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North American Observatory on Health Systems and Policies

# Rapid Review

## Health systems adaptations to support drug decriminalization

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The views expressed by the authors are not intended to represent the views of the North American Observatory on Health Systems and Policies.


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**About**

The North American Observatory on Health Systems and Policies (NAO) is a collaborative partnership of interested researchers, research organizations, governments, and health organizations promoting evidence-informed health system policy decision-making.



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# List of Abbreviations

| | |
|---|---|
| BHRN | Behavioral Health Resource Network |
| CRIs | Centres of Integrated Responses |
| CTDs | Commissions for Dissuasion of Drug Addiction |
| DCR | drug consumption room |
| GCDPC | Government Council for Drug Policy Coordination (Czech Republic) |
| HCV | Hepatitis C virus |
| NGO | non-governmental organization |
| PWUD | people who use drugs |
| SICAD | General Directorate for Intervention on Addictive Behaviours and Dependencies' (Portugal) |
| STI | sexually transmitted infection |
| WHO | World Health Organization |

# Executive Summary

Years of substantial evidence on the harmful impacts of prohibitory drug policies on the health and social well-being of people who use drugs, increasingly toxic drug supply, and ongoing overdose crises in some jurisdictions has placed drug decriminalization as a crucial step in a larger public health-oriented approach to drug policy. However, there have been various motivations and approaches to decriminalization. When decriminalization is framed in the context of a public health response, health and social systems can be leveraged to support people who choose to seek care related to their substance use. As a public health response, linkages to harm reduction interventions and the health system more broadly are important and may require adaptations or reforms to health and social systems to better support service access for people who use drugs (PWUD). This rapid review aims to uncover the types of health system adaptations, reforms, and policies that other jurisdictions have implemented to prepare their health systems to support drug decriminalization.

We conducted a rapid jurisdictional review to describe and compare health systems and broader social supports in place to support decriminalization of hard drugs in Portugal, the Czech Republic, and the US state of Oregon, with limited information about recent developments in British Columbia.

Findings are summarized using an overarching framework to consider health system reforms/ adaptations related to financing, delivery, governance, workforce, and other sectors, while drawing attention to broader social/public policy supports and community engagement strategies that emerged in these cases. We highlight several challenges and enablers to adaptations and integrations to support drug decriminalization, and offer key considerations for Canadian jurisdictions for health and social systems adaptations as part of their broader drug policies:

- A public health-oriented approach to decriminalization requires a **multi-sectoral and comprehensive strategy** that aims to strengthen the many programs, policies, and services needed to support PWUD who seek health and social services, and should be non-coercive in its implementation.
- **The ministry of health can take a lead role in implementing and operationalizing these strategies** by adapting or expanding health service delivery, health promotion activities, and health workforce training, as well as liaise with other ministries involved in creating strategies and plans related to decriminalization.
- **Consistent and adequate funding** is required for substance use treatment and recovery services, harm reduction services, peer support services, and social supports to allow various referral pathways of care to be available for people who choose to access them.
- Decriminalization efforts may require **independent governance and oversight**, with representation from all sectors and stakeholders, including affected communities, to ensure a comprehensive approach that considers the health, social, and economic needs of PWUD.
- **Robust monitoring and evaluation approaches** are needed to capture the full range of possible intended and unintended outcomes, considering intermediate, process-related outcomes in the health system (e.g., healthcare utilization), public health and outcome measures, criminal justice metrics, as well as disaggregation of indicators to consider inequities throughout.

# Introduction & Background

The current global discourse on drug policy has recognized that the prohibitory and criminal justice-based approach to drug use has not only stigmatized people who use drugs (PWUD), but has also contributed to significant health harms (Office of the Provincial Health Officer, 2019). Additionally, it has been acknowledged that substance use disorder takes place on a continuum of overall substance use, rather than previous frameworks that equated all substance use as harmful (Office of the Provincial Health Officer, 2019; Csete et al., 2016). Accordingly, many jurisdictions have shifted towards public health- and human rights-based approaches to drug policy that emphasize harm reduction principles, especially in response to ongoing overdose crises (Csete et al., 2016; UNODC, 2016). Several jurisdictions have sought alternatives to criminal penalties for people who possess drugs for personal use.

Decriminalization is one such alternative. Often, decriminalization shifts the possession, consumption, and acquisition of drugs from a criminal offence to an administrative offence. However, there has not been a singular approach to decriminalizing drugs, including the types of drugs decriminalized – i.e., soft drugs (cannabis) vs. hard drugs (opioids, cocaine, methamphetamine, ecstasy, etc.). Indeed, the term "decriminalization" has been used to characterize many different legislative and regulatory models, as well as various motivations and approaches to decriminalization (Greer et al., 2022).

When decriminalization is framed in the context of a public health response, health and social systems can be leveraged to support PWUD who choose to seek care related to their substance use (Csete et al., 2016), or who are directed to seek treatment as part of administrative proceedings related to their substance use. Therefore, linkages to harm reduction interventions and the health system more broadly are important for PWUD who are seeking health services. Drug policy reform may thus require adaptations or reforms to health and social systems to better support service access for PWUD.

This rapid review aims to uncover the types of health system adaptations, reforms, and policies that various jurisdictions have implemented at both national and sub-national levels to prepare their health systems to support the decriminalization of hard drugs.

# Methods

We conducted a rapid jurisdictional review to describe and compare health systems and broader social supports established to support the decriminalization of hard drugs. For this report, "hard drugs" are defined as those listed under the *Controlled Drugs and Substances Act*, including opioids, cocaine, methamphetamine, ecstasy, etc. (Government of British Columbia, 2023). We focus on Portugal, the Czech Republic, and the state of Oregon (United States), as well as emerging decriminalization efforts in British Columbia. We employed PubMed, Google Scholar, and Google search engines, sources drawn from the reference lists of relevant studies and documents, as well as references provided by key expert consultations.

**TABLE 1.** Inclusion and exclusion criteria

| Inclusion | Exclusion |
|---|---|
| - Academic and grey literature<br>- English language (or reports/webpages that can be easily translated into English)<br>- Consultations with key experts to validate findings and fill knowledge gaps<br>- Focus on decriminalizing hard drugs<br>- Articles and documents published from 2000 – present | - Not focused on hard drugs (e.g., focus on cannabis)<br>- Not focused on health policy, health systems, or broader social supports<br>- Articles and documents published before 2000 |

Given our focus on health systems, we extracted information based on the World Health Organization (WHO) health system building blocks as our overarching framework (World Health Organization, 2010). The framework was used to identify and categorize health system reforms/adaptations related to financing, delivery, governance, workforce, etc., as well as broad social/public policy supports and ways of engaging with communities that emerged from the literature review.

We created case study summaries of Portugal, the Czech Republic, and Oregon based on data extracted from the sources; British Columbia was not developed into a case study summary as it only recently initiated decriminalization in January 2023. The three case summaries were sent to local experts to validate findings and fill any knowledge gaps (e.g., clarifying ambiguities, providing more up-to-date information, etc.). Experts were contacted by email to provide feedback via email, phone, or videoconference.

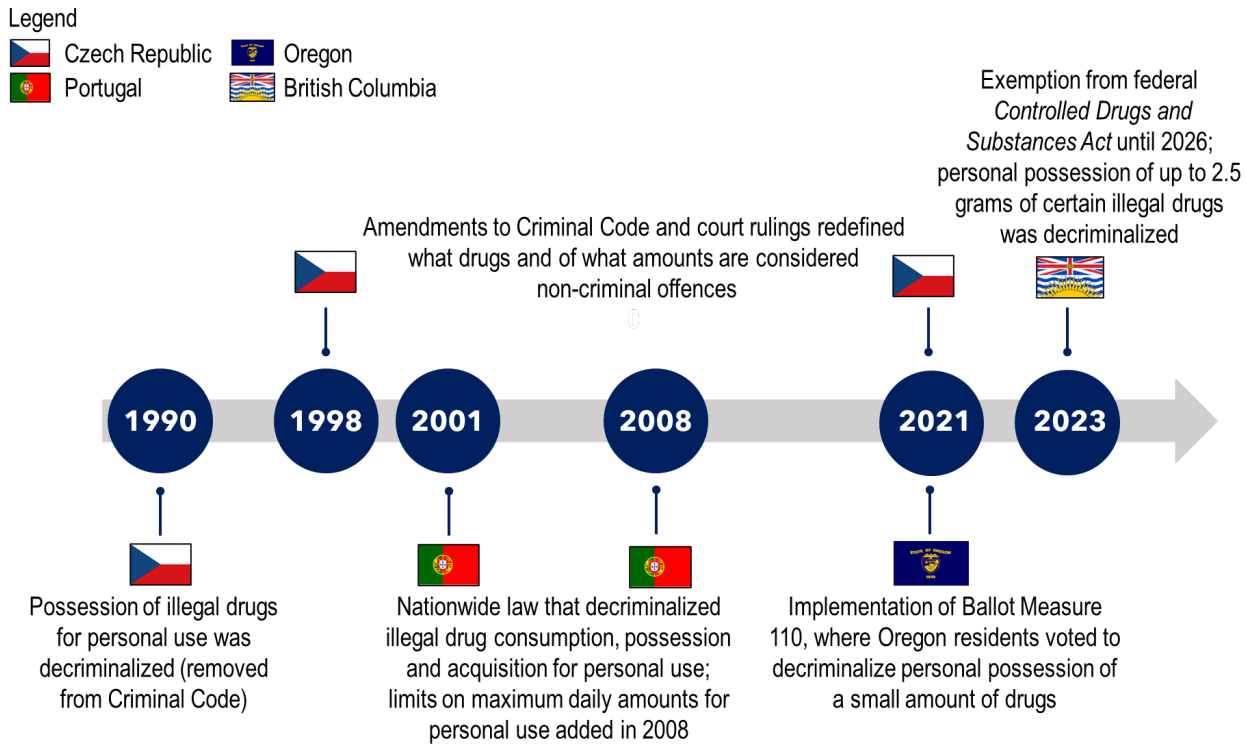
## Limitations

This work has a few limitations. First, for information from Portugal and the Czech Republic we relied mostly on English sources. This limits the reach of our data collection and subsequent analysis. Where possible, we translated non-English documents using DeepL; however, it is possible that discrepancies may have arisen during the translation process. Second, there is an evidence gap within the academic literature in examining decriminalization through a health-systems-and-services lens. We found few pertinent studies that explored how care is organized and delivered in response to decriminalization or comparing health services pre- and post-decriminalization. Furthermore, although we identify some of the outcome measures that jurisdictions collect for monitoring and evaluation, reporting the impacts of decriminalization on health system and/or population health outcomes is out of scope of our review.

# Background: Decriminalization in Selected Jurisdictions

There has been no singular approach to decriminalizing drugs and each of our selected jurisdictions illustrate how different regulatory and legislative models have addressed decriminalization. What follows is a brief overview of decriminalization efforts in each of the selected jurisdictions—the Czech Republic, Portugal, and Oregon. We also briefly describe emerging decriminalization efforts in British Columbia.

**FIGURE 1.** Timeline of legal and regulatory reforms for drug decriminalization in the Czech Republic, Portugal, Oregon, and British Columbia




## Czech Republic

From 1990–1998 the possession of illegal drugs for personal use was removed from the Criminal Code and made an administrative offence (Belackova & Stefunkova, 2018). However, due to political and social pressures for stricter legal regulations on drug use, the Criminal Code was amended in 1999 to criminalize personal drug possession for quantities "greater than small" (Mravčík, 2015); interpretations of these quantities were up to judicial practice and applied in different quantities per drug and per offender (Belackova & Stefunkova, 2018; Mravčík, 2015). From 1999–2001, the *Impact Analysis Project of New Drugs Legislation* (PAD) examined the impacts of the 1999 amendment and recommended that drugs be grouped in criminal law according to the level of risk entailed by ingesting them (Mravčík, 2015). In 2010, a new Criminal Code came into effect, formally defining "greater than small" quantities based on government regulations and introducing a distinction between cannabis and other illicit drugs (European Monitoring Centre for Drugs and Drug Addiction, 2017; Mravčík, 2015). However, in 2013, the Constitutional Court annulled the "greater than small" threshold values, stating that only criminal law (not government regulations) can define criminal offences (Mravčík, 2015).

In 2014, the Supreme Court outlined and re-interpreted the "greater than small" threshold quantities to be an amount several times higher than a normal dose by a typical consumer (Mravčík, 2015). Although most threshold quantities remained unchanged from the previous regulation, the court ultimately lowered the allowed threshold quantities of methamphetamine and cannabis (Mravčík, 2015). The decision was in opposition to evidence put forth by drug policy researchers who advised the court to increase threshold quantities of drugs based on other European countries' threshold values and evidence of the harms of repressive drug laws (Mravčík, 2015). In 2021, the Constitutional Court annulled the "greater than small" threshold values for quantities of plants and mushrooms containing narcotics and psychotropic substances, in terms of cultivation for personal use; it has been left to law enforcement to interpret the threshold values case-by-case (Chomynová et al., 2022).

The Czech Republic's current national strategy on drug addiction reflects its public health orientation. The strategy aims to "scale up prevention and raise awareness of the negative effects of substance use and the development of addictive behaviour, ensure a network of high-quality and accessible addiction services, provide for effective regulation of markets in addictive substances and products with addictive potential, and to improve the effectiveness of management, coordination, and funding" (Rous et al., 2021). Furthermore, a 2022 policy statement by the Czech government stated that it will apply a balanced approach to risk prevention and harm reduction, "while ensuring sufficient funding for both prevention program[s] and services and the regulation of addictive substances corresponding to their degree of harmfulness" (Government of the Czech Republic, 2022). Beyond its national strategy, the most recent Priorities for the Czech Presidency of the Council of the EU (CZ PRES) outlines more human rights- and evidence-based approaches (specific to public health) to drug policy centering around discussions on decriminalization and to try to "eliminate the adverse consequences of the 'war on drugs'" (Horáčková et al., 2022).

## Portugal

In November 2000, the Portuguese Parliament passed legislation that decriminalized illicit drug consumption, acquisition, and possession, and on July 1, 2001 the law came into force nationwide (Domosławski, 2011). The law applies to all substances typically considered illicit, including heroin, cocaine, and others. Under this law, drug consumption, acquisition, and possession for personal use are considered administrative offences rather than criminal offences (Domosławski, 2011). To obtain most substances, however, people must still rely on illicit markets. Criminal penalties are still applied to people who produce, deal, or traffic substances (Domosławski, 2011). The decriminalization law outlines a dichotomy between "dependent drug users" and "nondependent drug users"; some sources suggest that this distinction materialized due to the political debates occurring at the time that outlined concerns for the "psychosocial vulnerability of high-risk users," especially related to stigma and social exclusion (Rêgo et al., 2021). The law also created Commissions for Dissuasion of Drug Addiction (CDTs), where people who are found with drugs are required to surrender them and attend a dissuasion commission (Domosławski, 2011). The primary goals of the CDTs are to dissuade drug use and encourage "dependent drug users" to access treatment and social services (Hughes & Stevens, 2010); the CDTs can also impose sanctions and fines, and stop proceedings if they deem a person's drug use as "nondependent." In 2008, the Supreme Court of Justice added threshold values for maximum quantities of drugs, essentially recriminalizing drug use for quantities exceeding 10 daily doses for an individual (Rêgo et al., 2021). The decision outlines that the acquisition and possession of drugs found over the maximum limit is deemed a criminal activity and can be punishable by imprisonment and fines.

The approach to decriminalization in Portugal is based in promoting public health. Complementary reforms there have focused on the expansion of programs providing treatment, prevention, and social services for people who use drugs. The 2013–2020 *National Plan for Reducing Addictive Behaviours and Dependencies* describes a person-centered and life-course approach that includes health promotion, prevention, dissuasion, risk and harm reduction, as well as treatment and social reintegration (SICAD, 2014). The plan explains how interventions to address these will be developed in accordance with the presiding legal framework on drugs. In doing so, the plan aims to promote health and access to care and services as a way to increase health and social welfare outcomes.

## Oregon, United States

In November 2020, residents of the state of Oregon voted to pass Measure 110, a ballot measure that decriminalized personal possession of drugs, including methamphetamine, LSD, heroin, cocaine, and others (Beaumont, 2022). Officially implemented in February 2021, Measure 110 (also known as the *Drug Addiction Treatment and Recovery Act)* reclassified personal possession of a small amount of controlled substances from a criminal misdemeanor to a civil violation, resulting in a maximum fine of $100 (Baumle, 2022). Part of the two-pronged approach outlined by Measure 110 is the creation of a telephone hotline, in which fines for drug possession can be waived by calling the hotline to complete a health assessment over the phone and be linked to resources to access treatment and harm reduction services (Beaumont, 2022). The second approach established by Measure 110 is the distribution of funds and grants for the creation and maintenance of substance use treatment programs, including the establishment of a Behavioral Health Resource Network (BHRN) that will supply every county in the state with a health network to increase coordination of care (Oregon Health Authority, 2022b). However, preliminary evaluations of Measure 110 reported low uptake rates for the hotline, significant delays in funding reaching grantees, and a lack of government leadership over funding distribution and policy implementation (Good et al., 2023; Clemans-Cope, 2023). In early 2023, House Bill 2513 was introduced to improve the shortfalls of Measure 110, including streamlining funding processes to bolster Oregon's substance use treatment infrastructure and clarifying the roles of the oversight council in charge of funding distribution (Thomas, 2023); as of April 2023, the bill is in the state senate awaiting passage (Relating to Drugs, 2023).

The move to decriminalize drugs in Oregon is based on framing substance use disorder as a health condition and ensuring that health services for those who need and want access to services are available (Harrington, 2023). Specifically, Measure 110 aims to "(1) reduc[e] drug penalization, saving money in the process, (2) diver[t] said savings, coupled with marijuana sales revenue, to fund drug treatment and addiction programs, and (3) establis[h] a bureaucracy to manage these directives" (Gerstner, 2021). Furthermore, the measure aims to initiate multiple pathways to service access instead of having police as initial points of contact to reduce the harms in racialized communities impacted by drug criminalization – i.e., the "war on drugs" (Good et al., 2023; *RE: Testimony in Support House Bill 2513*, 2023). In particular, Measure 110 is estimated to reduce the overrepresentation of Black and Indigenous populations who are arrested and convicted for drug offences (Baumle, 2022).

## British Columbia, Canada

British Columbia is the first province in Canada to decriminalize personal possession of small amounts of hard drugs such as opioids, cocaine, methamphetamine, and ecstasy (Government of British Columbia,

2023). In May 2022 the federal minister of mental health and addictions, and the associate minister of health granted British Columbia an exemption under the *Controlled Drugs and Substances Act*; the reform came into effect in January 2023 and is valid until January 2026 (Health Canada, 2023). Details of the reform describe how adults who are found to possess less than 2.5 grams of four illicit drugs (opioids, cocaine, methamphetamine, and MDMA) will not be criminally charged and no drugs will be seized (Government of British Columbia, 2023). Alternatively, people will be given information about various health and social supports, including support for referrals to local treatment and recovery services if desired (Government of British Columbia, 2023).

British Columbia's approach to drug decriminalization stems from years of public health advocacy calling for substance use to be addressed as a public health issue rather than a criminal justice issue, deviating from the failed "war on drugs" approach (Hathaway, 2022). The province reports that decriminalization is a key step to address the toxic drug crisis and reduce the stigma that prevents people accessing life-saving services and supports for substance use (Government of British Columbia, 2023; Office of the Provincial Health Officer, 2019).

## Analytic Overview

Given our focus on health systems, we used WHO health system building blocks as an overarching framework to consider any reform/adaptation related to financing, delivery, governance, workforce, and other sectors, while drawing attention to broader social/public policy supports and community engagement strategies that emerged in our cases (see **Figure 1**). Key terms and their definitions are provided in **Table 2.** Below we offer key insights synthesized from our analysis, followed by relevant examples.

**FIGURE 2.** Key domains

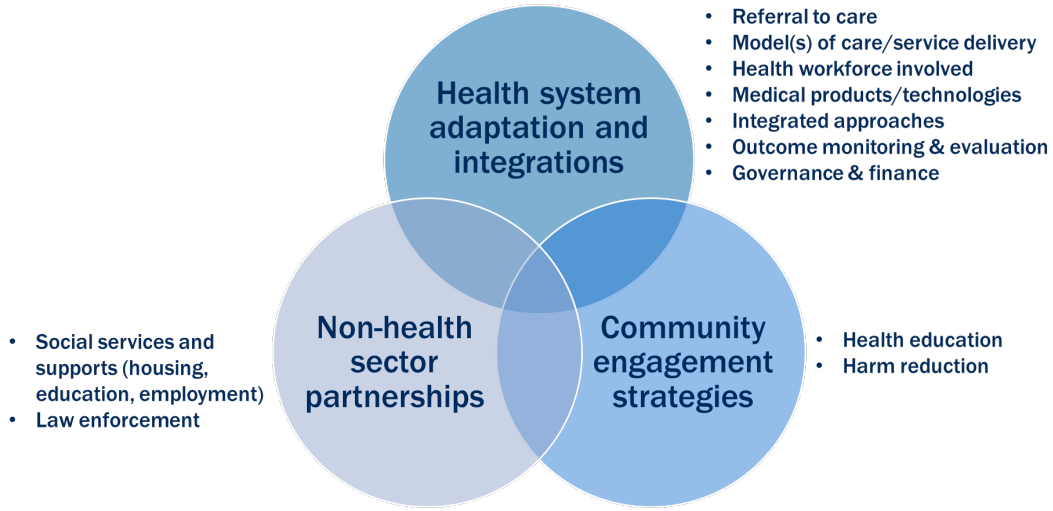



**TABLE 2.** Key terms

| Term | Definition and source |
|---|---|
| **Community engagement** | A process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impacts and outcomes (World Health Organization, 2020). |
| **Harm reduction** | An evidence-based approach consisting of strategies and interventions aimed at reducing the harms associated with drug use, focusing on public health and safety and the reduction of stigma and discrimination associated with drug use (e.g., naloxone distribution, needle exchange sites, supervised consumption sites, drug-checking programs, safe supply of drugs) (Harm Reduction TO, n.d.). |
| **Low-threshold/low-barrier services:** | Models of services that make minimal demands on the person, and reduces/removes barriers for access to care and treatment; services are harm reduction-oriented and should be accessible, accommodating, affordable, welcoming, and supportive (Alberta Health Authority, 2019). |
| **Peer Support Workers/Mentors:** | People with lived/living experience of substance use who are involved in a variety of services to aid in recovery and harm reduction services (BCCDC, n.d.). |

## Health System Adaptation and Integrations

### Model(s) of care/service delivery

In the context of decriminalization, person-centered, low-threshold, and community-based models of care are important when providing health services for PWUD who choose to access care. In the literature, sites of care include street outreach teams (to identify and connect with people who may need care), mobile support, harm reduction services (i.e., needle/syringe exchanges, safe consumption sites, drug checking services, etc.), peer support services, and more traditional models of care through a range of outpatient and inpatient specialized medical centres. These models of care are delivered by multidisciplinary staff, aimed at linking PWUD to harm reduction services, substance use disorder treatment (should they wish to access it), and other health services in addition to social and peer supports.

In the Czech Republic, for example, there are six categories of services: 1) prevention services, 2) harm reduction services, 3) outpatient treatment and counselling services, 4) short-term treatment services, 5) residential treatment services, and 6) aftercare treatment (Horáčková et al., 2022). Harm reduction is provided in low-threshold drop-in centers and outreach programs, and many are run by non-governmental organizations (NGOs) (Csete, 2012; Rous et al., 2021). Networks of outpatient services provide treatment in various settings (e.g., psychiatric settings, non-psychiatric health settings, social services settings, crisis centres, and programs targeting specific groups such as youth), with many providing opioid agonist therapy (Rous et al., 2021). Other outpatient services include crisis centres, aftercare programs (i.e., programs that support clients in recovery and assist in social reintegration), and prison-based counselling and treatment (Rous et al., 2021). Networks of inpatient addiction treatment facilities include centres for detoxification, inpatient psychiatric care, therapeutic communities that provide residential long-term treatment, residential education facilitates for youth, and sheltered housing as part of aftercare programs (Rous et al., 2021).

In Portugal, literature on street outreach teams indicated that communities are important sites of service delivery. Social workers and people with addiction-specialized psychology training visit common public spaces where open drug use occurs to distribute kits with clean syringes and needles, hygiene supplies and condoms; to receive a kit users must give back used syringes (Domosławski, 2011). Outreach teams also provide counselling, mediate with treatment centres, and help people engage with psychological and medical help (Domosławski, 2011). Outreach teams are complemented by other mobile support units where care is delivered from vans (Silvestri, 2015). Nurses and support workers attend to people's health and medical appointments, provide referrals and advice, keep medical records, and provide transport to emergency care if needed. The vans serve as sites for medical check-ups and screening, psychological assessments, testing for HIV, hepatitis, and other sexually transmitted infections (STIs), medication distribution, including methadone, common antibiotics, tuberculosis (TB) treatment, and antiretrovirals, as well as psychiatric and contraceptive medications (Silvestri, 2015).

In Oregon, as part of the formal Measure 110 that enacted decriminalization, plans for the BHRN are underway and undergoing legislative changes to improve inefficiencies in implementation (Oregon Health Authority, n.d.-a; Thomas, 2023). The BHRN aims to initiate networks in each county in the state to increase coordination of care by linking low-barrier substance use treatment and recovery, case

management, harm reduction services, peer support services, and housing services (Oregon Health Authority, 2022a).

In British Columbia, a requirement from the Canadian federal government for the province's decriminalization exemption included the commitment to improve the "readiness and capacity of the health and social systems" (Health Canada, 2022). Specifically, British Columbia aims to strengthen the current substance use system of care by improving access to specialized treatment, harm reduction and safer supply programs. The province plans to work closely with all regional health authorities and the First Nations Health Authority to establish and improve pathways to care.

## Referral to care

Our review found that flexible and low-barrier referral pathways are available for people who choose to access substance use treatment, with links to other health and social services. In the Czech Republic, people can self-refer to care at multiple levels, including at low-threshold harm reduction (drop-in) centres, outpatient centres, prison-based counselling and treatment, crisis centers, and inpatient services (European Monitoring Centre for Drugs and Drug Addiction, 2017; Rous et al., 2021). In some jurisdictions, referral processes may involve the justice system, depending on how decriminalization is operationalized. In Portugal, people can self-refer to care at many levels and CDTs function as supplementary referral platforms for people stopped by police for drug offences (personal correspondence, 2023; Silvestri, 2015). During CDT proceedings, discussions with the referred person occur regarding treatment or other support options. For individuals that the CDTs deem to be "dependent," they can recommend treatment or education programs; for individuals that CDTs deem "non-dependent" they can suspend proceedings and recommend entry to a treatment or education program, psychological services, and other options (Hughes & Stevens, 2010). In this way, CDTs aim to provide an individualized and flexible substance use prevention and treatment approach with referral to different levels and types of services. By contrast, private and government physicians may refer patients directly to treatment or harm reduction services (personal correspondence, 2023).

In Oregon, a referral pathway was created with the establishment of a telephone hotline that can waive callers' drug possession fines issued by police (i.e., Class E violations) if a health assessment is conducted through the hotline or at a local BHRN (Baumle, 2022; Good et al., 2023). A circuit court can dismiss Class E violations after an assessment, and callers can be linked to resources for treatment and recovery programs, harm reduction services, and social supports (Good et al., 2023). However, evaluations of this referral system noted challenges linking callers with treatment and recovery services that could take on new patients as well as inconsistencies across counties with how police administer violations (Baumle, 2022; Beaumont, 2022; Good et al., 2023). Callers undergoing the health assessment also experienced barriers, including the need to provide a mailing address to receive verification that the assessment was completed and the requirement that the caller file their own verification with the court system (Good et al., 2023). Nonetheless, since Measure 110 came into effect in February 2021, 60,000 people have accessed services ranging from substance use treatment to harm reduction and housing supports, with 3,858 people cited (i.e., not arrested) for drug possession over the same time period (Oregon Health Authority, 2023; Hurst, 2023). This indicates that direct referral pathways outside of law enforcement are still widely accessed. Furthermore, recommendations from Oregon's formal audit of its decriminalization measure advised eliminating the requirements to introduce multiple new hotlines in

addition to the existing Drug and Alcohol Prevention Hotline, in order to reduce inefficiencies (Oregon Secretary of State, 2023).

## Health workforce involved

Delivering comprehensive care for PWUD requires a multidisciplinary health workforce to provide services across levels of care. Substance use and addiction counsellors, outreach workers, and peer support specialists are important to support service delivery and referrals to care directly in communities. In Portugal, street outreach teams are comprised of psychologists, sociologists, and social workers (Silvestri, 2015). In the Czech Republic, low-threshold NGO-run sites include counselors, social workers, and nurses among others (Sananim, n.d.).

In Oregon, part of the funding that encapsulates the establishment of the BHRN is dedicated to "increase the recruitment and retention of providers in the behavioural healthcare workforce who are people of color, tribal members, or residents of rural areas in the state, in order to provide culturally responsive care for diverse communities" (Oregon Health Authority, 2022a). Additionally, there has been funding allocated to increase hiring of peer support mentors (encapsulated within the overall distribution of funding and grants associated with the decriminalization measure) to connect with people who may need care through street outreach, addiction services, mental health and homeless services, hospitals, and jail settings (Green, 2023).

Decriminalization is also an opportunity for health workforce capacity building towards a holistic understanding of substance use. In Portugal, decriminalization has increased awareness among health workers that a one-size-fits-all approach is inappropriate given that people have different motivations and patterns of drug use. There has been increasing awareness among health workers that a broader range of multi-disciplinary responses is needed to support people with substance use disorder (Hughes & Stevens, 2007a). In addition, substance use, harm reduction, and mental health are embedded in medical education in Portugal (Drug Policy Alliance, 2018).

## Medical products/technology

Access to medications for substance use disorders is important in jurisdictions that have decriminalized drugs. These medications are prescribed by physicians and addiction specialists and are made available to people who choose to enter treatment for substance use disorder. However, ensuring widespread access is key.

In the Czech Republic for example, five types of opioid agonist therapy are available: methadone, three buprenorphine medications, and a sublingual medication that contains buprenorphine and naloxone (*Suboxone*) (European Monitoring Centre for Drugs and Drug Addiction, 2017). Any physician can prescribe buprenorphine to treat opioid use disorder (Csete, 2012); however, the number of physicians that do provide this and other opioid agonist treatment are limited (Rous et al., 2021). As of early 2010, treatment with Suboxone has been covered by health insurance in the country under certain conditions, including when patients strictly adhere to a schedule of doctor visits (Csete, 2012). However, solely buprenorphine-based agents are not covered by health insurance even though they are the leading medication for treatment of opioid use disorder (Mravčík et al., 2018).

Low-threshold facilities are key sites for linking people to medications. In Portugal, opioid agonist treatments, including methadone and buprenorphine, are available at low-threshold sites (Laqueur, 2015). For example during street outreach in Portugal, people who use heroin are informed about the option of exchanging heroin for methadone for free in special centres (Domosławski, 2011). The only authorized distributor of methadone in Portugal is the Service of Intervention on Addictive Behaviours and Dependencies (Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências) known as SICAD, that provides methadone through Centres of Integrated Responses (CRIs) (described in greater detail below) (Pontes & Dores, 2015).

## Integrated approaches

People who seek care for substance use disorder may have other healthcare needs that can be met through integrated health services offered at point-of-care. Specific integrations that were identified include mental health services, HIV, TB, and hepatitis screening and treatment, as well as obstetrical services.

In the Czech Republic, for example, integrated screening, treatment, and management of HIV and substance use disorder is available at low-threshold facilities; many addiction service delivery sites also offer testing for HIV, hepatitis, and syphilis (Csete, 2012; European Monitoring Centre for Drugs and Drug Addiction, 2017; Rous et al., 2021). Treatment for Hepatitis C virus (HCV) is also available to people who inject drugs in public health facilities across the Czech Republic, including in prisons, and is free of charge (European Monitoring Centre for Drugs and Drug Addiction, 2017). Furthermore, recommendations from Oregon's formal audit of its decriminalization Measure listed the need to publish a formal plan on how the intended BHRNs will integrate into the current statewide behavioural health system (Oregon Secretary of State, 2023).

In Portugal, CRIs provide treatment, prevention, harm reduction, and social reintegration in each sub-jurisdiction through a multi-disciplinary team approach. The first centres were initially run by the Ministry of Justice, then transferred to the Ministry of Health, under which the network was completed (Personal correspondence, 2023). A complementary network of private or NGO-run treatment facilities, such as therapeutic communities and detoxification units, coordinate their work with CRIs. Some CRIs can have local arrangements with prisons in terms of visiting and supporting prisoners. CRIs can hire services such as outreach and harm reduction services provided by street teams (Pontes & Dores, 2015).

## Outcome monitoring and evaluation

Health systems research, evidence and evaluation is important to inform evidence-based decision-making on the impact and outcomes of drug policies. The role of research, evidence, and evaluation can be emphasized at the highest levels of decision-making to ensure a comprehensive approach. For example, the Czech Republic's National Drug Policy Strategy underscores the importance of policy research and key stakeholders in generating data and research outcomes, including academic institutions and the National Monitoring Centre for Drugs and Drug Addiction (Secretariat of the Government Council for Drug Policy Coordination, 2019).

Below are examples of outcome measures that the jurisdictions have collected, plan to collect, or have been suggested to collect by researchers who conducted evaluations on substance use treatment and recovery and/or drug decriminalization (Table 3). It is important to note that many of these measures

are not specifically related to drug decriminalization, but rather were reported as outcomes that measured access to general substance use treatment, recovery, and harm reduction services, as well as on the health statuses of PWUD. Moreover, there are many challenges with attributing outcome measures to decriminalization policies and their impacts on populations and health systems. Indicators and measures are shaped by a multitude of context-specific factors that limit our ability to draw causative links. Future research is needed to evaluate the impacts of decriminalization on health systems by assessing outcome measures through robust and long-term monitoring and evaluation.

**TABLE 3.** Select sources for outcome reports and evaluations

| Jurisdiction | Outcome measure |
|---|---|
| Portugal | • Drug consumption prevalence (by age group);<br>• Injecting drug use (case rate/1,000 population);<br>• Drug-related deaths (all adults);<br>• Total number of people in treatment for substance use disorder;<br>• Number of people treated for substance use disorder by care setting;<br>• Proportion of people receiving opioid agonist treatment by medication (methadone vs. buprenorphine) and trends in total numbers;<br>• Number of syringes distributed;<br>• Newly diagnosed HIV/AIDS among people who inject drugs;<br>• HIV prevalence among people who inject drugs; and<br>• Hepatitis C prevalence among people who inject drugs (European Monitoring Centre for Drugs and Drug Addiction, 2019). |
| Czech Republic | • Deaths from fatal drug overdoses (Horáčková et al., 2022);<br>• Newly reported HIV cases due to injection use (Horáčková et al., 2022);<br>• Number of clients that are served by addiction services (Rous et al., 2021);<br>• Prevalence of high-risk drug use (Rous et al., 2021);<br>• Number of syringes distributed (Rous et al., 2021);<br>• Number of people arrested for drug offences (Rous et al., 2021). |
| Oregon (US) | • Number of drug-related arrests (Baumle, 2022);<br>• Number of people accessing services funded by Measure 110 (e.g. harm reduction, housing, and peer support services) (Baumle, 2022);<br>• Uptake rate of telephone hotline access (Beaumont, 2022);<br>• Metrics that were suggested for collection and reporting by (Netherland et al., 2022):<br>  ○ Confounding variables that affect drug use (e.g., rise of fentanyl in drug supply, impact of COVID-19); and<br>  ○ Domains within law enforcement interaction and culture, healthcare, stigma, and cost savings (sub-analyses should capture race/ethnicity, geography, income etc.). |
| British Columbia (CAN) | The province has a formal monitoring and evaluation plan that is required within its federal exemption for decriminalization (Government of British Columbia, 2023). Examples of measures that will be collected include:<br>• Improvements to experiences and outcomes for PWUD (e.g., improved interactions with police);<br>• Health system implementation (e.g., improved linkages for substance use and support for PWUD); and<br>• Public awareness and understanding of substance use and decriminalization. |

## Governance and financing

Decriminalization is a multi-sectoral effort requiring collaboration and partnerships across ministries. Yet the health sector plays an important role in operationalizing and implementing strategic plans related to decriminalization. In Portugal, dedicated government councils oversee decisions on drug policy reforms, funding, and coordination; specifically, the Inter-Ministerial Council for Drug-related Problems, Drug Abuse and the Harmful Use of Alcohol is responsible for drug policy coordination. The council is chaired by the prime minister and comprises the national drug coordinator and ministers of Justice, Health, Education and Science, Labour, Home Affairs, Foreign Affairs, National Defence, Finance, Environment, Solidarity and Social Security, Agriculture, and Economy (Moreira 2011). Each ministry appoints a representative to a technical committee, overseen by the National Coordinator for Drugs, Drug Addiction and Harmful Use of Alcohol, that devises strategic and action plans and supports implementation. The national drug coordinator is also the General Directorate for Intervention on Addictive Behaviours and Dependencies' (SICAD)'s general director, responsible for implementing the national drug strategy and action plans. The Ministry of Health is responsible for CDTs (CDT activities described above) (Rêgo et al., 2021). Police forces, on the other hand, are most often responsible for detecting drug use and referring PWUDs to CDTs (Rêgo et al., 2021).

In the Czech Republic, the Government Council for Drug Policy Coordination (GCDPC) includes all ministries involved in the delivery of the national drug policy and representatives of other stakeholder groups, including NGOs and professional associations (European Monitoring Centre for Drugs and Drug Addiction, 2017). The secretariat of the GCDPC, which is supervised by the prime minister, and the Czech National Monitoring Centre for Drugs and Addiction are jointly responsible for the implementation of the National Drug Policy Strategy and coordination of the activities of the involved ministries (European Monitoring Centre for Drugs and Drug Addiction, 2017). To ensure uniform implementation across the country, 14 regional drug coordinators comprise a network across municipalities (European Monitoring Centre for Drugs and Drug Addiction, 2017). These coordinators manage activities related to substance use and addiction at the regional and local levels, including the implementation of the national drug policy (European Monitoring Centre for Drugs and Drug Addiction, 2017). The regional drug coordinators meet regularly with the national drug coordinator (Csete, 2012).

In Oregon, decriminalization Measure 110 authorized the Oregon Health Authority to establish and manage an Oversight and Accountability Council to distribute and oversee funding for the implementation and maintenance of the BHRN (Gerstner, 2021). Council membership was described as "intentionally diverse," and included members with lived experience with substance use disorder, members from communities that were disproportionally affected by drug criminalization, service or care providers working in recovery, treatment, harm reduction, and mental health, and members from housing, employment and drug policy fields (Good et al., 2023). As mentioned previously, legislation is currently underway to streamline funding and increase transparency and accountability over the council's responsibilities (Thomas, 2023). The proposed legislation includes the creation of a director position for the council and reduces the council's agreement vote from two-thirds to a majority, requires data to be collected regarding the decriminalization measure, and clarifies that existing community mental health organizations are to be coordinated with each county's BHRN (Thomas, 2023).

Decriminalization efforts also require increased funding to strengthen treatment, harm reduction, community-based peer support and other services. Some jurisdictions reported multi-sectoral funding

partnerships. In Oregon for example, a proportion of regulated marijuana tax revenue was re-directed from city budgets to a dedicated funding stream to supplement harm reduction, drug treatment, and recovery services (Gerstner, 2021; VanderHart, 2023). In the Czech Republic, drug treatment and care services are funded by subsidies from multiple ministries and organizations: the Ministry of Health, the Ministry of Labour and Social Affairs, the GCDPC, regional and municipal administrations, and health insurance companies (European Monitoring Centre for Drugs and Drug Addiction, 2017). However, the most recent *National Strategy for the Prevention and Harm Reduction of Addictive Behaviour 2019–2027* aims to change its current funding scheme to be less fragmented and in partnership with local governments (Secretariat of the Government Council for Drug Policy Coordination, 2019).

## Community Engagement Strategies

### Health education

In some jurisdictions partnerships between the health sector, NGOs, and Ministries of Education support upstream prevention activities to educate young people on the risks for developing substance use disorder and chronic dependence on drugs. In the Czech Republic, the Ministry of Education, Youth and Sports provides guidance and coordinates health education and primary prevention activities. NGOs are widely involved in these activities and receive project-based funding to carry out additional activities in schools (European Monitoring Centre for Drugs and Drug Addiction, 2017). Portugal has also emphasized upstream prevention by educating young people on the risks associated with drug use through telephone hotlines and websites (Domosławski, 2011).

Peer support services are offered at many health service delivery sites and are frequently used to provide mentorship and resources for people who are in recovery, seeking treatment, or accessing harm reduction services. In Oregon (as detailed above in the Health Workforce section), peer support workers (or peer mentors) are people in recovery who have been hired to help engage with PWUD and provide mentorship and resources for those seeking treatment, in recovery, or accessing harm reduction services (Green, 2023). The increased hiring of peer support workers is emphasized throughout the implementation of the BHRNs. In terms of governance, two members of the Oversight and Accountability Council (that oversees funding for grantees) are recognized as peer support workers (Good et al., 2023).

### Harm reduction

Strengthening harm reduction services in the context of decriminalization leverages ongoing activities, including syringe and needle distribution and exchange, safer smoking kits, drug checking services, supervised consumption facilities, and naloxone distribution. In the Czech Republic, given the prevalence of *Pervitin* (methamphetamine) use, low-threshold facilities provide empty gelatin capsules that can be filled with *Pervitin* and ingested orally as a less harmful alternative to injection (Rous et al., 2021). Low-threshold facilities also use social media and online discussion fora as part of their outreach efforts, which have become known as “virtual outreach” among practitioners (Rous et al., 2021). Furthermore, there have been a few harm reduction programs that operate out of recreational/nightlife settings (Rous et al., 2021).

In Portugal, harm reduction is a component of the National Drug Policy Strategy, with services mainly comprised of needle and syringe exchange programs across the country; an estimated 2,137 programs

were in operation in 2020 (Slade, 2021). Additionally, the first drug consumption room (DCR) opened in Lisbon in 2019, part of a city-wide initiative in partnership with harm reduction NGOs (Taylor et al., 2019). However, there have been critiques on how long it took to establish the first DCR, as well as the lack of investments by the federal government to establish other effective harm reduction initiatives such as drug checking services, overdose prevention centres, prison-based needle and syringe exchange programs, and outpatient naloxone prescriptions (Taylor et al., 2019; Rêgo et al., 2021).

Harm reduction services in Oregon are a vital component of the decriminalization Measure that aims to establish networks in each county to link low-barrier substance use treatment and recovery, case management, harm reduction services, peer support services, and housing services (i.e., the BHRNs). Although some critics have argued that the Measure overemphasizes investments in harm reduction services at the expense of treatment services, advocates of the Measure have pointed out that harm reduction services are usually not covered by health insurance in the US, unlike many treatment services that are covered by health insurance regulations and law (Clemans-Cope, 2023).

## Non-Health Sector Partnerships

### Social services and supports

Social determinants of health continue to be important in the context of drug decriminalization and jurisdictions have made ongoing efforts to strengthen partnerships and linkages between health and social service actors. In Portugal, Social Reintegration Teams coordinate with treatment centres and work with patients to draft action plans, set goals, and build skills regarding returning to education, work, or both (Silvestri, 2015). Additionally, Reintegrative Housing are intermediate stages between therapeutic communities and complete autonomous living. In the Czech Republic, there have been increasing numbers of aftercare outpatient services that offer sheltered housing and assistance in social reintegration (i.e., 23 out of 35 centres provide housing) (Rous et al., 2021). In Oregon, a telephone hotline created by the decriminalization Measure was established to link callers to housing assistance and services (Baumle, 2022). Furthermore, as of April 2023 a bill to provide $1,000 USD a month over two years to unhoused or low-income individuals is awaiting decision-making in the state senate (Hayden, 2023; Relating to Income Supports for Low-Income Individuals, 2023). Unlike other basic income pilot programs, the bill would not restrict people with substance use disorder from qualifying (Hayden, 2023). Additionally, though just recently implemented, some of the requirements from the Canadian federal government for British Columbia's decriminalization exemption include engagement and continued consultations with non-health sectoral partners and stakeholders such as Indigenous governments and communities, law enforcement, PWUD, racialized and diverse communities, and youth (Health Canada, 2022).

### Role of law enforcement

In Portugal, law enforcement refers people found using, buying, or in possession of drugs to CDTs (in which they are required to present themselves within 72 hours) and seizes personal possessions of drugs (Silvestri, 2015). If a person is stopped with an amount over the maximum limit of 10 daily doses for personal use, the case is usually diverted to the criminal justice system. Cases referred to the justice system can be re-referred to the CDT if the public prosecutor assesses that the amount seized was for personal use only (Silvestri, 2015). In Oregon, police administer fines for personal possession of small

amount of drugs in lieu of criminal charges; fines can be waived if individuals call the hotline and undergo health assessments over the phone (Quinton, 2021). In British Columbia, law enforcement will not seize drugs if an adult is found with quantities of drugs for personal use within the established limit of 2.5 grams (Health Canada, 2023). Rather, law enforcement will provide information and voluntary referral to local health and social services. Guidelines and training for police officers have been developed related to decriminalization, with a health-focused approach to substance use awaiting to be launched (Government of British Columbia, 2023). In the Czech Republic, formal reference pathways from law enforcement to substance use counseling or treatment (as an alternative to punishment or in parallel to it) does not exist on the level of policing or public prosecutors (personal correspondence, 2023).

# Conclusions

Using an adapted WHO health systems building blocks framework, this rapid review aimed to uncover the types of health system adaptations, reforms, and policies that certain jurisdictions have implemented to prepare their health systems to support drug decriminalization. We included Portugal, the Czech Republic, and Oregon in our review as well as emerging decriminalization efforts in British Columbia. In reviewing these adaptations and reforms we highlight several challenges and enablers and offer key considerations for Canadian jurisdictions. **Table 4** provides an overview of key challenges and enablers to health system adaptation and integration in support of drug decriminalization.

**TABLE 4.** Challenges and enablers for health systems adaptations and integrations to support drug decriminalization

| **Challenges** |
| --- |
| • Infrastructure and coordination of addiction and substance use treatment, recovery, and harm reduction services<br>• Stagnation and/or decrease of funding for certain treatment, recovery, and harm reduction services<br>• Ethical issues around coercive treatment, autonomy, and voluntariness in accessing services |
| **Enablers** |
| • Training and education for doctors, psychologists, nurses, and first responders on substance use disorder and treatment<br>• Ensuring sufficient capacity and building upon models of care already in place to support PWUD<br>• Investing in health and health system research and evaluation to create evidence-informed drug policies |

## Challenges

Challenges found in the literature regarding health system adaptations and integrations to support drug decriminalization mostly centered around jurisdictions' infrastructure and coordination of addiction and substance use treatment, recovery, and harm reduction services. For example, before decriminalization was implemented in Oregon, the state reported significant service gaps for drug recovery and treatment services. Specifically, an inventory and gap analysis conducted by the Oregon Health & Science University in collaboration with the Oregon Health Authority reported that between 2021–2022, there was a 49% gap in services needed for substance use disorder and a 51% gap in healthcare providers who are authorized to prescribe buprenorphine, an opioid agonist therapy drug (Lenahan et al., 2022). While one of the approaches to decriminalization in Oregon was the creation of a hotline that linked callers to services, hotline operators reported difficulty connecting callers to available detox and residential treatment beds that had space for new patients (Beaumont, 2022). In the Czech Republic, there are also reported gaps across the country in the distribution of specialized addiction services, as well as the availability, accessibility, and affordability of services for people with substance use disorders (Rous et al., 2021).

The stagnation and/or decrease of funding for certain treatment, recovery, and harm reduction services also make it difficult to support people who choose to access these services. In Oregon, there were significant delays by the Oversight and Accountability Council to send funding to awaiting recovery and treatment services during the Council's first year of implementation, with many service providers still

awaiting funding (Selsky, 2022a). Stakeholders in Portugal also reported inconsistent funding for harm reduction interventions, particularly in the forms of bureaucratic delays and lack of investments in street outreach teams and other community programs (Rego, 2017). Furthermore, challenges beyond the health system were found to impact health system adaptations and integrations, such as an increasingly toxic drug supply, and staff and resource shortages. The impacts of the COVID-19 pandemic in Oregon, for example, was reported to have reduced the number of treatment services due to social distancing protocols and exacerbated staffing and resource shortages (Lininger, 2022).

Finally, some sources described how certain jurisdictions that have decriminalized drugs still have coercive aspects for referrals to treatment and recovery services, which oppose health-and-human rights tenets of consent and self-determination (Rêgo et al., 2021; Canadian Drug Policy Coalition, 2022; Clemans-Cope, 2023). Specifically, the Canadian Drug Policy Coalition defines human rights-based approaches to decriminalizing simple drug possession as being completely voluntary, including "participation in a health assessment, addiction treatment services, psychosocial and mental health services, and harm reduction or support services" (Canadian Drug Policy Coalition, 2022). In Portugal for example, some sources described the mandatory appearance before CDTs as coercive (Rêgo et al., 2021; Clemans-Cope, 2023). Furthermore, the law that established CDTs identified abstinence as a goal to dissuade drug use (Rêgo et al., 2021), which can be interpreted as divergent from harm reduction values since harm reduction does not require "people who use substances from abstaining" (Canadian Mental Health Association, n.d.). Although coercive aspects of the CDTs and sanctions they can employ were described as minimal by some sources (Clemans-Cope, 2023; Domosławski, 2011), the right to access or decline treatment services should be considered when linking health services in the context of decriminalization.

## Enablers

A key aim of decriminalization is to reduce the stigma around drug use. Decriminalization opens the opportunity for people to more freely seek and access treatment, without fearing the repercussions associated with criminal offences. In Portugal, decriminalization has strengthened societal ideas that PWUDs are not criminals and people who seek treatment are doing so for a medical issue (Hughes & Stevens, 2007b). Among health workers, training and education for doctors, psychologists, and nurses on substance use disorder and treatment has led to a more well-informed workforce ready to provide care for people with substance use disorders (Drug Policy Alliance, 2018). In this way, reform has been seen to contribute to greater tolerance and social integration (Hughes & Stevens, 2010). Furthermore in some jurisdictions, decriminalization dramatically reduced drug-related arrests, with Oregon reporting a 60% decrease in arrests related to drug offences during the first year of decriminalization implementation (Baumle, 2022). As Black, Indigenous, and other racialized communities in the US and Canada have historically disproportionately experienced and continue to experience the harms of drug criminalization from the "war on drugs" approach, decriminalization is one strategy that aims to reduce and address some of these harms.

Decriminalization can also provide opportunities for jurisdictions to increase capacity, evaluate, and improve upon the models of care already in place to support PWUD, for example harm reduction, treatment, and recovery services, among others. In Oregon for example, although there have been considerable critiques on lack of capacity and care coordination for PWUD to enter treatment and recovery services, statistics from the first year of decriminalization did report services access through

the Measure's funding: 60% accessed harm reduction services, 15% accessed housing services, and 12% accessed peer support services (Selsky, 2022b). Furthermore, budgetary reports from the Oregon Health Authority stated that in 2021, 70 organizations across the state were awarded grants to increase access for housing, harm reduction services, low-barrier treatment, and peer support services; long-term goals include the planned BHRNs in each county and tribal area (Oregon Health Authority, 2022a).

Investment in health and health system research and evaluation can also help to create evidence-informed drug policies. In the Czech Republic, there has been ongoing government investment in and prioritization of monitoring and evaluation (e.g., the National Monitoring Centre for Drugs and Addictions; the Centre/Department of Addictology). The aims of these research efforts are to generate evidence on the impact of drug policies to inform drug policy debates and decisions (Csete, 2012). Furthermore, recommendations from Oregon's formal audit of its decriminalization Measure listed the need to improve data collection and develop metrics to assess its impact and effectiveness (Oregon Secretary of State, 2023); legislation currently in the state senate intended to improve aspects of the Measure explicitly requires data to be collected, monitored, and evaluated (Thomas, 2023).

## Considerations for Canadian Jurisdictions

As this review has indicated, several jurisdictions have shifted to formal decriminalization of hard drugs. Years of substantial evidence on the harmful impacts of prohibitory drug policies on the health and social well-being of PWUD (Csete et al., 2016), an increasingly toxic drug supply, and ongoing overdose crises in some jurisdictions has placed decriminalization as a crucial step of a larger public health-oriented approach to drug policy. Drawing on the varied experiences in Portugal, the Czech Republic, and Oregon, Canadian jurisdictions could consider the following emerging lessons when adapting their health and social systems as part of their broader drug policies:

- A public health-oriented approach to decriminalization requires a **multi-sectoral and comprehensive strategy** that aims to strengthen the many programs, policies, and services needed to support PWUD who seek health and social services, and should be non-coercive in its implementation.
- **The ministry of health can take a lead role in implementing and operationalizing these strategies** by adapting or expanding health service delivery, health promotion activities, and health workforce training, as well as liaise with other ministries involved in creating strategies and plans related to decriminalization.
- **Consistent and adequate funding** is required for substance use treatment and recovery services, harm reduction services, peer support services, and social supports to allow various referral pathways of care to be available for people who choose to access them.
- Decriminalization efforts may require **independent governance and oversight**, with representation from all sectors and stakeholders, including affected communities, to ensure a comprehensive approach that considers the health, social, and economic needs of PWUD.
- **Robust monitoring and evaluation approaches** are needed to capture the full range of possible intended and unintended outcomes, considering intermediate, process-related outcomes in the health system (e.g., healthcare utilization), public health and outcome measures, criminal justice metrics, as well as disaggregation of indicators to consider inequities throughout.

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# Appendix A. Case Summaries

**TABLE A1.** Definitions of key concepts used to describe health system adaptations in each case

| Adaptation/Strategy | Definition |
|---|---|
| **Referral to care** | How people are referred to substance use disorder treatment programs and harm reduction services. |
| **Model(s) of care/service delivery** | The ways health services, including preventive activities, screening, diagnoses, treatment, and management, are organized and delivered within a health system. |
| **Health workforce involved** | The people who deliver or assist in the delivery of health services in health facilities or in the community. |
| **Medical products/ technologies used and where they are accessed** | These include medicines, vaccines, medical devices, and other technologies that support screening, diagnosis, treatment and management, and the delivery of health services. |
| **Integrated approaches** | Managerial or operational changes to health systems that bring together inputs, delivery, management, and organization of particular service functions with the aim of improving coverage access, quality, acceptability and/or (cost)-effectiveness. |
| **Outcome monitoring and evaluation** | The metrics and frameworks used to evaluate the outcome of drug decriminalization. |
| **Finance and governance** | The ways financial resources are pooled and mobilized to deliver health services, as well as purchasing mechanisms for health services; and the framework of actors, policies and guidelines that inform health decision-making and service implementation. |

## Portugal

**TABLE A2.** Summary of adaptations, integrations, and strategies to support decriminalization in Portugal

| Adaptations/ Strategies | Details |
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| **Health System Adaptations and integrations** | |
| **Referral to care** | • CDTs, made up of lawyers, social workers and medical professionals, function as referral platforms (Silvestri, 2015).<br>• CDTs discuss options with the referred person. For people they deem to be dependent, they can recommend treatment or education programs; for people they deem non-dependent they can suspend proceedings, recommend entry to a treatment or education program, psychological services, among others (Hughes & Stevens, 2010).<br>• CDTs encourage an individualized and flexible harm-reduction approach and aim to avoid causing stigma (Domosławski, 2011). |
| **Model(s) of care/service delivery** | • **Street outreach teams**: Social workers and people with psychology training visit places where substance users gather. They distribute kits that include clean syringes and needs, hygiene supplies, and condoms. To receive a kit users must give back used syringes. Outreach teams also provide counselling, mediate with treatment centres, and help people engage with psychological and medical help (Domosławski, 2011).<br>• People who are dependent on substances/have substance use disorder can be treated in **specialized medical centres**. For example, TAIPAS in Lisbon provides comprehensive care including psychiatric, psychological, and methadone treatment, along with physiotherapy and skill building activities (Domosławski, 2011).<br>• **Mobile support units** that rely on vans to reach underserved people. Vans are staffed by nurses and support workers who check on people, keep track of their health appointments, provide referrals and advice, keep records, and manage emergency decisions. Main interventions delivered from the vans are medical check-ups and screening, psychological assessments, testing for HIV, hepatitis, and sexually transmitted infections (STIs), medication distribution, methadone, as well as medication for common infections, TB, antiretrovirals, as well as psychiatric and contraceptive medications (Silvestri, 2015). |
| **Health workforce involved** | • Broadly, decriminalization has increased the understanding among health professionals that PWUD have various motivations for and patterns of drug use. There has been increasing awareness that a one-size-fits-all approach is not appropriate, and a broader range of multi-disciplinary responses is needed to support people with substance use disorder (Hughes & Stevens, 2007a).<br>• Only law enforcements and the court system can refer people to CDTs; private and government physicians may refer patients directly to treatment or harm reduction services (Personal correspondence, 2023).<br>• Health workforce involved in specific activities:<br>  ○ Street outreach workers – psychologists, sociologists, and social workers<br>  ○ Mobile units – nurses and support workers |

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| | ○ TAIPAS (Lisbon) – psychiatrists, psychologists, and social workers<br>○ CDTs – social workers and medical professionals |
| **Medical products/ technologies used and where they are accessed** | • Opioid agonist therapy, namely methadone and buprenorphine, are available (Laqueur, 2015); for example, during street outreach people who use heroin are informed about the option of exchanging heroin for methadone for free in special centres (Domosławski, 2011).<br>• Naloxone prescriptions are not available for outpatient use, it is only available in hospitals and through emergency medical services (Rêgo et al., 2021).<br>• Needle and syringe exchange has been a focus of harm reduction interventions.<br>• Safer smoking kits also distributed, but limited (Harm Reduction International, 2022). |
| **Integrated approaches** | • There are linkages with maternity wards and obstetric services for pregnant people who use substances (Silvestri 2015).<br>• Integrated screening, treatment and management of HIV and substance use disorder is available, as well as for TB and hepatitis.<br>• Comprehensive mobile support units (as described above).<br>• Drug consumption rooms (DCRs) |
| **Outcome monitoring and evaluation** | • "Central register of drug users" monitors the main reasons people use substances, which substances are currently in use, in what proportion and in what regions. This information provides a snapshot of the drug market and users and allows for prevention methods to be adapted so service delivery is contextualized and relevant (Domosławski, 2011).<br>• Outcomes are monitored in relation to morbidity and mortality, HIV and TB rates, youth substance use, treatment centre use, crime rates, etc. |
| **Finance and governance** | • Funding has increased for programs aimed at treatment and prevention of substance user disorder and the provision of more targeted responses (Greenwald, 2009).<br>• The health sector budget for substance use in 2010 was 75 million Euros, but other sectors provide additional resources including the ministry of internal affairs (policing), as well as the ministries of justice and education (Domosławski, 2011).<br>• The Inter-ministerial Council is the coordinating body responsible for drug policy coordination. The council is chaired by the prime minister and comprises the National Drug Coordinator and 10 other ministers from relevant agencies. The Institute on Drugs and Drug Addition is located under the Ministry of Health and is charged with implementation the national strategy and action plan. The National Council for the Fight Against Drugs, Drug Addiction and the Harmful Use of Alcohol is an advisory body chaired by the Ministry of Health, composed of representatives of the regional governments and other advisors. It is tasked with advising the government on national strategies and action plans and follows reports of their implementation (Moreira 2011).<br>• The CDTs are the responsibility of the Ministry of Health and are responsible for psychological assessment, for providing technical support in determining suspensive measures or sanctioning measures, for referral to health structures and follow-up in the provisional suspension of the procedure, for the determination and execution of those measures, as well as for the |

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| | application of other alternatives. Police forces remain the primary source of detection of drug use and subsequent referral (Rêgo et al., 2021).<br>• Funding for subsidized programs recommended by CDT panels from Ministry of Health; funding also generated from the national lottery.<br>• Service of Prevention and Treatment of Drug Addiction (Serviço de Prevenção e Tratamento da Toxicodependência, SICAD): supports government in the elaboration of the national strategy for reducing the use of psychoactive substances, prevention of addictive behaviours, reduction of dependencies, and their evaluation (SICAD, n.d.); this body is the only authorized distributor or methadone in the nation (Pontes & Dores, 2015).<br>• Centres of Integrated Responses (CRIs): "provide public responses in terms of treatment, prevention, harm reduction, and reintegration through a multi-disciplinary teams approach; initially run by the Ministry of Justice, then transferred to the Ministry of Health. Today, CRIs hold and distribute methadone nationally, including to prisons. Some CRIs can have local arrangements with prisons in terms of visiting and supporting prisoners. CRIs hire services, like outreach and harm reduction proximity work by Street Teams" (Pontes & Dores, 2015). |
| **Community engagement strategies** | |
| **Health education** | • Peer and mobile support and counselling for people with substance use disorder.<br>• Portugal has emphasized upstream prevention by educating young people on the risks associated with drug use. Special telephone lines for young people and their parents for information and advice, and a website were also established by the IDT (Domosławski, 2011). |
| **Prevention/ Harm reduction** | • Needle and syringe exchange<br>• Safer smoking kits<br>• Drug checking service<br>• Supervised consumption facilities |
| **Referral and treatment** | • Outreach worker referral to treatment (substitution, psychological, psychiatric, etc.) |
| **Non-health sector partnerships and processes** | |
| **Role of the police or administrative bodies** | • When a person is found using, buying, or in possession of an illicit substance over the maximum daily limit, the substance is seized. The police ask to see identification and produce a report which states the date on which the person is required to present themselves to the local CDT (within 72 hours of the police encounter). Referrals to CDTs are set in proximity to where the person lives. The police notify the CDT, but the individual has to contact the CDT to reschedule if they cannot make the date. If a person is stopped with an amount over the maximum daily limit, the case is usually diverted from the CDTs to the criminal justice system for prosecution and a court hearing. However, the public prosecutor can dismiss a case and refer them to a CDT if they assess the amount to be only for personal use (Silvestri, 2015). |

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| | • The police have also been reported to support some prevention efforts, such as the "safe school" program (escola segura). The program involves discrete police patrolling of school surroundings, mainly in high-risk areas, to "scare off dealers" (Domosławski, 2011). |
| **Social supports (housing, education, employment)** | • Social reintegration teams cooperate with treatment centres and work with patients to draft action plans, set goals, and build skills regarding returning to education, work, or both (Domosławski, 2011).<br>• Day centres where users can develop social and work-related skills; "reintegrative housing" (an intermediate stage between therapeutic communities and complete autonomy); vocational courses and (re)employment programs.<br>• The Vida Emprego (Life Employment) program offers employers subsidies if they take on stabilised or ex-substance users. Every person involved in the program has a dedicated mentor and personalised work plan. In one version of the scheme the employer receives tax deductions during six months of apprenticeship, and the employee is paid the minimum wage by the state.<br>• Housing – In the Housing First (Casas preimeiro) two-year pilot program, people could still access shelters even if they use drugs outside (Braham, 2018). |
| **Challenges, enablers and suggestions for further adaptations** | |
| **Challenges** | • Advocates have reported "frustration about stagnation and inaction" since decriminalization came into effect, particularly in relation to overdose prevention centres, naloxone provision, and needle and syringe programs in prison. In 2007, a needle and syringe (NSP) pilot-project ran in two Portuguese prisons for six months but was not used by any prisoners (Rêgo et al., 2021), leading to the pilot's termination (Sander et al., 2016); It was subsequently revealed that prisoners' feared discrimination if they participated in the NSP.<br>• Lack of funding for safer smoking kits (Harm Reduction International, 2022).<br>• The policy has an inequitable impact upon the young and those with low socioeconomic status. People more often referred to CDTs by police are those who are not able to use drugs in the home, such as young people, or those whom police often target, usually people with low socioeconomic status from disadvantaged neighborhoods (Domosławski, 2011).<br>• Long wait times often keep users from getting into free residential treatment care (Bramham, 2018) |
| **Enablers** | • By sending the message that drug users are not criminals, decriminalization intended to change social perceptions of drug use and drug users – reform is seen to have contributed towards more tolerance and integration of drug users (Hughes & Stevens, 2007a).<br>• Health workers, including doctors, psychologists, and nurses in Portugal receive education and drugs and addiction as part of their formal medical training (Drug Policy Alliance, 2018).<br>• Decriminalization is only part of the reform model; takes a multi-disciplinary public health approach that involves numerous ministries. |

## Czech Republic

**Table A3**. Summary of adaptations, integrations and strategies to support drug decriminalization in Czech Republic

| Adaptations/ Strategies | Details |
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| **Health System Adaptations and integrations** | |
| **Referral to care** | • People can access care at low-threshold harm reduction (drop-in) centres, outpatient centres, prison-based counselling and treatment, crisis centers, and inpatient services (European Monitoring Centre for Drugs and Drug Addiction, 2017; Rous et al., 2021). |
| **Model(s) of care/service delivery** | • Addiction services are provided within the framework of social services and the health services network. Inter-disciplinarity is regarded as key for services, but is limited by the incompatibility of the different sectoral frameworks within a single program (Horáčková et al., 2022).<br>• *The Concept for the Development of Addictology Services* (2021) sets out the framework and content of the field of addictology and addictology services, and defines the six basic types of services, including 1) prevention services, 2) harm reduction services, 3) outpatient treatment and counselling services, 4) short-term treatment services, 5) residential treatment services, and 6) aftercare treatment (Secretariat of the Government Council for Drug Policy Coordination and Society for Addictive Diseases of the Czech Society for Addictive Diseases, 2021; Horáčková et al., 2022).<br>• Prevention, harm reduction, treatment, and social rehabilitation comprise the aspects of substance use models of care/service delivery (Rous et al., 2021).<br>• Network of outpatient addiction services include: treatment (psychiatric, non-psychiatric healthcare, social services providing services, outpatient programs targeting children and youth), opioid agonist therapy providers, prison-based counselling and treatment, crisis centers (programs that provide crisis intervention), and aftercare programs (supporting clients in recovery and assisting them in social reintegration) (Rous et al., 2021).<br>• Network of in-patient addiction treatment facilities include: detoxification, inpatient psychiatric care, therapeutic communities (residential long-term treatment; approx.15 communities across the country), residential education facilitates for youth, and sheltered housing as part of aftercare programs (Rous et al., 2021).<br>• Harm Reduction: Low-threshold drop-in centers and outreach programs (Rous et al., 2021).<br>• NGO drop-in centers (“contact centers”) offer needle exchange, clean needles and syringes and other drug use paraphernalia, voluntary counselling, HIV and other infectious disease testing, risk-reduction information, crisis management, and other health and social services. NGOs also maintain vending machines for syringes and special street bins for safe disposal of used injecting equipment (Csete, 2012; European Monitoring Centre for Drugs and Drug Addiction, 2017). |

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| | • As of 2009, 9 out of 36 prisons and remand centres offered methadone therapy to those in custody. Within these facilities, NGOs provide counseling and therapy for substance use disorder as well as linking persons awaiting release to community-based care (Csete, 2012). |
| **Health workforce involved** | • Primary care physicians, psychiatrists, specialized addiction physicians.<br>• Staff at all outpatient and harm reduction services.<br>• NGO staff include counselors, social workers, nurses, etc. |
| **Medical products/ technologies used and where they are accessed** | • Any physician can prescribe **buprenorphine** to treat opioid use disorder (Csete, 2012). However, the number of physicians that do provide this and other opioid agonist treatment are limited (Rous et al., 2021).<br>• As of early 2010, treatment with **Suboxone** (buprenorphine plus naloxone) is covered by health insurance in the country under certain conditions, including when patients strictly adhere to the schedule of doctor visits (Csete, 2012). However, solely buprenorphine-based agents are not covered by health insurance even though they are the leading medication for treatment (Mravčík et al., 2018).<br>• Five types of opioid agonist therapy are available: methadone, three buprenorphine medications, and a composite sublingual preparation that contains buprenorphine and naloxone (European Monitoring Centre for Drugs and Drug Addiction, 2017).<br>• Low-threshold facilities provide **empty gelatin capsules** for *Pervitin* (methamphetamine), that can be filled with the drug and ingested orally as a less harmful alternative to injection (Csete, 2012).<br>• **Needle and syringe exchange, aluminum foil for smoking heroin,** have also been a focus of harm reduction interventions (Rous et al., 2021). |
| **Integrated approaches** | • Integrated screening, treatment and management of HIV, and substance use disorder is available at low-threshold facilities (Csete, 2012; European Monitoring Centre for Drugs and Drug Addiction, 2017).<br>• Treatment for Hepatitis C Virus (HCV) is available to people who inject drugs in public health facilities across the Czech Republic and in prisons and is free of charge (European Monitoring Centre for Drugs and Drug Addiction, 2017).<br>• "In 2019 testing for HIV was offered by 79 programmes, 61 programmes provided testing for HBV, 84 for HCV, and 82 for syphilis" (however refers to all addiction services, including alcohol and tobacco) (Rous et al., 2021). |
| **Outcome monitoring and evaluation** | • *The National Strategy Prevention and Harm Reduction of Addictive Behaviour 2019–2027* emphasizes the **role of monitoring, information, research, and evaluation** as core strategies to improve addiction policy field in the Czech Republic (Secretariat of the Government Council for Drug Policy Coordination, 2019). The *Action Plan 2013–15* emphasizes the principle of integrating licit and illicit substances into one policy, and support for drug research is explicitly mentioned (Csete, 2012). The Centre for Addictology contributes research evidence relevant to policymaking.<br>• Drug policy decision-making processes are supported by the drug information system, which is coordinated by the National Monitoring Centre for Drugs and Addictions (Csete, 2012). The National Monitoring Centre for Drugs and Addictions publishes an annual report that summarizes available data about drug use and impacts (European Monitoring Centre for Drugs and Drug Addiction, 2017). |

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| | • Drug law offence (DLO) data are the foundation for monitoring drug-related crime and are also a measure of law enforcement activity and drug market dynamics; they may be used to inform policies on the implementation of drug laws and to improve strategies (European Monitoring Centre for Drugs and Drug Addiction, 2017).<br>• The 2020-2022 National Action Plan for Information System in Addictions builds upon previous national strategies for monitoring and evaluation and led by the National Monitoring Centre for Drugs and Addictions (National Monitoring Centre for Drugs and Addictions, 2020).<br>• Outcomes are monitored in relation to:<br>  ○ Deaths from fatal drug overdoses (Horáčková et al., 2022)<br>  ○ Newly reported HIV cases due to injection use (Horáčková et al., 2022)<br>  ○ Number of clients that are served by addiction services (Rous et al., 2021)<br>  ○ Prevalence of high-risk drug use (Rous et al., 2021)<br>  ○ Number of syringes distributed (Rous et al., 2021)<br>  ○ Number of people arrested from drug offences (Rous et al., 2021) |
| **Finance and governance** | • In 2020, expenditures for addiction policy were comprised of: law enforcement (52%), harm reduction (16%), treatment (12%), prevention (4%), coordination, research, evaluation (1%) (Horáčková et al., 2022).<br>• The most recent *National Strategy for the Prevention and Harm Reduction of Addictive Behaviour 2019–2027* lists changes to the current funding structure for addiction services as a priority, specifically by "[…] changing the system of funding programs and services to responsibly plan and cultivate a defined network of services in partnership with local governments; (d) to avoid fragmentation of multi-source funding and thus enable a more efficient and coordinated approach to the implementation of integrated drug policy in cooperation with local governments" (Secretariat of the Government Council for Drug Policy Coordination, 2019).<br>• Drug treatment and care services are funded by subsidies from multiple ministries and organizations: the Ministry of Health, the Ministry of Labour and Social Affairs, the Government Council for Drug Policy Coordination (GCDPC), regional and municipal administrations and health insurance companies. An independent agency is responsible for the accreditation of drug treatment programs at clinics and inpatient facilities (European Monitoring Centre for Drugs and Drug Addiction, 2017).<br>• The Secretariat of the GCDPC (which is supervised by the prime minister), is responsible for the overall implementation of the National Drug Policy Strategy. The GCDPC includes all ministries involved in the delivery of the national drug policy and representatives of other significant stakeholders, including representatives of non-governmental organizations (NGOs) and professional associations. The Secretariat of the GCDPC and the Czech National Monitoring Centre for Drugs and Addiction oversees implementation of the National Drug Policy Strategy and the coordination of the ministries' activities (European Monitoring Centre for Drugs and Drug Addiction, 2017).<br>• A network of 14 regional drug coordinators based at regional municipalities manages drug-related activities at the regional and local levels, including the implementation of the national drug policy (European Monitoring Centre for Drugs and Drug Addiction, 2017). The regional drug coordinators meet regularly with the national drug coordinator (Csete, 2012). |

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| | • For NGOs, a "licensing-type certification process run by the office of the national drug coordinator is meant to ensure quality of services provided outside government facilities. NGO facilities are periodically inspected by a certification team and facility managers provide a wide range of information on their activities. NGOs are important service-providers and participate in regional drug bodies in most regions" (Csete, 2012). |
| **Community engagement strategies** | |
| **Health education** | • NGOs offer counselling and risk-reduction information for people with substance use disorder.<br>• The Ministry of Education, Youth and Sports provides guidance and coordinates health education and primary prevention activities. NGOs are widely involved in these activities and receive project-based funding to carry out additional activities in schools. Fundings comes from subsidy proceedings at the national level, through the Ministry of Education, Youth and Sports and the GCDPC (European Monitoring Centre for Drugs and Drug Addiction, 2017). |
| **Prevention/ Harm reduction** | • Prevention is "one of four intervention areas of the Czech policy dedicated to addiction" (Rous et al., 2021).<br>• Prevention of addiction among children and adolescents is part of a broader framework of the prevention of risk behaviour, that is coordinated by the Ministry of Education. There are regional school prevention coordinators that operate on the regional level. As well, on the level of the former administrative districts, "the agenda is covered by prevention methodologists, working within the system of pedagogical and psychological counselling" (Rous et al., 2021).<br>• There are limited prevention-oriented projects outside of the school system.<br>• Needle and syringe distribution and exchanges are available.<br>• In April 2020, a pilot project was approved to distribute naloxone among clients and staff in low-threshold programs (Rous et al., 2021)<br>• "Harm reduction strategies pursued by low-threshold programmes include the supply of aluminium foil for smoking heroin, gelatine capsules intended for the oral application of methamphetamine, in particular, and 'snorters' as alternatives to injecting drug use. Gelatine capsules are distributed by over 90 programmes, with an estimated 171,000 of them being given out in the Czech Republic on a yearly basis. In recent years low-threshold programmes have also used social media and online discussion fora as part of their outreach efforts. This approach has become known as "virtual outreach" among practitioners" (Rous et al., 2021).<br>• Testing for HIV, HBV, HCV, and syphilis at certain programs.<br>• 10–18 harm reduction programs operate out of recreational/nightlife settings (although limited in number and financial support). |
| **Referral and treatment** | • NGOs can refer people in communities to treatment (medication, psychological, psychiatric etc.) and link people leaving prison to community supports and additional substance use treatment. |
| **Non-health sector partnerships and processes** | |
| **Role of the police or administrative bodies** | • No role of the police or public prosecution for referrals to substance use counselling and treatment (Personal correspondence, 2023). |

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| | • Police still involved in drug-related arrests for larger quantities of drug possession and for administrative offences for small quantities of drug possession (Rous et al., 2021). |
| **Social supports (housing, education, employment)** | • NGOs provide various social supports.<br>• Increasing number of aftercare outpatient services that offer sheltered housing and assisting in social reintegration (23 out of 35 centres provide housing) (Rous et al., 2021). |
| **Challenges, enablers and suggestions for further adaptations** | |
| **Challenges** | • There are many barriers faced by PWUD to enter into treatment, such as other responsibilities (e.g., child care, family, work), previous negative experience with treatment and staff (including attitudes), financial difficulties and formal barriers (e.g., outstanding health insurance payments, legal issues, cost of buprenorphine), concerns about treatment being too complicated and difficult, and a lack of confidence in treatment (Mravčík et al., 2018; Rous et al., 2021).<br>• The network of addiction services has been described as continuing to be regarded insufficient because access to addiction services (e.g., outpatient treatment centres, substitution centres, care for clients with multiple diagnoses) are unevenly distributed. Moreover, it is reported that there remains a lack of health professions – particularly outpatient psychotherapists, psychiatrists, and other physicians – who are willing to work with PWUD (Rous et al., 2021).<br>• NGOs generally limited to receive one year of government funding at a time, with many NGOs experiencing uncertainty of the amount of funding available for the following year. These limits affect NGOs' activities and strategy planning for future years (Csete, 2012).<br>• PWUD were heavily stigmatized during city election campaigns in 2010 in Prague, and used as scapegoats for societal problems (Csete, 2012).<br>• Multi-source funding for addiction services considered to increase administrative complexity and reduce efficiency of service provision; new funding strategy aimed to streamline funding and involve more cooperation with local governments (Secretariat of the Government Council for Drug Policy Coordination, 2019). 2023-06-27 9:24:00 AM |
| **Enablers** | • Various research and evaluation approaches and the continued investment of the government (e.g., the Centre for Addictology) to generate research on the impact of drug policies has resulted in copious amounts of evidence to inform drug policy debates and decisions (Csete, 2012).<br>• The role of civil society (e.g., NGOs and their low-threshold and harm reduction services) was crucial for the establishment and maintenance of a multi-pillar drug policy (Csete, 2012).<br>• Relatively high proportion of people who use illicit drugs are in contact with care system (i.e., estimated that 45,000 people in contact with addiction services annually; majority contacting low-threshold and outpatient services) (Secretariat of the Government Council for Drug Policy Coordination, 2019). |

## Oregon

**Table A4.** Summary of adaptations, integrations, and strategies to support decriminalization in Oregon, US

| Adaptations/ Strategies | Details |
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| **Health system adaptation and integrations** | |
| **Referral to care** | • Establishment of telephone hotline for callers to complete health assessment and access resources to treatment programs, harm reduction services, and social supports (Baumle, 2022).<br>• Approval and forthcoming implementation of Behavioral Health Resource Network (BHRN); planned networks in each county to link low-barrier substance use disorder treatment, case management, harm reduction, peer-support services, and housing services (Oregon Health Authority, 2022a). |
| **Model(s) of care/service delivery** | • Forthcoming implementation of BHRN: Planned implementation of substance use treatment programs, screening and assessment, case management, harm reduction services, peer support services, and social supports in every county (Oregon Health Authority, n.d.-a). |
| **Health workforce involved** | • Certified alcohol and drug counsellors/addiction treatment professionals (Gerstner, 2021)<br>• Intensive care managers (Gerstner, 2021)<br>• Peer support mentors/specialists (Green, 2023)<br>• Physicians/providers specialized in substance use disorder<br>• Clinic managers |
| **Medical products/ technologies used and where they are accessed** | • Opioid agonist therapy (Harm Reduction International, 2022). |
| **Integrated approaches** | • Hotline to link access to resources for treatment, harm reduction, and housing assistance (Beaumont, 2022).<br>• Part of the funding that encapsulates the BHRN will also invest substantially into improving the mental health sector, including mobile crisis services, outpatient services, crisis stabilization services, and others (Oregon Health Authority, 2022a). |
| **Outcome monitoring and evaluation** | Could not discern from literature review, however there are some reported outcomes such as:<br>• In Measure 110's first year of operation, there was a 60% decrease in drug-related arrests (Baumle, 2022)<br>• First year of operation reported 16,000 people that accessed services funded by Measure 110 (majority accessing harm reduction services, housing assistance, and peer support services) (Baumle, 2022) |

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| | • Data from first year of hotline operation reported a very low uptake rate (out of 1,885 people who received citations for drug possession, only 91 called the hotline; approximately 4.8%) (Beaumont, 2022). |
| **Finance and governance** | • Marijuana tax revenue to primarily fund the Drug Treatment and Recovery Services Fund (Quinton, 2021; Gerstner, 2021).<br>• Non-profit (Lines for Life) to operate hotline (Beaumont, 2022).<br>• Oregon Health Authority to establish and manage the Oversight and Accountability Council to distribute grants and funding (Gerstner, 2021).<br>• Approximately $302 million in new investments was promised over two years to expand treatment and harm reduction services (Netherland et al., 2022).<br>• As of September 2022, Oregon Health Authority spent $67.4 million in Q3 2022 and obligated $234.7 million in Q4 2022 for Measure 110 funding and grants; Total behavioural health funding included investments to increase behavioural health beds, provide scholarships, tuition, and other supports to diversify behavioural health workforce, federal approval for increasing behavioural health provider rates (Oregon Health Authority, 2022a); early 2023 more funds expected for mobile crisis services and expand housing for people in treatment (Oregon Health Authority, 2022b). |
| **Community engagement strategies** | |
| **Health education** | • Measure 110 plans to increase the number of peer support mentors to provide mentorship and resources for people in recovery/seeking treatment/accessing harm reduction services. |
| **Prevention / Harm Reduction** | • Syringe exchange services (including free sterile needles and syringes, safe disposal areas, access to prevention services such as HIV and HCV testing); naloxone distribution (Oregon Health Authority, n.d.-b).<br>• Funding to increase harm reduction services part of Measure 110. |
| **Referral and treatment** | • Peer support services |
| **Non-health sector partnerships and processes** | |
| **Role of the police or administrative bodies** | • Police to administer fines for personal possession of small amount of drugs (Quinton, 2021). |
| **Social supports (housing, education, employment)** | • Hotline to link to housing assistance and services (Baumle, 2022).<br>• Some funding allocated for supportive employment services (Oregon Health Authority, n.d.-a). |
| **Challenges, enablers, and suggestions for further adaptations** | |
| **Challenges** | • Hotline operators reported difficulty linking callers to detox and residential treatment beds that had space for new patients (Beaumont, 2022). |

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| | • Before implementation of Measure 110, Oregon had significant service gaps for drug recovery and treatment services: (94% service gap for recovery community centers, 60% gap for inpatient treatment facilities, other gaps for provider-specific prescribing authorization for certain treatments) (Lenahan et al., 2022).<br>• Racial/ethnic disparities for access to care: (Underrepresentation of Black, Hispanic, and Indigenous physicians able to prescribe treatments; Underrepresentation of Hispanic addiction counselors and peer specialists; lack of culturally specific treatment services and prevention programming) (Lenahan et al., 2022).<br>• COVID-19 pandemic impacts reduced number of treatment services due to social distancing protocols and exacerbated staffing and resource shortages (Lininger, 2022). |
| **Enablers** | Intended and estimated outcomes and estimated cost savings:<br>• Decrease in drug-related arrests.<br>• People linked with services and care.<br>• Oregon Criminal Justice Commission estimated Measure 110 will substantially reduce overrepresentation of Black and Indigenous populations arrested and convicted for drug offences (Baumle, 2022).<br>• Cost savings from reduced criminal justice prosecutions related to drug offences is estimated to generate between $103-$157 million a year; savings to be 4–6 times more than prior spending on non-Medicaid funding for addiction services (Harrington, 2023). |
| **Suggestions** | • Audit of implementation of Measure 110 recommends integrating the measure into the state's overall behavioural health system, improving data collection and measures for monitoring and evaluation, and setting clear responsibilities and roles for oversight (Selsky, 2023).<br>• In terms of principles and metrics for evaluating drug decriminalization, metrics should include confounding variables (e.g., rise of fentanyl in drug supply, increases in arrests for non-drug related "vagrancy laws," impact of COVID-19), and domains such as criminal/legal, law enforcement interactions and culture, healthcare, stigma, cost, and cost savings; sub-analyses should include race/ethnicity, geography, income, pregnant and parenting/guardian people, and sexual orientation (Netherland et al., 2022). |

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