse to the services of emergency responders in the surrounding area (72);
- be cost-effective (62; 69).

Furthermore, the evaluations demonstrate that the implementation of SCSs possibly tended to:

- reduce the incidence of STBBIs.

Methodological quality of evaluation. The strengths and limitations of the evaluations that formed the basis for the INSPQ report on SISs were extensively covered in that report, whether individually or as a set.

With regards to the evaluations covered in this document, let it simply be noted that the evaluation concerning overdoses does not address the issue of morbidity. Other strengths and limitations will be discussed in the subsection on cross-cutting methodological issues.

In addition, the services studied may be referred to as "high capacity" (for example, more than 600 injections take place daily at Insite), and the magnitude of the effects observed should take this fact into consideration.

2.2.5 Legal aspects

Any organization wishing to implement an SCS must file an application for exemption with the federal Department of Health, in accordance with section 56 of the *Controlled Drugs and Substances Act* (CDSA). In its judgment concerning Insite, the Supreme Court of Canada clearly specified the factors that the Minister must take into account when making a decision in respect of any application for an exemption for such a service.

In Québec, undertaking certain steps at the outset facilitates meeting these conditions. To be specific, the MSSS has produced a document establishing guidelines for organizations wishing to provide these services (57). However, only a response to an application for exemption can elucidate the federal Minister of Health's interpretation of the Supreme Court's guidelines.

2.2.6 The intervention in the Québec context

The concept of SISs seems to have gained widespread acceptance in Québec, whether within groups representing drug users, within NPOs serving IDUs or among health authorities. SISs have been integrated into the provincial public health program since 2003 and, as was mentioned, the MSSS recently developed guidelines to support the development of these services.[5]

[5] Retrieved on June 17, 2015 from: http://www.espaceitss.ca/DATA/DOCUMENT/217~v~Balises_du_MSSS_en_matiere_de_services_d_injection.pdf

At the regional level, following an implementation process involving many partners and actors (the Service de police de la ville de Montréal (SPVM) [the City of Montréal’s police service], the Association québécoise pour la promotion de la santé des personnes utilisatrices de drogues (AQPSUD) [Québec association for promoting the health of persons who use drugs], the Centres de santé et services sociaux (CSSS) [health and social services centres], NPOs, etc.), the Direction de la santé publique de Montréal (DSP-Mtl) [Montréal’s public health department] concluded that such intervention was relevant in Montréal. Consequently, the Agence de la santé et des services sociaux [health and social services agency] endorsed the principle. An assessment of the relevance of the intervention, including an assessment of the needs of IDUs, is currently being conducted in Québec city.

Finally, consumption practices are changing rapidly in Québec (71). Indeed, there is an increasingly large number of people consuming by means of inhalation. Therefore, it is becoming a matter of importance to evaluate the relevance of providing inhalation rooms for those using this mode of consumption.

2.3 Prison syringe exchange programs (PSEPs)

2.3.1 Description

The concept of a prison syringe exchange program refers to a service for distributing and recuperating injection equipment in a correctional detention facility. These programs make it possible to offer users front-line health services as well as referrals to other types of social and health services, such as drug addiction treatment services or education and advice about how to inject safely. Nevertheless, because of the type of place where these programs are implemented they often have certain particularities attached to the way they operate (2).

2.3.2 Logic of action and objectives

The primary goal of PSEPs is a reduction in the incidence of STBBIs and, over the long term, in their prevalence. However, more generally, improving the overall health of the IDU prison population is often identified as a goal. Providing sterile injection equipment is a way of reaching IDUs who do not access prison health services and is a key mechanism of action. Indeed, this is necessary to help reduce the number of used syringes in circulation and to increase the number of persons who have sterile syringes and who receive advice about not sharing used injection equipment. Another aim is to reach people to provide them with front-line social and health services, whether offered by the institution or another provider, in order to improve their overall health.

2.3.3 Precedents and institutional endorsement outside Québec

The first prison syringe exchange program was established in Switzerland in 1992. Today, there are around sixty programs in over ten countries, including Armenia, Belarus, Spain, Luxembourg, Moldova and Romania (64). However, some programs have been abolished. This seems due to the fact that PSEPs are controversial and generally unpopular among politicians (44).

Several Québec, Canadian and international organizations support the development of PSEPs. The World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have made the case for such programs in a joint publication (65).

2.3.4 The evaluations

The evaluations demonstrate that the implementation of PSEPs likely tended to:

- have a neutral effect on, or reduce the amount of drug use (64);
- have a neutral effect on the use of injection as a mode of consumption (64);reduce needle sharing (64).

Furthermore, the evaluations demonstrate that the implementation of PSEPs possibly tended to:

- reduce the incidence of STBBIs among IDU prisoners (64);
- increase the use of prison health care services by DU prisoners (64);
- have a neutral effect on, or improve, safety, safety conditions, and perceived safety in correctional facilities (64).

Methodological quality of evaluations

In the review of the literature synthesized in this document, attention is drawn to a few methodological implications of the evaluations reviewed. Firstly, it is worth noting that the evaluations focused on programs in relatively small institutions with fewer than 300 inmates, and that these results are more or less generalizable to larger centres. Moreover, as is the case for many other interventions covered in this report, data collection relied mainly on self reporting by those participating in the studies, which are observational in nature (64). As was noted in reference to other interventions, these methodological issues will be discussed in a subsequent section on cross-cutting issues that apply to several interventions.

2.3.5 Legal aspects

As early as the mid-1990s, a law professor noted that the potential for prosecuting Correctional Service Canada for neglecting to provide sterile syringes was significant (51). Such a case was actually filed in 2012.[6] The complainants are seeking to force the federal correctional service to establish PSEPs in all of their institutions. However, Canadian courts generally interpret the Canadian Charter of Rights and Freedoms solely as a protection against actions taken by public authorities. Indeed, they have been reluctant to make a specific intervention mandatory, which would allow litigation on the basis of inaction or, in other words, to interpret the Charter in terms of positive rights. In this case, a judgment in favour of the plaintiffs would signal a change in jurisprudence and would probably have implications for Québec prisons - in addition to affecting federal penitentiaries, which are the subject of the dispute.

Apart from this outstanding issue, the legal issues specific to PSEPs (as compared with SEPs) all seem centred on the issue of the medical confidentiality of DUs.

2.3.6 The intervention in the Québec context

In epidemiological terms, in 2003 in Québec, 3% of inmates were infected with HIV and 19% with the hepatitis C virus. These rates of infection mainly affected IDUs (2). In addition, 4% of men and 1% of women reported having injected drugs while incarcerated (2). According to a survey conducted in 1995 in federal institutions, 11% of inmates reported having injected drugs since arriving in prison (15). To deal with these phenomena, various harm reduction measures have already been implemented in provincial and federal prisons including: the provision of "condoms, bleach and methadone maintenance treatment" (15).

With regard to PSEPs, the Public Health Agency of Canada wrote in 2002 as follows:

"Correctional Service Canada (CSC) currently provides bleach kits to inmates for cleaning needles and most recently has instituted a pilot project for tattoo parlours in six federal prisons. Currently, CSC does not provide needle-exchange services to inmates, citing its zero-tolerance policy toward drug use and trafficking in prison, as well as concerns about the health of inmates and the security of the institution. Discussions between CSC and the Public Health Agency of Canada about possible collaborative projects in federal correctional facilities are underway.[7] "

The fact that the situation has not evolved in more than 10 years now - and that the situation is the same in the provincial prison network - indicates that these programs lack acceptability. This lack of acceptability derives from the stance of a number of actors on this issue, including correctional services and a significant portion of the population, along with its elected representatives.

Indeed, the establishment of a syringe exchange program in prisons raises concerns within the correctional community in general, and among correctional officers in particular. The main fear expressed concerns the safety of officers, but also that of inmates. Officers fear that they themselves or inmates may be attacked with syringes, or that they may be accidentally injured by a syringe during a search. They also fear possible infection due to contact with a used syringe (2). These fears, which arise within the context of a correctional community that is faced with many challenges related, in particular, to the management of mental disorders and prison overcrowding, represent a major obstacle to the implementation of such programs. Moreover, both within the general population and among elected officials, the idea of "accepting" the consumption of drugs in prison generates cognitive and ethical dissonance creating significant divisions and tensions.

6 Retrieved on March 15, 2015 from: http://www.cbc.ca/news/canada/lawsuit-seeks-needle-exchange-programs-for-prisons-1.1221229

7 Retrieved on March 27, 2014 from: http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/section-6-2-eng.php

This is because prison is an important part of mechanisms for ensuring abstinence from drug use.

However, the situation is not immutable, as is illustrated by the fact that PSEPs have existed in several countries for many years, including in countries faced with the same challenges.

2.4 Low threshold housing programs (LTAHPs)

2.4.1 Description

The concept of low threshold of accessibility housing programs refers to the provision of housing and social and health services to a group of persons who have been living on the street for an extended period. The service is provided specifically for persons with serious addiction problems and, very often, with broader mental health problems. Such housing is said to have a low threshold of accessibility because it is offered without requiring a commitment to a rehabilitation or treatment process as a precondition.[8] The offer of housing is not revoked once a beneficiary is “rehabilitated” or has “readapted.” In order to entrench the separation between the two types of services, the organization that manages housing is usually not the same as the one providing social and health services.

Two major models for the provision of low threshold housing can be distinguished. On the one hand, the housing supplied may consist of multiple dwelling units grouped together in a single building. These buildings are usually public or social property and are managed by non-profit organizations.[9] On the other hand, the housing supplied may consist of separate apartments dispersed throughout a given territory. These apartments are usually privately owned and profit generating.

2.4.2 Logic of action and objectives

Because of their living situations and their social and health status, many people who are homeless and are living with significant addiction and mental health problems are unable to initiate a rehabilitation process. Such persons are usually considered “hard to house” (or “impossible to house”) in dwellings without services and, at the same time, are excluded from housing services tied to treatment. In addition, due to their largely public living circumstances, they are often at the heart of significant community tensions - tensions that expose them to various judicial sanctions and other significant consequences, both social and health related. The primary aim of these programs, which is also their primary mechanism of action, is to stabilize the housing situation and the social and health status of these persons.

2.4.3 Precedents and institutional endorsement outside Québec

The origin of public housing buildings comprising several units managed by NPOs can probably be traced to Portland, Oregon, USA. The origin of the model that consists of providing housing in scattered units, offered on the private market, can probably be traced to New York City. Low-threshold housing appears to be offered in over 200 cities in this country (78). Both these developments occurred during the 1990s. In the United States, they fall within the context of local and federal strategies aimed at “ending chronic homelessness.”

Programs also exist in several European cities and a European research project focused on some of these is underway (Amsterdam, Budapest, Copenhagen, Glasgow and Lisbon).[10] In 2011, the French government also launched a research program focused on low-threshold housing programs.[11]

2.4.4 The evaluations

The evaluations demonstrate that the implementation of LTAHPs likely tended to:

- stabilize the housing situation of difficult to accommodate and treat DUs, more successfully than regular high threshold of accessibility housing (61; 85; 66; 33; 78; 68; 52; 31);
- produce divergent effects (increase, stabilize, reduce) on the use of specific social and health care services, within an overall context characterized by apparent stability or by a slight decrease in the intensity of support (33; 85; 66; 31; 84);

[8] The expressions “Housing First” and “Treatment First” quickly indicate the contrast between low threshold and high threshold approaches.

[9] Housing of this type in Seattle, Washington: http://www.desc.org/aurora_house.html. Retrieved on November 16, 2013.

[10] Retrieved on November 7, 2013 from: http://www.socialstyrelsen.dk/housingfirsteurope

[11] Retrieved on November 8, 2013 from: http://www.cairn.info/resume.php?ID_ARTICLE=INPSY_8903_0233

- have a neutral effect on psychiatric symptoms and have a neutral effect on, or reduce, consumption of psychoactive substances by participants (85; 66; 63; 68; 18; 84);
- improve DUs' perception of their own mental health and social situation (31, 67);
- reduce the police and penal sanctions to which DUs are subject (31; 16).

Methodological quality of evaluations

The number of evaluations, the diversity of evaluated sites, of evaluated programs and of methodologies used, frequently applied controls for several characteristics of participants and highly congruent results indicate a relatively high degree of validity and reliability. In addition, the evaluations both reveal the effects of the interventions on various health indicators and shed light on many of the mechanisms that explain the patterns and variations observed.

However, there remain many unknowns, including some tied to explanations for the variability of the results and some tied to certain public health concerns, such as STBBIs. Also, the methodological challenges associated with this type of research and with the benefits these interventions can be expected to have are significant. For example, it was noted that some of the low-threshold programs evaluated sometimes welcomed clients with low intensity substance abuse problems, thereby limiting the magnitude of the results observed, which could be expected to be greater for persons with severe problems.

2.4.5 Legal aspects

The tenants of these apartments can, like anyone else, be arrested if they are discovered to be in possession of drugs. In Vancouver, there exist agreements between the non-profit organizations that manage the housing units and the city police service that allow the housing programs to function well. Such agreements would likely need to be made more or less explicit for these housing services to function smoothly.

2.4.6 The intervention in the Québec context

In Canada, the research project "At Home/Chez Soi," was, until very recently, being carried out under the auspices of the Mental Health Commission of Canada. One of the five sites for the project was located in Montréal, where about 200 people were provided with housing with services according to the New York model.[12] Low-threshold housing is, in any case, identified in the *Plan d'action interministériel en itinérance 2010-2013* [interministerial action plan on homelessness] (56). This plan refers to the principle of residential stabilization and to the need to improve the services offered to this group.

This need derives from the fact that those persons targeted by LTAHPs, at present, generally fall through the cracks of Québec's health and social safety net, except in extreme cases of urgent and deteriorated circumstances. For example, this group is generally not among the "priority clienteles" of addiction services programs. Moreover, because of behaviour in public that sometimes falls outside acceptable norms, this group of persons is subject to numerous criminal sanctions.

On the other hand, the allocation of resources is a fraught issue. Although LTAHPs apparently have a high cost-efficiency ratio, the actors who could be called upon to contribute to them or who would benefit from them (those within the health and social services system, the police, judicial and correctional organizations, the organizations responsible for the housing supply) are multiple and each has a responsibility to optimize resources within a context of increasing scarcity. If we wish to move forward with this type of intervention, a detailed analysis will be needed, along with some creativity to enable the reallocation of resources and to manage the impact of implementing these new services on the current distribution of resources.

2.5 Crack smoking equipment distribution programs (CSEDPs)

2.5.1 Description

The concept of crack smoking equipment distribution programs refers to the provision of sterilized materials and social and health services to users of this substance. The content of a kit varies, but it usually includes at least one stem, mouthpieces, filters and swabs. The service provided is similar to that of providing injection equipment. Thus, it is often accompanied by education about safe consumption practices (in particular, about risk practices for STBBIs), by equipment recovery services and by detoxification and rehabilitation referral services.

[12] Retrieved on November 7, 2013 from: http://www.mentalhealthcommission.ca/Francais/Pages/rechercheMontreal.aspx

2.5.2 Logic of action and objectives

One of the predominant objectives used to justify sterile inhalation equipment provision services is to reach drug users who make little or no use of regular social and health services or of SEPs. Reaching new people through the distribution of sterile equipment is also a mechanism of action for the achievement of other objectives, since it creates an opportunity to offer advice about safe consumption and safe sexual practices, primary health care, or referral services directing users, in particular, toward detoxification and substance abuse rehabilitation treatments. However, a significant portion of crack users also inject substances and already make use of SEPs. In such cases, harm reduction practices are simply being expanded to include a mode of consumption other than injection for current users.[13] In both cases, the ultimate goal is an overall improvement in physical and mental health, always considering specifically the incidence of STBBIs.

2.5.3 Precedents and institutional endorsement outside Québec

CSEDPs exist in several western countries. The first in Canada was established in Toronto, but already by the middle of the previous decade, others could be found in Vancouver, Winnipeg, Guelph and Ottawa, among other places (35). In Québec in particular, it appears that the first two were implemented in the Outaouais region and on the island of Montréal. There are now programs in Laval and in Québec City.

2.5.4 The evaluations

The evaluations demonstrate that the implementation of CSEDPs likely tended to:

- allow a new segment of vulnerable DUs to be reached or provide sterile equipment for a mode of consumption adopted by IDUs already participating in a SEP (27, 50, 87).

Furthermore, the evaluations demonstrate that the implementation of CSEDPs possibly tended to:

- produce divergent effects (neutral, positive and negative) on various specific at-risk practices, within an overall context of apparent stability (27; 8; 50; 87);
- have a neutral effect on drug use patterns, except perhaps for reducing polydrug use and heroin consumption (27, 50, 87);
- have a neutral effect on the overall health status of participants (27; 87);
- have a neutral effect on the frequency and location of in-public consumption by inhalation or injection (49).

Methodological quality of evaluations. The number of evaluations (4) is limited, and one of them, a formative evaluation, was published by the organization that implemented the CSEDP. The results are sometimes relatively congruent, for example, as regards the ability of these programs to reach DUs. However, this is not always the case, and it is difficult to understand these incongruities. For example, the evaluations show an increase in the consumption of crack by inhalation which results from a transfer from injection to inhalation in one case but not in the other. However, nothing explains these differences. Moreover, it should be noted that the evaluations of the effects of CSEDPs are observational and are largely based on self-reported data. As these issues are also relevant to other interventions covered in this literature review, their importance will be weighed in the section on cross-cutting methodological issues.

2.5.5 Legal aspects

The legal issues related to CSEDPs are essentially the same as those related to SEPs. In large part, they are tied to the ambiguous legal status of sterile equipment which is distributed for consumption purposes. Despite this ambiguous status, and despite the fact that these two types of practices have existed for several years, no program personnel appear to have been charged or convicted for distributing injection or inhalation equipment in Canada. This is likely due to the fact that distribution through SEPs or CSEDPs is always carried out within a disease prevention framework.

[13] In one case, an attempt was made to reduce injection practices by prompting a transfer to inhalation (a mode of consumption that is less risky in terms of STBBIs and overdoses). In the unanimous opinion of the members of the working committee established in support of this synthesis, the benefits of such a transfer seem neither obvious nor potentially substantial if aspects of health other than STBBIs are considered. Such a transfer should not, in our opinion, be included among the intervention's objectives nor among the indicators used to evaluate it.

2.5.6 The intervention in the Québec context

In Québec, most harm reduction efforts remain focused on STBBI transmission through injection. However, a recent study concerning the DU population in central Montréal indicates that crack consumption represents an increasingly large portion of overall consumption and that this has resulted in a diversification of substances consumed and of modes of consumption (71). Indeed the adoption of crack use, according to the same study, has contributed to the fact that the majority of persons in this population group now consume several substances of either of the two types by means of inhalation and injection. In the regions where CSEDPs were implemented, it seems these trends have been identified, along with the need to explore new harm reduction avenues (46). The CSEDPs implemented seem to represent a relatively easy initial step toward reaching the population consuming crack by inhalation, either exclusively or in combination with other substances and modes of consumption.

Furthermore, it appears from the literature that consumption of crack has been independently associated with various phenomena such as STBBIs or cardio-pulmonary arrest. In Québec, however, there is no monitoring data that would make it possible to assess the volumes of mortality and morbidity arising specifically from the consumption of crack, even though the Montréal report just mentioned tends to confirm the effect of crack inhalation on the prevalence of STBBIs (46). To assess the relevance of increasing provision of this service, it would seem important to produce such knowledge.

Finally, if the decision is made to further develop this type of program in Québec, it will be necessary to reflect on the contents of the kit distributed through these programs.

2.6 Programs for prevention and substance analysis in festive environments (PPSAFEs)

2.6.1 Description

The concept of programs for prevention and substance analysis in festive environments here refers to NPOs providing education about safe consumption as well as substance analysis ("Drug Checking," "Pill Testing" or "Testing") in festive environments. The purpose of the analyses is to identify and characterize substances that DUs have in their possession. Substances are submitted to support workers from NPOs at the scene of events (for example, at "raves") or prior to events on the "fixed" premises of NPOs. Analyses are performed *in situ* or in laboratories. In addition, these programs offer education about safe consumption and, often, provide referrals to detoxification, rehabilitation, or other health services. The analysis technologies used vary and provide varying results (74).

2.6.2 Logic of action and objectives

Offering to analyze substances would make it possible both to provide information about the substances and to reach DUs who do not make contact through existing prevention mechanisms. This contact would then allow for discussion about safe consumption practices (at-risk consumption contexts, combining substances, hydration and other risk or protective factors, for example).

2.6.3 Precedents and institutional endorsement outside Québec

Such programs exist in several European countries, including Germany, Austria, Belgium, France, the Netherlands, and Switzerland (24). It seems that NPOs also perform this type of work in the United States of America and in Canada (Dance Safe is an NPO that has "branches" in Canada[14] and in Australia) (11).

[14] Retrieved on January 12, 2015 from: http://www.dancesafe.org/about-us/

2.6.4 The evaluations

The evaluations demonstrate that the implementation of PPSAFEs likely tended to:

- allow a segment of the DU population to be reached that does not access regular harm-reduction services (7; 39);
- provide information of limited quality about the nature of analyzed substances when so-called presumptive detection technologies were used *in situ* (11; 39).

Furthermore, the evaluations demonstrate that the implementation of PPSAFEs possibly tended to:

- allow DUs with particularly risky consumption practices to be reached (42);
- allow DUs to acquire knowledge about safe consumption practices (7);
- have a neutral effect on, or reduce, consumption or at-risk practices (7);
- prompt a switch to the consumption of other substances (42);
- delay the initiation of consumption (7).

Methodological quality of evaluations. The number of evaluations that exist is limited. Indeed, only four evaluative studies were identified. Also, the evaluations suggest that several of the mechanisms of action posited by the logic of action are affected, often positively. In addition, the evaluations of the quality of the tests focused on PPSAFEs that did not apparently use the most reliable and rapid analysis technologies (the technologies used in the programs evaluated perform what is referred to as presumptive recognition of products (the Marquis test), whereas in some Swiss jurisdictions, the technologies used instead are referred to as high performance liquid chromatography tests). Moreover, the evaluations did not directly address the issue of health effects, either in terms of incidence or of the severity of consequences. Other methodological issues (such as the use of self-reported data) will be discussed in the section on cross-cutting issues that are relevant to several of the interventions covered here.

2.6.5 Legal aspects

Support workers from NPOs as well as the consumers providing the drug samples could be arrested and charged for possession of controlled substances, in cases where the substances in their possession are listed in the CDSA schedules. That said, the *Food and Drugs Act* (FDA) authorizes the use of “devices” or “instruments” that can be used or are represented for use in “preventing a disease” (12). Substance testing devices likely fall into this category. However, to our knowledge, this has never been tested in the courts because, in Canada, it seems that charges have never been laid in this type of situation.

Further, support workers from NPOs and those who authorize them or equip them to perform these analyses and to communicate their results probably expose themselves to the risk of civil suits. It is likely that certain precautions, such as proper training for analysts, the creation of working conditions that facilitate the correct interpretation of results, and clear communication of the meaning and limitations of the analyses are factors that would mitigate these risks.

2.6.6 The intervention in the Québec context

The most recent evaluation of drug use in festive environments dates back more than 10 years. In a study of the consumption habits of the public attending raves in Montréal, it was estimated in the period close to the year 2000 that 65.2% of youth had consumed ecstasy during their lifetimes (28). However, the incidence of mortality, morbidity and other consequences (such as the frequency of sexual assaults which could be facilitated by the use of GHB) associated with this type of event in Québec are not known, nor, a fortiori, are those specifically related to variations in the quality of the substances consumed. Thus, it seems at this time quite difficult to assess, even in approximate terms, the potential benefits of implementing programs of this nature. It would therefore be advisable to produce a clear epidemiological portrait of these phenomena. Perhaps, the strongest rationale for considering such a program, at this time, is its potential to contribute to producing such a portrait.

A European Union (EU) program has, in fact, allowed a grouping of non-profit organizations offering PPSAFEs to develop analyses of substances sold in various cities, and their effects.[15] The system relies on analyzing substances and on conducting interviews with users when the latter bring their substances to the testing sites. The information gathered through the interviews makes it possible to characterize the users (age, gender, socio-economic status), the products consumed and their effects, as well as consumption modes and practices (83). The aim is to support the practices of NPOs and other actors responding to the problems engendered by the consumption of these substances by producing analyses of European trends. In addition, these analyses allow "alerts" to be issued when certain clearly dangerous substances are detected. For example, a report by the European grouping of NPOs allowed information about certain health problems associated with emerging substances to be disseminated.

Furthermore, if the decision were made to move forward with such a program, it would be necessary to consider which analysis technologies to use and which goals and objectives to target. As mentioned above, some technologies used *in situ* do not provide very reliable information about the substances analyzed. There are, however, technologies specifically for use *in situ* that appear to be both more reliable and more expensive, such as those used in Berne and Zurich, in Switzerland (41).

For that matter, there seems to be nothing, a priori, that requires the analysis of illicit substances to be limited to festive environments. Many segments of the population (homeless DUs and DUs in athletic, academic or professional environments, for example) could benefit from reliable information about the substances they consume and are not currently being reached by harm reduction or specific prevention campaigns. In the context of future discussions concerning PPSAFEs, it would be relevant to reflect on the implications of offering prevention and substance analysis programs to various other segments of the population.

2.7 Commissions for the dissuasion of drug addiction (CDTs)

2.7.1 Description

Portuguese authorities have established commissions for the dissuasion of drug addiction (*Comissões para a Dissuasão da Toxico dependência* or CDTs*)* in each of the country's 18 administrative regions. These commissions are responsible for managing administrative penalties for drug possession/use which are defined in law 30/2000 - the same law that created the above-mentioned commissions. The commissions are composed of two representatives from the health and social services sectors and another representative from the judicial sector. The definition of these administrative penalties was accompanied by a repeal of the sanctions provided for in the criminal code for the possession or consumption of drugs.

The "clients" of these commissions are individuals found to be in possession of drugs by police services. If the amount of drugs found exceeds the equivalent of 10 days worth of personal consumption (volumes for each substance are specified in the law), the case is directed towards the authorities responsible for the enforcement of criminal laws that impose sanctions for drug trafficking, importation and production. On the other hand, if the amount of drugs found corresponds to the equivalent of up to 10 days worth of personal consumption, police can confiscate it and summon the possessor to appear before a CDT within 72 hours. The commission would then evaluate the possessor's relationship to drugs.

The commissions can have recourse to various sanctions for the purpose of discouraging drug use and encouraging addicts to use rehabilitation services. The commissions may not oblige a person to enroll in a rehabilitation program, but they can apply sanctions in a manner that induces a person to do so. In addition, they can suspend sanctions if a person considered an addict agrees to undergo and to complete "treatment," or if a person using drugs recreationally undertakes to respect certain conditions, such as not committing a new offence. Finally, they have the power to reinstate the sanctions if individuals do not respect these conditions (92).

[15] Retrieved on January 15, 2015 from: http://www.tediproject.org

The establishment of CDTs was accompanied, notably, by an intensification and reorientation of efforts focused on prevention, rehabilitation and harm reduction. Moreover, the establishment of these commissions and of the law meant that application of the criminal code would focus on the aim of reducing supply (importation, production, trafficking). Overall, the strategy, of which the establishment of the dissuasion commissions was a part, provided for a two-fold increase in the financial resources devoted to all public actions related to drugs (59).

Logic of action and objectives

These commissions were established in the wake of a government report affirming the ineffectiveness, even counter-productivity, of criminal sanctions with respect to reducing drug consumption, drug addiction, and their social and health consequences (including the HIV epidemic) (25). The CDTs were explicitly set up to encourage those who “simply use” drugs to stop consuming and to urge users living with addiction to commit to a rehabilitation process while sparing them the social and health consequences associated with the criminalization process that had previously applied (40).

2.7.2 Precedents and institutional endorsement outside Québec

Portugal established the commissions for the dissuasion of drug addiction in 2001. To our knowledge, it is the only state to have done so concurrently with abolishing criminal sanctions and replacing these with administrative sanctions.

2.7.3 The evaluations

The evaluations demonstrate that the implementation of CDTs in Portugal likely tended to:

- allow for the administrative sanction and the social and health management of DUs who previously were criminally sanctioned, without increasing the total number of DUs sanctioned (40; 25).
- contribute to an increase in the use of rehabilitation services (40);
- contribute to an increase in the number of persons arrested for “trafficking” and in the volume of drugs seized (40);
- contribute to an increase in the number of homicides linked to the illicit drug market (93).

Furthermore, the evaluations demonstrate that the implementation of CDTs in Portugal possibly tended to:

- have little or no effect on population consumption patterns (40);
- contribute to a decrease in the number of IDUs (40);
- contribute to a decrease in the number of DUs and IDUs incarcerated, and in the amount of drug use in prisons (40);
- contribute to a decrease in the number of DUs struggling with addiction problems (40);
- contribute to a reduction in the incidence of STBBIs (40).

Methodological quality of evaluations. As is the case for all of the interventions evaluated in the context of this report, the Portuguese CDTs belong to a set of interventions implemented to act on drugs and their consequences. They are implemented in environments characterized by multiple and shifting dimensions - including, for example, drug markets. Moreover, the researchers who produced the evaluations examined in this document themselves point out that it is impossible to attribute any change observed either directly or exclusively to the administrative structure that was set up in lieu of the prohibitive regime that existed previously.

The comparative study examining numerous aspects of the situation in Spain and Italy partially clarifies that which can be attributed to the implementation of CDTs and to the Portuguese drug strategy of which they are a part. But this type of exercise can only offer partial explanations. Not all jurisdictions compile their data in the same way; nor do they systematically collect data on all the phenomena examined. In fact, while the political changes that took place in Portugal are rather well-documented, the other countries are treated to some degree like a black box, as if everything there had remained stable. These last points are realities with which practitioners of comparative sciences have come to terms, but they are also difficult to reconcile with certain standards of proof held to by some in the public health community.

2.7.4 Legal aspects

Provincial authorities have jurisdiction over criminal law enforcement, including application of the CDSA. Thus, prosecutors with the *Bureau du Directeur des poursuites criminelles et pénales du Québec* (DPCP) [the office of the Director of Criminal and Penal Prosecutions] already have a certain margin of manoeuvre when cases of simple cannabis possession are referred to them. Under certain conditions, the *Program to deal non-judicially with certain criminal offences committed by adults* offers them the option of

not prosecuting individuals who police find in possession of small amounts of marijuana (30 grams or less) or of hashish (1 gram or less). This program allows for sanctioning offenders by sending a warning letter, a demand or through "alternative measures."

It seems plausible to assume that, with a few modifications, this program could be made to resemble more or less closely the legal framework governing CDTs. This would, on the one hand, involve including in the list of eligible offences the possession of all drugs identified in the CDSA - implying that their possession would then be regarded as a minor offence. And on the other hand, it would also be necessary to include in the list of alternative measures a commitment on the part of an offender to appear before a "dissuasion commission" (which would of course have to be created). Or, it would be necessary to allow attorneys to work with representatives of the health and social services sector to add a few more options to the current list of alternative measures. The elimination of some of the program's conditions of eligibility, such as the absence of a criminal history, might also need to be considered if the program is be aligned with the Portuguese CDT program.

Contemplating taking such a step necessarily entails entering into dialogue with the Department of Justice and the Director of Criminal and Penal Prosecutions.

2.7.5 The intervention in the Québec context

According to information released by the DPCP, a little over 2,300 people benefited from the *Program to deal non-judicially with certain criminal offences committed by adults* in 2012, while this number was a little under 1,400 in 2007. At the same time, the same source of information reveals that over 12,000 charges were laid for "simple possession" in 2012, a figure that represents an increase of almost 50% compared to 2008, when just under 8,000 charges were laid.

The clearest benefit of establishing CDTs, along with a corresponding judicial framework, would consist in helping decriminalize a greater number of cases of "simple possession" contravening the *Controlled Drugs and Substances Act*. Such decriminalization could both spare DUs some of the negative consequences of a conviction and relieve some components of the criminal justice system (police services, courts, the correctional system) of a portion of the work associated with legal proceedings.

It is not possible to precisely evaluate the potential impact of such decriminalization, but it would likely affect far fewer than the 12,000 charges reportedly laid in 2012. If we wish to move ahead with such action, a more detailed analysis of the situation will be required to better assess the current realities of enforcing drug possession laws in Québec and, thus, the benefits of establishing CDTs by expanding or modifying the program for dealing non-judicially with certain offences.

As regards the other benefits associated with the Portuguese experience related to CDTs, they have either already been largely achieved in Québec (likely as a result of programs already established here, such as SEPs, methadone maintenance programs and others) or are impossible to achieve without significantly expanding the rehabilitation services now provided.

It is difficult to predict the public reaction, of the general public or of certain actors in particular, to a proposal to create CDTs in Québec. This option has simply not been the subject of much public discussion here. Generally, debate has been much more focused on major legislative changes (the options of decriminalization or legalization) than on the positive form that public action can take, in this context. To our knowledge, there has been no public controversy surrounding the *Program to deal non-judicially with certain criminal offences* established in Québec.

2.8 Cannabis ticketing schemes (CTSs)

2.8.1 Description

The concept of a cannabis ticketing scheme refers to the introduction into the legal code of the possibility of issuing tickets to penalize persons found to be in possession of cannabis "for personal consumption." Some Australian CTSs also allow for the possibility of growing a certain amount of cannabis, also provided it is "for personal consumption."[16] The criminal sanctions provided for in the existing legal codes are not eliminated. In other words, after such a legislative provision is introduced, an offence may be dealt with by

[16] In these cases, it seems that the desired objective is to reduce the amount of cannabis purchased from large criminal organizations. As this does not appear to be a provision in the majority of CTSs and since it does not appear to be part of what is envisaged for Canada, it will not be referred to in the following section. This said, it will be discussed in the section covering the legal aspects.

the police, at their discretion, either as a crime or as an administrative offence punishable by ticketing.

2.8.2 Logic of action and objectives

CTSs are almost always justified by invoking the idea that the possession (or production) of cannabis for “personal consumption” is a minor offence.

Moreover, two objectives, considered complementary, are generally advanced to justify CTSs, although either one or the other is sometimes given much greater emphasis. Firstly, one stated aim is to spare offenders the consequences of a criminal conviction, insofar as possible. In parallel, some CTSs are also seen as a means of creating incentives to use education and rehabilitation services related to cannabis use. A second stated aim is to reduce the burden that the processing of possession offences imposes on various components of the criminal justice system.

2.8.3 Precedents and institutional endorsement outside Québec

Several jurisdictions have passed legislation of this nature. In the United States of America, at least eleven states have adopted such provisions. The first was Oregon in 1973, and ten others followed suit between then and 1978 (77). Also, the state of South Australia developed a CTS in 1987 and was followed by 4 other Australian states or regions in the following years (77). Some European countries, including Spain and Italy, have done the same.

The Canadian Association of Chiefs of Police (CACP) adopted a resolution in support of a CTS in 2013.[17]

2.8.4 The evaluations

The evaluations demonstrate that the implementation of CTSs likely tended to:

- have a neutral effect on cannabis consumption patterns (48; 22; 77; 5);
- limit the consequences for people sanctioned through ticketing, as compared with those sanctioned criminally (48);
- increase confusion about the legal status of cannabis (36);
- be applied inconsistently from one region to another (3);
- increase the over-representation of Indigenous persons in cannabis related “drug cases” (3);
- decrease the number of DUs processed through the criminal system (3);
- increase the total number of persons sanctioned for possession either through the criminal system or through ticketing (3).

2.8.5 Legal aspects

The establishment of a CTS in Québec is dependent upon the federal government enacting a legislative modification. Because power is shared between the federal government and the provinces, it is in fact impossible for Québec to establish a system of administrative penalties in this area.[18]

Moreover, the introduction of a provision allowing the cultivation of cannabis for personal consumption seems unlikely, given the changes made at the beginning of 2014 to the medical marijuana access program.

2.8.6 The intervention in the Québec context

The establishment of a CTS by the federal government would provide a framework for cases that are currently covered, in Québec, by the *Program to deal non-judicially with certain criminal offences committed by adults*. Thus, there would be two competing options for managing these “minor offences.” In other words, the implementation of a federal CTS would probably render obsolete the existing Québec program. A CTS could thus result in a certain “toughening” of the penalties for DUs in Québec, and perhaps an increase in the number of persons sanctioned.

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[17] Retrieved on June 2, 2015 from: https://www.cacp.ca/r%C3%A9solution.html#40

[18] Municipalities have already attempted to establish ticketing penalty systems in parallel with the criminal code for prostitution. The Supreme Court of Canada ruled in a case involving one of these that such a system is unconstitutional by virtue of the current division of powers in the country, according to which criminal jurisdiction is exclusively federal (Canada 1983). This case law applies in all likelihood to provincial authorities in matters concerning the controlled substances identified in the CDSA.

2.9 Drug treatment courts (DTCs)

2.9.1 Description

The concept of drug treatment courts ("Drug Courts") refers to judicial initiatives that consist of allowing persons living with addiction to enrol, under judicial supervision, in programs for treating their addiction. This possibility is offered when the alleged offence is considered to be the consequence of addiction. DTCs deal with various types of offences (criminal or other), of "clienteles" (adult or juvenile), and of illicit or other substances (some specialize in alcohol-impaired driving, for example).

Despite these variations and the differences among the descriptions gathered, these initiatives generally share certain features:

- an intensive judicial monitoring process that is non-adversarial and "motivational" in character, in which the judge and the prosecuting and defence attorneys form a "legal team" focused on the successful completion of addiction treatment by their "clients";
- the integration of addiction treatment professionals into the judicial process;
- the adjustment of criminal sanctions (application or non-application, severity of sanctions) dependant on the successful completion of treatment;
- an abstinence-based treatment program, verified by periodic urine tests (90; 10; 79).

Furthermore, different types of DTCs are often distinguished based on how they manage the charges laid before them. In some cases, access to the DTC program is offered prior to arraignment and successful completion of treatment opens up the possibility of the charges being dropped (pre-plea/diversionary court). In other cases, a condition of access to the court is a plea of guilty to the charges (post-plea court). In this latter case, the "success" of the treatment allows for the expungement of the offence from the criminal record or for the adjustment of the gravity of the charges or the severity of sentencing (90; 58).[19]

2.9.2 Logic of action and objectives

The logic underlying DTCs is that a certain number of minor offences or crimes are committed because of the offenders' addiction problems and that they must be dealt with more effectively than they are generally dealt with by the criminal justice system. The idea is to move towards a new balance between the rehabilitative and punitive functions of the justice system, or even, in some cases, to completely eliminate the punitive function (pre-plea/diversionary courts), while using penalties as an incentive to seek treatment for drug addiction.

Thus, treatment is seen as the key to preventing recidivism. In this specific case, a commonly-used indicator of the success of treatment is abstinence from consumption, as evidenced by the ongoing requirement to submit to drug testing. In addition, another objective is almost always stated: the aim of reducing the burden placed on the judiciary system by this type of offence.

2.9.3 Precedents and institutional endorsement outside Québec

The first DTCs appeared in Chicago and New York (USA) in the early 1950s. However, these programs disappeared and only reappeared in the late 1980s (9; 79). There were recently estimated to be 2,459 DTCs active throughout the country (76). Some now exist in a few other countries, such as the United Kingdom, Australia and Belgium.

In Canada, the first DTC was implemented in Toronto in 1998. They now also exist in Regina, Winnipeg, Vancouver, Ottawa and Edmonton. A federal funding program administered by the Department of Justice has existed since the mid-2000s to support authorities implementing DTCs.[20] In Québec, a pilot project called the *Québec court-supervised drug treatment program* was set up by the Québec Superior Court in 2012. It follows the post-plea model, and requires participants to plead guilty.

[19] Apart from the requirement for abstinence, which is always present, the criteria for success vary from one DTC to another.

[20] http://www.justice.gc.ca/eng/fund-fina/gov-gouv/dtc-ttt.html, retrieved on August 27, 2014.

2.9.4 The evaluations

The evaluations demonstrate that the implementation of DTCs likely tended to:

- reduce recidivism among participants, whether new arrests or reconvictions are being considered (86; 45; 90; 34; 10; 73 and 58).

Furthermore, the evaluations demonstrate that the implementation of DTCs possibly tended to:

- have a neutral effect on, or reduce, drug consumption and addiction among participants (91);
- improve various dimensions of participants’ social lives (91).

Methodological quality of evaluations. Of the interventions covered in this review, DTCs are, by far, the type that has been most subject to evaluation. Despite clear variations in the methodologies used by these evaluations and despite the introduction of several controls for various potential biases, the results are relatively consistent from one evaluation to another, at least with regard to the effects of DTCs on recidivism. When the focus is narrowed to types of research that are deemed valid and reliable and that control the most for potential methodological bias, even supporters of the most rigorous approaches arrive at more or less the same conclusion regarding recidivism.

For their part, evaluations that examine drug use, drug addiction and rehabilitation are rarer. However, they are relatively congruent. There seems to be an even greater scarcity of evaluations that examine the effects of DTCs on the judicial and correctional systems, even though this is central to the logic of action of DTCs.

The difference between the results of observational studies and those of quasi-experimental studies is an issue that will be discussed in the section on cross-cutting methodological issues.

2.9.5 Legal aspects

DTCs are explicitly included among the prerogatives of the provincial judiciary. They are in fact explicitly authorized under section 720 (2) of the *Criminal Code of Canada*. The wording of this provision and its inclusion in the chapter of the Criminal Code concerning the determination of sentencing suggests that the code does not explicitly allow the establishment of the pre-plea/diversionary court model of DTCs. This said, provincial authorities have jurisdiction over criminal law enforcement. Thus, it seems plausible to assume that this margin of manoeuvre would allow Québec authorities to establish diversionary or pre-plea courts if they so desire. In fact, it is conceivable that the *Program to deal non-judicially with certain criminal offences committed by adults* could provide a framework for the development of DTCs. This would involve including in the list of alternative measures a commitment on the part of the offender to appear before a DTC (which, of course, would have to be created). Contemplating doing so seems necessarily to entail entering into dialogue with the Department of Justice and the Director of Criminal and Penal Prosecutions.

2.9.6 The intervention in the Québec context

The pilot project implemented in Montréal by the Court of Québec has been the subject of an evaluation, but this has not yet been published. As elsewhere, this program was put in place to reduce pressure placed on the judicial and correctional system by offenders with addiction problems, while reducing recidivism and drug addiction among such offenders. For this reason, it would be interesting to see the extent to which the program was able to reduce this pressure, and the associated recidivism and addiction problems, and to see what systemic effects it might have had. With respect to the latter, three areas of particular interest seem to be: reconciliation of the abstinence requirement of DTCs with the harm-reduction approach adopted by the Centre de réadaptation en dépendance de Montréal [Montréal addictions rehabilitation centre] (where abstinence may be proposed if deemed important or necessary, but where it is not absolutely essential); the effects of the introduction of DTCs on opening access to services to other clienteles; and the cost-benefit ratio of this approach as compared with how rehabilitation is typically handled elsewhere in Québec. The evaluation produced should provide a better understanding of the implications of introducing DTCs in Québec.

2.10 Assessment of cross-cutting methodological issues

Here we examine the choice to rely on self-reported data. We then examine how the evaluations allow for measurement of the same intervention, for extensive assessment of all the potential effects of the interventions, and for assessment of the effects of other interventions or processes on the results.

Self-reported data. Although one cannot deny the possibility that some of the responses included in the material analyzed in the evaluations were affected by a desirability bias, it seems it can no more be asserted that this was consistently or significantly the case nor that this would have systematically increased the benefits or decreased the adverse effects identified.

Evaluating the same intervention. Overall, it seems that the evaluations allow analytical distinctions to be established that are of potential significance when assessing the documented effects in relation to the specific characteristics of particular interventions. However, readers should exercise caution in extending the results of evaluations on EPOPMNs, SCSs and PPSAFEs.

Extensive coverage of potential effects. Overall, the evaluations appear to reasonably cover the main substantive effects expected of interventions, and also to examine any adverse effects brought up in debates and controversies surrounding the interventions.

On the other hand, few authors devote much consideration to the varying geographical scales and varying time horizons in which interventions are likely to be effective. There are two exceptions to this general rule: CTSs and some studies related to the *Insite* SIS. With respect to time horizons, CTSs, SISs and DTCs were the subject of evaluations examining their effects more than 2 years after the interventions were implemented.

In addition, discussion concerning the procedural effects of the interventions is generally limited. On the other hand, several studies examined the ability of interventions to reach DUs and some evaluations even reached beyond the “standard” framework.

An adequate assessment of the effects of other interventions and processes on the results. In general, little effort is made in the evaluations to assess, or even identify, the effects of those processes and interventions being carried out simultaneously. This said, special efforts were concentrated in this area within the context of certain evaluations or series of evaluations, such as those focused on EPOPMNs, SCSs, LTHAPs, CDTs and CTSs.

3 Conclusion

These interventions were examined as part of an attempt to identify courses of action that can mitigate the negative effects of the current control framework or enhance its positive effects on public health. To begin with, it can be noted that Québec authorities appear, within the context of the federal legal system, to possess a margin of manoeuvre sufficient to permit the introduction of most of these interventions. Moreover, most of these interventions have already been implemented in Québec or elsewhere in Canada, with the exception of CTSs, which would likely require the establishment of a new regulation by the federal government. In the case of CDTs, it seems that a closely related intervention could be implemented, within the framework of the current *Program to deal non-judicially with certain criminal offences committed by adults.* In this case, they would have to be introduced without the legislative change that accompanied their introduction in Portugal (the repeal of criminal penalties for possession of all currently illicit drugs), as this falls within the federal government’s authority.

Finally, within Québec there is a significant lack of knowledge concerning at least two aspects of drug use. On one hand, the overall rates of psychoactive substance consumption, "abuse" and addiction at the population level are known. However, in specific contexts, the consumption rates, practices and health effects could be much better documented. Similarly, although information about addiction rehabilitation services is available, much is unknown about the use of other social and health services directly linked to drugs. For example, little is known about the universe of practices for enhancing sports, academic or professional performances or about practices in festive environments, either regarding consumption or the use of social and health services that can ensue. This lack of knowledge deprives us of the means of evaluating

several potential forms of intervention that might be more efficient, effective or cost-effective.

This synthesis has proposed an intervention that could allow us to better document consumption in festive environments: programs for prevention and substance analysis in festive environments (PPSAFEs). It has already been suggested that a pilot project could be initiated with the aim of gathering this knowledge as a backdrop. But this type of program could serve equally well as a means of approaching other practices and consumption environments, including those just mentioned. In the same vein, we know little about the therapeutic uses of certain substances, such as marijuana or opioids. In light of the consequences they can engender, it seems important to better understand, for example, the evolution of consumption practices in this context and the potential effects of these various substances, as well as of some of their determinants, such as medical prescription practices.

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