Health & Human Services and Public Safety Committee

Tuesday, May 28, 2019, 5:30 PM
Room 209, City Hall

Councilor Belinda Ray, District 1, Chair
Councilor Brian Batson, District 3
Councilor Pious Ali, At-Large

1. Announcements

2. Review and Approval of Minutes from May 14, 2019

   a. May 14, 2019 Draft Meeting Minutes

3. Opioid Misuse Crisis

   a. Follow up from corporation counsel's office on Safehouse case and legal issues associated with safe injection sites.
   b. Update from Kristen Dow on Gordon Smith visit to discuss Opioids, what the state is doing, and the state position on OPS
   c. Committee discussion of Gordon Smith visit, what we hope to accomplish

4. Positive Healthcare Committee Discussion

5. Committee Work Plan & Future Meeting Dates

6. Next Meeting: June 11, 2019

NOTE: Since there are no action items on the agenda, there will be no opportunity for public comment at this meeting, however an item may lead to an executive session. Please feel free to send comments to members of the committee on any issue at any time via email. Councilors email addresses are available on the city website: www.portlandmaine.gov

Executive Session - When there is a motion, it may go into Executive Session to discuss and consider property negotiations pursuant to 1 M.R.S. section 405(6)(C).

The meeting can be watched online via livestream: www.portlandmaine.gov/livestream

Keep up to date with the new shelter design and planning process at the City's website

www.portlandmaine.gov/shelterplanning

Health & Human Services and Public Safety Committee Minutes

Tuesday, May 14, 2019, 5:30 PM, Room 209, City Hall

Committee Attendance:

Belinda Ray, Chair (District 1), Brian Batson (District 3), Pious Ali (At-Large)

Councilors in Attendance: Spencer Thibodeaux: (District 2)

City Staff: Kristen Dow, Interim Director of Health and Human Services; Andy Downs, Director of Public Assembly Facilities; Verne Malloch, Interim Police Chief; Jessica Hanscombe, Licensing and Registration Coordinator; Dr. Kolawole Bankole, Director of Public Health; Bridget Rauscher, Substance Use Prevention Coordinator; Henry Tarlow, Community Health Promotions Specialist. Kevin Cashman, Police Lieutenant and Sound Oversight Committee; Jen Thompson, Corporation Council; Anne Torregrossa, Corporation Counsel; Zoe Brokos, Community Health Promotions Specialist; Lizzy Garnatz, Community Health Promotions Specialist; Adam Harr, Executive Assistant.

Meeting called to order at 5:30 PM.

AGENDA ITEM 1 – Announcements

- Next Monday the Council will be having a public hearing on the two proposed locations for the Homeless Services Center

AGENDA ITEM 2 – Approval of Minutes

- Councilor Batson moved to approve the minutes; Councilor Ali seconded and the minutes were approved unanimously.

AGENDA ITEM 3 – Sound Ordinance

- Background:
    - Current Entertainment Licenses:
        - With dance license or without dance license
            - Indoor or outdoor
        - Single concert: one off event license
        - Dance Concert Hall License (2 in the City)
        - After-hours 1:00 AM to 3:00 AM (2 in the City)
- Proposed: Indoor and outdoor licenses with new decibel requirements
    - A Weighting upper limit: 85 dBa
    - C weighting upper limit: 95 dBc.
- Concerns from last reading.
    - Definition of entertainment

        - Spoken word was removed from the definition
    - Added ability to measure from any outside point of a building
        - Not just a means of egress.
        - Excludes sporting events hosted by the schools.
- Committee questions
    - Is there an example for the full council of what exceeds 85 dBa (to capture the practical impact)?
        - Majority of concerts at Maine State Pier were at 85 dBa
        - There were no bars or restaurants that have exceeded 92 dBa.
            - Usually mid to high 80s.
        - There was one concert that briefly exceeded 92.
    - dBc scale was added as it was the bass sound that the C weighted scale measures that were the cause of the majority of complaints.
    - The sound mitigation plan would be needed for any new applicant and not current indoor up for renewal would not.
        - All outdoor require sound mitigation plans.
- 457 B.1 and page 48 E23Any means of egress and above 8 feet from the building.
- Char Ray suggested striking music videos from the entertainment definition.
    - Why was it added to the list?
        - To be inclusive/fair for all possible scenarios.
        - Example: a neighboring bar playing live music vs. a bar playing music videos.

A public hearing opened at 4:45 PM.

- Chair Ray explained the rules and procedure for public comment.
- Cait Salzberg, Cofounder of Rad Plaid would like clarification on why the licenses are changing. Did something happen and what are the reason to change the Dance/Without Dance licenses to indoor/outdoor? What constitutes a sound mitigation plan for outdoor? Indoor doesn't allow for opening windows and doors; will that stay in the summer?
- Bret Gabore of Frederic Street – Thanked staff for the effort. He suggests that there be a more casual permit level for places that don't allow bars or concerts: Acoustic bands, etc. 85 dBa is pretty loud. The City's response seemed to be when it wants to, it can be stricter but he is not sure where in the ordinance the council can step in, if that is the intent.
- Bruce Mills, Amigos Mexican Restaurant. Why at 10:00 PM on weekdays and 11:00 PM on weekends. Most entertainers start at 9:00 and the ordinance would harm his business. There should be more flexibility in the overlay zone. What was used to determine similar Cities? Population or entertainment density? Capping entertainment capped 8-11:00 pm would be moot and know 30% of his business off as most people go out in the evenings. When would the ordinance take effect, as he has already contacted entertainers and would be liable? He is surprised stakeholders weren't contacted sooner.

- Doug Fuss of Bull Feeney's and former chair of nightlife oversight committee – There was a Portland memo sent by Portland Downtown about eliminating the separation of dance licenses. Is that included? If it is about separation of venues, the concern was safety, not sound to prevent people from spilling out into the streets all at 1:00 AM to help police do their job.

The Public hearing closed at approximately 5:50 PM.

- Chair Ray explained that the ordinance came to committee in 2016 due to the large volume of complaints.
    - The 92 dBa limit was only in the downtown overlay.
    - The need has expanded with increased events throughout the City, not just downtown.
        - Example: Thompson's Point
    - The Council reviews noise complaints when licenses are granted and renewed.
    - Wanted sound mitigation on the front end.
- What is a sound mitigation plan
    - Sound mitigation on the front end rather than the back end.
    - Noted it Includes:
        - Speaker location and direction
        - Sound system details and controls;
        - Stage and site layout and direction;
        - Any noise cancelling or mitigating measures proposed; and
        - Anticipated sound readings at the proposed source of the sound, at a location 8' from the means of egress located nearest to the noise source and/or 8' from any outer wall of the premises (for indoor entertainment), at each property line of the premises (for outdoor entertainment).
    - Mitigation plan will have to reflect the areas it will be in.
- Windows: If you have indoor entertainment, do you have to close windows
    - Understands the concern about heat.
    - The closed windows also address the ban on using speakers to attract business.
- If license is coming before the council, what can the council do to alter it.
    - Decibel level.
    - Where is somewhere that would not allow a permit and asked for one.
        - Need to be zoned properly as entertainment and business licenses go hand in hand.
    - Hour restrictions can be conditioned if needed.
- Why are hours being limited in the Ordinance?
    - What would happen if the hour restriction was taken out?
        - To limit complaints.
        - Every license will be asked for conditions.
        - What then determines who receives a license and who doesn't?

        - Would need to be moved by complaints and ultimately creates a burdensome amount of work to look at each individual license.
    - Goal was consistency but the expanded entertainment addendum can change the curfew.
    - Only the outdoor hours are being changed.
        - Only Brian Boru's and Amigos have later hour licenses
            - Only one complaint in Brian Boru's.
            - Could these businesses approach the city and ask for extended hours as the proposed ordinance is written?
                - Yes
                - Likely several establishments would seek extended hours.
                - Councilor Batson would like to keep the hours and allow businesses to apply for extensions*
            - *Licensing then clarified extensions were then clarified that the extensions are per event and cost $100.
        - Only the Maine State Pier had its own self-imposed curfew
        - How many establishments would be effected by changing the hours?
            - 34 indoor/outdoor licenses.
            - 1 outdoor license only at Thompsons Point.
                - Limited under zoning to 11:00 PM.
            - If enacted as is, businesses could approach the City to get council approval for extended hours.
- When does to go into effect?
    - Late July (Would be taken up in June and then go into effect 30 days later.)
    - Could parts of the ordinance go into effect staggered or change the enactment date to adjust for the next year.
    - Councilor Batson is interesting in honoring current licenses hours and use the new hours for new licenses and renewals as the businesses in the room explained they already have many events booked already.
- Similar Sized Cities.
    - Austin, Burlington, Hartford, etc.
    - Acetic helped search and had their own expert criteria.
- Dance/Without Dance.
    - Understand the safety origin and disbursal.
        - Dispersal is mitigated with the 100-foot rule.
    - Will modernize to allow dance.

Committee Discussion

- Chair Ray made a motion to strike music videos; Councilor Ali seconded. The Motion passed 2 – 0 with Chair Raya and Councilor Ali in the affirmative and Councilor opposing.
- Hours Change

    - Why would Sunday through Thursday be changed when there were no complaints.
    - When outdoor DJs play, do they go to 1:00 or end earlier.
    - What are the current hours (previous language): 1:00 AM every Day
        - Moving to 11:00 PM on the weeknights and 10:00 PM on the weeknights; why?
        - There were complaints from neighbors around establishments and from hotels.
        - The PD is still getting calls even though it appears complaints aren't making it to the council.
            - About 10-20 for newer licenses and mostly stopped after speaking with police.
            - The outdoor speaker change helped.
    - Wants an ordinance for the whole city but the hours seem to be appropriate for neighborhoods with establishments like breweries and tasting rooms but not Downtown.
        - Should hours be struck to not need two ordinances?
- When can a license come before the Council when there is a problem prior to renewal?
    - It doesn't have to wait for sound oversight.
    - Only ability to bring it back to Council without violations is by renewal.
        - If a business is a problem it must go before sound oversight.
        - If you want a business to come back to council mid license, the ordinance needs clarification.
            - Could add some protections in the ordinance.
        - Any mid license issues can also go through the normal enforcement process.
            - In the past there were many complaints but no violations.
- If a hotel is located between three establishments and complaints are made, how does PD determine which establishment is causing the nuisance?
    - PD will take a reading at each place's means of egress.
    - If an establishment A is getting blamed, PD can explain establishment B and C's ratings and that it is not just establishment A.
    - Decibels get exponentially louder.
- Chair made a motion to change 457 B1 to eliminate B1 and change b2 to read outdoor entertainment 8:00 AM to Midnight. Councilor Batson seconded.
    - Councilor Batson is more concerned about weekdays not weekends and is inclined to support it but is entertaining 11:00 PM for weekdays and Midnight for weekends.
    - Councilor Ali acknowledged that people go out at night and that is when establishments make their money; He suggested weekends should remain until 1:00 AM and amend weeknights to Midnight.
    - Amendments
        - Sunday Through Thursday 8:00 AM to Midnight.

        - Friday and Saturday. 8:00 AM to 1:00 AM.
    - "The following day" is used to cover date change in the span of hours.
- Councilor Batson made a motion to forward on to Council for approval, Councilor Ali seconded. The motion passed unanimously.
    - It will likely get a first read June 3rd and second read likely on June 17th (public comment and vote)

AGENDA ITEM 4– Overdose Prevention Sites

- Public Health has done a lot of research available in the backup materials.
- Terminology: medically supervised spaces supervised by medical staff where individuals can use illicit substance, usually intravenously.
    - Safe injection Space/site: SIS
    - Safe Injection Facility: SIF
    - Overdose Prevention Site: OPS
    - Comprehensive User Engagement Site: CUES
- Community Impact
    - Harm reduction
    - Public Safety
        - Reduction in public disorder and public injection
        - Increased public safety.
    - Reducing HIC and Hep C risk behavior.
    - Increasing the delivery of Social Services
    - Increased uptake in Substance Use Disorder (SUD) treatment.
- Insite: Vancouver facility resulted in less use, less outdoor injecting and less unsafe syringe disposal.
    - Outcomes
        - Touted for harm reduction
        - Managing overdoses
        - Public safety
        - Reduced new HIV infection and HEP C Risk
            - Prevents 35 HIV infections per year.
        - Linking to treatment
        - Did not result in an increase in crime or substance use.
    - Received a federal exemption from the Canadian government
    - Studies are limited and not strongly demonstrating an increase nor decrease.
        - The study making a claim was retracted due to lack of evidence due to small sample size.
- Cost
    - Cost approximately $3 million dollars a year with a societal benefit of $6 million
    - A single site would generate about $7million in healthcare savings.
        - Sources describe how many individuals are served with each of these cost conclusions.
- Seattle passed and estimated it to $2.5 million/year.

- SPOT program
    - Safe drop in facility for people under the use of drugs
    - A nurse is there for a gateway to treatment
    - Injection is not allowed on site and it is not a needle exchange (a needle exchange is located nearby)
    - Emergency services reduction
- Legality
    - Federal government has asserted that these sites violate federal law~~Currently violate federal law~~.
    - Areas of concerns from other municipalities
        - State/federal law
        - Grant stipulations and clauses
        - 340 B status could be jeopardize
        - Police department has already lost funding due other programs when corporation council did not recommend signing certain funding contracts.
        - Disbarment
    - Vermont said safe injection sites were counterproductive.
    - SAFEHOUSE was called illegal.
    - April Boston despite support said it cannot open a facility unless there is a change at the federal level.
    - August of 2018 Dept. of Justice said it would not tolerate safe injection sites.
    - April 1st in Maine urged it ought not to pass
        - Against federal
        - Sanctioned use not right for Maine
        - Subsection 856
- Summary
    - Benefits
        - Access to clean syringes
        - Access to nolaxone
        - Medical supervision of overdoses
        - Public health benefits for users and the community at large.
            - Reduction in infectious disease transition
            - Testing and referral to treatment.
        - Healthcare cost savings.
        - Safe place to inject illicit substances (not in public)
    - Negatives
        - ~~—~~Federal government has asserted that these sites violate federal law~~Violates federal law~~
            - Could jeopardize other programs and services due to funding constraints.
        - Cost prohibitive
    - Portland

        - Already has many of the services and benefits without risking federal funding and complying with federal law.

Committee Questions and Discussion

- Bill
    - HHS has not been advised to follow the bill.
    - It was voted out of committee ought not to pass.
    - It would likely get vetoed by the governor due to violating federal law.
- Slide 5:
    - CA to US
        - How much is Portland currently spending on overdoes?
            - Emergency services responses
            - Staff are already working on, but it will be difficult to track and create an accurate number.
                - Accidents of prescribed medications skew the data.
        - The Canadian projections include medical savings and are not just the emergency response costs.
- Slide 6
    - Seattle is so much bigger: what are the numbers in context
        - Size of building
            - Mobile site suggested before legal issues stopped planning.
        - Number of people
        - Number of staff
            - How to make it sustainable?
- Slide 8: Efficacy
    - What studies are supporting?
        - Located in source list.
        - The retraction was made after the document was started.
- SAFEHOUSE
    - Countersuit made and there hasn't yet been a judgement/ruling.
        - Challenged the federal government's interpretation of the controlled substances act.
        - Religious freedom defense based on their non-profit status.
    - Philadelphia supports safe injection sites but would not operate one.
        - What can be done at the municipal level do to support the opening of a site that the City does not operate?
            - Possibly similar to marijuana as it is illegal at the federal level but unenforced then legalized in Portland and Maine.
              Suspected marijuana only did not initiate enforcement
            - Distinction at the time of marijuana the federal government had messaging that it would not seek enforcement versus the very active and litigious enforcement of the current administration.

- Portland murder rate is 2 deaths per year.
    - There were 44 overdose deaths in 2018.
        - 34 were opioids.
- Was SPOT publically funded?
    - Another specific revenue stream?
    - Secured third party reimbursement
    - Sounds like Milestone without the emergency shelter.
- Scientific evaluation of supervised injection results:
    - Increased treatment
    - Reduction of public disorder
    - Reduction of public injection
    - Reduction in HIV/HEP C risk behavior
    - Reduced Drug OD death rates
    - Asked clients where they would have injected and most said a public restroom or out in the public/park.
- Section 885 of federal controlled substances act
    - Provides exemption from federal controlled substances for municipal/state employees to carry out state law.
        - Likely immunity for enforcement not for a facility.
        - Requested a deeper read but a memo isn't needed.
- Needle exchange program data does not violate HIPPA
    - Some outcomes are more impressive than the safe injection sites.

AGENDA ITEM 3 – Needle Exchange Program

- Longest operating needle exchange in the state and the southernmost.
    - Many people from York County, Lewiston and along the coast.
- Number of needles almost always on the rise.
    - Increase in the number collected and distributed
    - It operates as a one for one needle
        - People bring in used syringes and get the same number of new needles back.
- Sharps boxes in public areas: parks, trails, community gardens and new boxes installed where need arises.
- Program is anonymous and given a card with an ID number.
- Low barrier and free of judgment
- Intakes collect housing information and HIV/HEP C status and when they were last tested.
- Some access the exchange daily or multiple times a week; especially those who identify as homeless.
- Distrubutes naloxone.
- Increase in pharmaceutical opioid use
    - Increase crystal meth use.

- Many people don't call 911
- Oliver Bradeen
- Overdose reversals is hard to capture as some folks aren't reporting.
    - 109 is lower than the actual number of reversals.
- Harm reduction
    - Referrals to treatment, case management and primary care.
        - It can take multiple referrals (as much as 10 to 25 tries)
        - It can be a starting point.
        - Works with providers
            - Referrals
            - Harm reduction training.
        - Tracking is hard as services are anonymous.
- Some clients fall off and it is unknown if it is a good or a bad indication.
    - Usually in recovery houses.
- Outreach for HEP C treatment.
- On site STI testing: usually during clinic hours on Tuesday and Thursday but the partnering Doctors will come in for emergency calls.
- Over 150 overdose prevention trainings
    - At OSS, Maine behavioral health, fisherman's forum, rotary club, UNE, etc.
        - These lead to solicitations from people and organizations that learned about the program from people who attended trainings.
            - A local clothing shop requested after an overdose happened in their store.
            - A lot of businesses want to do their part.
        - Upcoming training in long island for the fishing community and Sacred Heart Church in Spanish.
- Other Collaborations
    - Maine Family Planning reproductive empowerment project last year to connect opioid users or people who have had opioid use disorder who are at risk of unplanned pregnancy.
        - At India Street twice a month.
    - Medics come to India street on Mondays for wound care and infection prevention.
- Increase in healthcare workers wanting to learn about harm reduction.
    - Correlates to increase in substance use related services and costs.
    - UNE trainings including a cohort focusing on this field.
        - Insures the next generation of nurses and doctors are comfortable with the population they will be serving.
- Minority Health Program
    - Working on getting materials translated.
    - Translated materials currently available in:
        - French
            - French Language presentation TBD.

        - Spanish
            - Spanish language presentation in June.
        - Arabic
- Presented at Maine Public Health Conference
- Coordinated 1st Southern Maine Harm Reduction Conference
    - More well attended than expected
    - Happening again in October.
- Outreach on needle collection and sharps box locations.
- Easier to connect people to HEP C treatment.
    - Helping people access free care.
    - Easier as folks get enrolled in Maine Care
        - Leading to primary care and access to medically assisted treatment.

Committee questions and discussion

- The committee thanked the program staff and praised their outreach.
    - The rotary club as made the opioid crisis their issue.
    - SMCC was on board immediately and then requested a specific harm reduction training.
- How does staff interpret the increase in accessing the program? Unknown but:
    - Could be an increase in use;
    - An increase of people choosing to use a clean needle every time
    - More people learning about the program.
        - New people sign up all the time.
- Medics head to India Street every Monday.
    - One medic each day.
    - An extension of the mobile medical outreach clinic from a SAMHSA grant.
    - Medical coverage every day at India street between the different programs.
- How would the needle exchange program work with an overdose prevention site?
    - Too difficult to say at this stage in the process.
    - There are best practices.
    - The committee appreciates the difficulty of the conversation.
- Budget
    - Will be given in future back up.
    - Grants, state funding and private foundation grants.

AGENDA ITEM 3 – Next Steps

- Next meeting May 28, 2019
    - Safe Injection Sites
        - Corporation Council to look at Section 85
        - What is happening at the State level?
        - Any local cost estimates, possibly from hospitals.
        - Data from Police, Fire, EMS

- Needle Exchange Program Budget information.
- Sober Houses and Recover Houses.

Meeting adjourned at approximately 7:55 PM.

The Mayor's Task Force to

COMBAT THE OPIOID EPIDEMIC IN PHILADELPHIA

Final Report & Recommendations

MAY 19, 2017

City of Philadelphia

Mayor James F. Kenney, City of Philadelphia

MESSAGE FROM MAYOR KENNEY

The opioid epidemic affects all of us in Philadelphia. Drug overdoses, and overdoses involving opioids, are now a leading cause of death in our city. Opioids are also destroying families and relationships and undermining the quality of life in Philadelphia.

Our country has seen waves of drug use and addiction in the past, and it has made the mistake of managing them primarily as problems of law enforcement, leading to many unnecessary jail terms but little progress. With this new tragic turn in drug use, we have to be smarter and more compassionate.

In order to address this epidemic in a thorough and systematic way, I convened a Task Force of stakeholders working in public health, substance use disorder treatment, medical care, law enforcement, advocacy, and managed care, as well as representatives from the community. This Task Force, co-chaired by Commissioner Thomas Farley of the Department of Public Health and former Commissioner Arthur Evans of the Department of Behavioral Health and Intellectual disAbility Services, has committed over the last several months to identify ways that we can individually and collectively turn the tide on Philadelphia's opioid epidemic. This outstanding report contains recommendations that can do just that.

However, a report cannot itself solve this crisis. It will take a sustained commitment from the City and all of its partners, as well as from the general public, to implement this report's recommendations and drive down opioid use, addiction, and overdose. I hope you will join me in making that commitment.

Philadelphia has faced many crises over the years, but has overcome them when residents and leaders from businesses, community organizations, and government work together. If we work together again, I am confident that we can end the opioid crisis, too.

James F. Kenney

Mayor James F. Kenney

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This report describes a public health crisis in Philadelphia caused by prescription and illicit opioids, and characterized by high and increasing rates of opioid use disorder and overdose death, as well as their devastating personal, family, and societal consequences.. The Mayor's Task Force to Combat the Opioid Epidemic considered the causes of this crisis and its potential solutions and makes the following recommendations:

The Task Force was charged with developing a comprehensive and coordinated plan to reduce opioid use disorder and its associated morbidity and mortality in Philadelphia, and with drafting a report of findings and recommendations for action for the mayor. It conducted its work through meetings of the full Task Force as well as meetings of five subcommittees, each of which addressed a different aspect of the epidemic.

The Task Force also held four Community Listening Sessions across the city to hear directly from Philadelphians affected by the opioid epidemic. More details on the Task Force process and Community Listening Sessions are in Appendix III.

PREVENTION AND EDUCATION

1. Conduct a consumer-directed media campaign about opioid risks.
2. Conduct a public education campaign about naloxone.
3. Destigmatize opioid use disorder and its treatment.
4. Improve health care professional education.
5. Establish insurance policies that support safer opioid prescribing and appropriate treatment.

TREATMENT

6. Increase the provision of medication-assisted treatment.
7. Expand treatment access and capacity.
8. Embed withdrawal management into all levels of care, with an emphasis on recovery initiation.
9. Implement "warm handoffs" to treatment after overdose.
10. Provide safe housing, recovery, and vocational supports.
11. Incentivize providers to enhance the quality of substance use disorder screening, treatment, and workforce.

OVERDOSE PREVENTION

12. Expand naloxone availability.
13. Further explore comprehensive user engagement sites.
14. Establish a coordinated rapid response to "outbreaks."
15. Address homelessness among opioid users.

INVOLVEMENT OF THE CRIMINAL JUSTICE SYSTEM

16. Expand the court's capacity for diversion to treatment.
17. Expand enforcement capacity in key areas.
18. Provide substance use disorder assessment and treatment in the Philadelphia Department of Prisons.

TASK FORCE GUIDING PRINCIPLES

The recommendations in this report were guided by the following eight principles:

1. Prioritize intervening at the earliest possible time.
2. Recognize the diversity of the city and the varied populations affected by the epidemic, including race, ethnicity, gender, age, sexual orientation, pregnancy, and parenting status.
3. Ensure that the voice of lived experience is included.
4. Support recommendations with data.
5. Find a balance between actionable recommendations and aspirational recommendations.
6. Speak to all organizations and entities that could contribute to solutions, rather than just the mayor or City government.
7. Consider return on investment and maximize the impact of resources expended.
8. Be subject to continuous, ongoing, and frequent evaluation and monitoring with quantitative metrics.

FOREWORD

I am honored to have served as an ex-officio member of the Mayor's Task Force to Combat the Opioid Epidemic in Philadelphia. A diverse task force membership, deep community engagement, and key leaders' commitment to the process provided an impressive foundation for the development of this report.

Our Task Force's starting point evolved from a list of recommendations in common from similarly focused task force reports developed across the United States. This critical first step—to start with the end in mind—illustrated the credibility and seriousness of the city's leadership team. Thus all involved understood the importance of their individual and team role in meeting the high expectations of the mayor, the public, and city commissioners. Based on the clear guiding principles that were also provided, all were encouraged to develop recommendations of the highest caliber.

I encourage you to read this report in its entirety and to pay particular attention to the process followed and final recommendations. I ask that if you model future opioid planning on Philadelphia's report, you consider, as our leaders did, the importance of community input, task force membership composition, and an evidence-based approach.

As the regional administrator for the Substance Abuse and Mental Health Services Administration (SAMHSA) located in Philadelphia, responsible for Pennsylvania, Delaware, Maryland, Washington DC, Virginia, and West Virginia, I often share the SAMHSA messages that behavioral health is essential to health, prevention works, treatment is effective, and recovery is possible. I have been heartened to see each of these important points observed as a plan has been developed to help all Philadelphians. The value of this report will be realized as it is shared and in turn becomes the starting point for progress in your organization or jurisdiction—starting with the end in mind.

Jean Mackey Bennett, PhD, MSM, MSN, RN

Regional Administrator for Region III
(DC, DE, MD, PA, VA, WV)
Office of Policy, Planning, and Innovation
United States Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

PREFACE FROM TASK FORCE CO-CHAIRS

As the commissioners of the City of Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) and Department of Public Health (PDPH), we were honored to serve as co-chairs for the Mayor's Task Force to Combat the Opioid Epidemic. We are grateful for Mayor James F. Kenney's leadership, as he recognized the devastating effects of the opioid epidemic on Philadelphia and called for a plan to combat it.

During the early months of 2017 we convened over 100 experts, stakeholders, and community members to develop a plan that would meet that challenge. Coming together as a single unit allowed us to harness our collective expertise and put us in a stronger position to respond.

We are proud of the work conducted by members of the Task Force and its five subcommittees, and are grateful for their dedication and innovative ideas. Furthermore, we are thankful for community members who voiced their comments, which are embedded throughout this report.

While not every recommendation received unanimous support from all Task Force members, the recommendations in this report reflect the consensus of the Task Force and its co-chairs. Each organization involved in the Task Force will also be critical to the implementation of these recommendations, and to addressing the other issues related to the opioid epidemic that this Task Force could not cover.

We look forward to continuing the conversation with community members, stakeholders, the private sector, and City leaders.

Arthur C. Evans, Jr., PhD

Commissioner, 2004–February 2017
Department of Behavioral Health and Intellectual disAbility Services

Thomas Farley, MD, MPH

Health Commissioner
Philadelphia Department of Public Health

THE OPIOID CRISIS

The crisis caused by opioids encompasses opioid use, opioid use disorder, and related morbidity and mortality. Each of these is a problem of its own and each leads to many other individual and social problems. Opioid use and addiction are not new issues, but they have reached epidemic proportions in the city and demand a new and coordinated response.

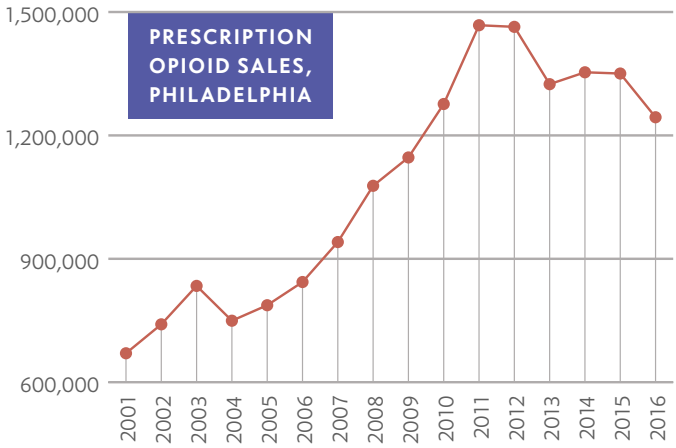
PRESCRIBING AND USE OF PHARMACEUTICAL OPIOIDS

> While heroin use has a long history, it is the rise in use of prescription opioid pain medication beginning in the late 1990s that has fueled this current crisis.[1]

Nationally, four out of five new heroin users have their first exposure to an opioid from a prescription opioid pain medication, such as Vicodin, Percocet, and OxyContin.[2]

Data from the Drug Enforcement Agency suggest that opioid sales in Philadelphia more than doubled between 2000 and 2012. Despite the attention that opioids have garnered over the last several years and a greater collective understanding of the risks, opioid sales in Philadelphia have only begun to decline since 2012 (see chart at right).[3] These data indicate that health care providers continue to prescribe opioid pain medication in greater quantities than are medically appropriate given the risks of these drugs.[4]

Nationally, nearly 70 percent of adults in the United States have used opioid pain medication in their lifetimes and approximately 30 percent have used these drugs in the previous year.[5] Using state and national data, we estimate that between 100,000 and 200,000 people in Philadelphia receive more than one prescription for an opioid pain medication each year.



PRESCRIPTION OPIOIDS IN PHILADELPHIA

Opioid sales more than doubled between 2000 and 2012.

ESTIMATED MISUSE OF PRESCRIPTION OPIOIDS IN PHILADELPHIA

50,000 people

While some of these prescriptions are medically warranted (e.g., for cancer-related pain or individuals receiving hospice care), many are for non-cancer, chronic pain, for which opioid treatment is not recommended. This exposure is dangerous because the probability of long-term opioid use increases with each day of use, including within the first week following an initial prescription.[6] Use of prescribed opioids can lead to subsequent opioid use disorder. Data from the National Survey on Drug Use and Health suggests that, in Philadelphia, between 50,000 and 60,000 people over age 12 misused a prescription opioid pain medication in the previous year.[7]

The Philadelphia Department of Public Health and Department of Behavioral Health and Intellectual disAbility Services recently released guidelines to promote judicious opioid prescribing, and have distributed these guidelines to physicians and other prescribers in the Philadelphia area.

HEROIN AND ILLICIT OPIOIDS

> Because of the expense of prescription opioid pain medication, some users transition to heroin, which is inexpensive and more readily available.[8]

Nationally, four out of five individual who begin using heroin have made this transition from initial prescription opioids.[9] While more than 90 percent of people who use prescription opioids for nonmedical purposes do not transition to heroin use,[10] given the large number of people receiving prescription opioids, a significant number of individuals make the transition to heroin.

ESTIMATED HEROIN USERS IN PHILADELPHIA

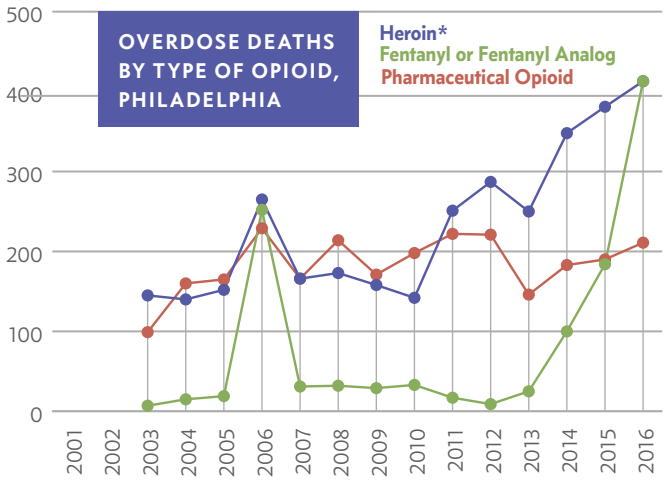
70,000

This transition is particularly likely to occur in Philadelphia because heroin in the Philadelphia-Camden area is especially pure and cheap. In 2014, Philadelphia's heroin averaged 65 percent purity, the highest in the country among all samples tested.[11] Based on national data showing that 20 percent of heroin users seek or participate in treatment for their heroin use, we estimate that there are at least 70,000 heroin users in Philadelphia.[12] This is likely a conservative estimate, as it does not include individuals who may have obtained care in the private treatment system.

In 2014, the synthetic opioid fentanyl began to appear in testing of opioid overdose victims, indicating that criminal drug networks were producing the drug and selling it on the street to heroin users. By 2016, fentanyl was found in nearly half of drug overdose deaths (see graph below).

FENTANYL

By 2016, fentanyl was found in nearly half of overdose deaths.



OPIOID USE DISORDER

> The physical and psychological impact of opioid use disorder on the residents and communities of Philadelphia is difficult to measure but cannot be overstated.

Approximately 14,000 people were treated for opioid use disorder in Philadelphia's publicly funded system in the 12-month period from October 2015 through September 2016.[13] The patients actively seeking and participating in care still represent only a fraction of those with opioid use disorder, including those who use heroin and those in need of treatment.

NUMBER OF MEDICAID RECIPIENTS IN PHILADELPHIA TREATED FOR OPIOID USE DISORDER IN ONE YEAR

14,000

DEATHS

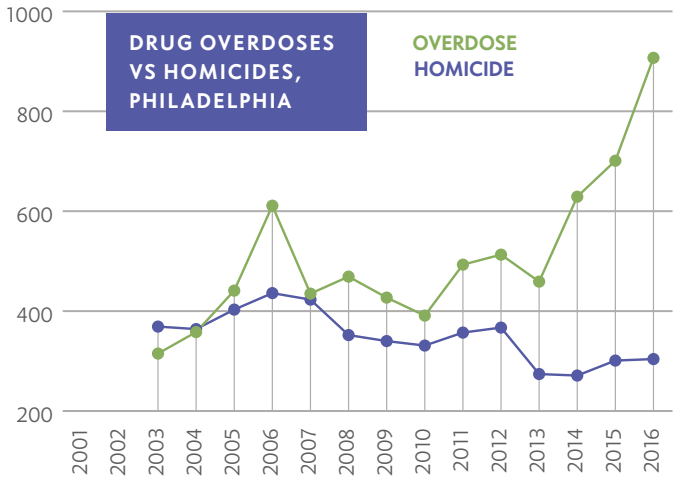
In 2016, opioid overdoses were three times the number of homicides.

OVERDOSES

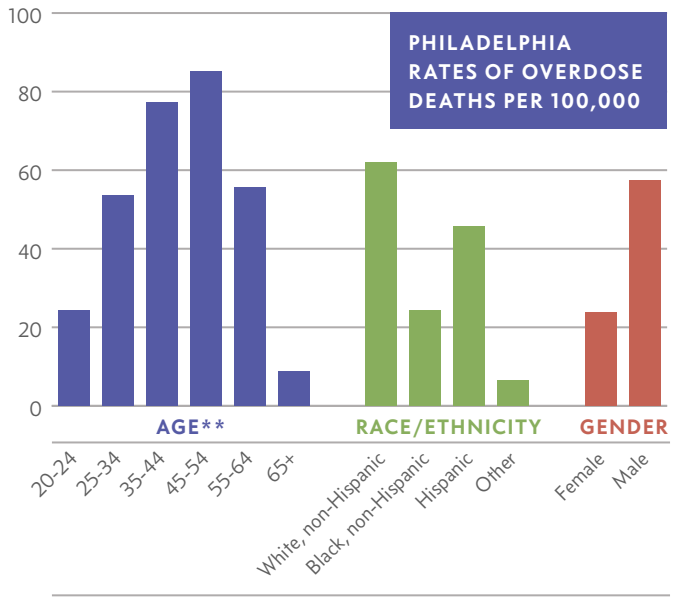
> In Philadelphia, 907 died due to drug overdose in 2016—an increase from 702 in 2015 and three times the number of homicides (see graph below).[14]

In 2015, Philadelphia's rate of 46.8 drug overdose deaths per 100,000 residents far outpaced other large cities, such as Chicago (15.4) and New York City (11.2).[15]

Approximately 80 percent of drug overdose deaths in Philadelphia involve opioids, including prescription opioids, heroin, and fentanyl. The increasing presence of fentanyl, a potent synthetic opioid pain medication that is 50 to 100 times stronger than morphine, is contributing to overdose fatalities. In 2016, fentanyl was found in 412 drug overdose decedents in Philadelphia, a sharp increase from nine deaths in 2012.[16]



Fatal opioid overdoses predominantly occur in Philadelphia in non-Hispanic white males, although no demographic or socioeconomic group has been unaffected (see chart below). The peak age group for overdoses is 45-54, which represents a distinct change from earlier periods when opioid overdose deaths were far higher in those age 20-29 that any older age group.[17] This older age group for fatal overdoses likely represents a consequence of recruitment of adults into drug dependence by over-prescribing of opioids.



* Rates are calculated using Philadelphia county population denominators from the 2015 American Community Survey five-year estimates. Rates are adjusted to the 2000 U.S. Standard Population age distribution.

** Age-specific death rates are shown. Deaths among persons ages 10-14 and 15-19 years were too few to calculate a rate.

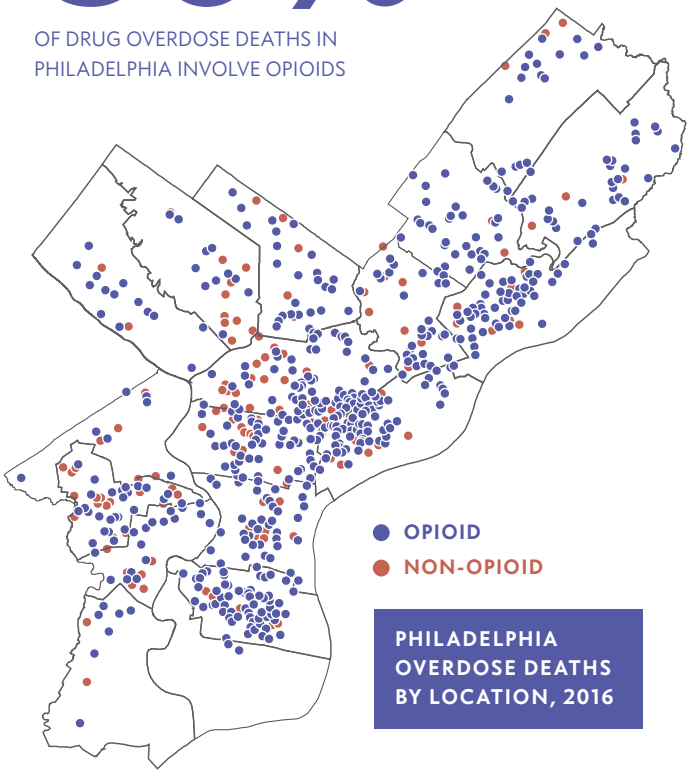
Similarly, while many overdoses happen in the Kensington and North Philadelphia neighborhoods, overdoses have occurred in every corner of the city (see map).[18] In addition to fatal overdoses, thousands of non-fatal overdoses occur each year in Philadelphia.[19] While lives are saved through the use of naloxone, a medication that reverses opioid overdoses, these overdoses continue to be traumatic and burden the city's emergency medical services, part of the Philadelphia Fire Department, and hospitals.

In 2014, Dr. Rachel Levine, Pennsylvania's Physician General, signed a statewide "standing order" enabling any Pennsylvanian to obtain naloxone from a pharmacy without an individual prescription. This order was part of Act 139, which both allows first responders and community members to administer naloxone to someone who they are concerned has overdosed on opioids and provides immunity from prosecution to those reporting or responding to an overdose (a "Good Samaritan" provision).

In Philadelphia, naloxone has been widely used and distributed: it was administered approximately 4,000 times by the Fire Department and 200 times by Philadelphia police in 2016. Additionally, approximately 5,500 doses of naloxone were distributed from a syringe exchange program in Philadelphia to people who use drugs and are at high risk for overdosing.

80%

OF DRUG OVERDOSE DEATHS IN PHILADELPHIA INVOLVE OPIOIDS

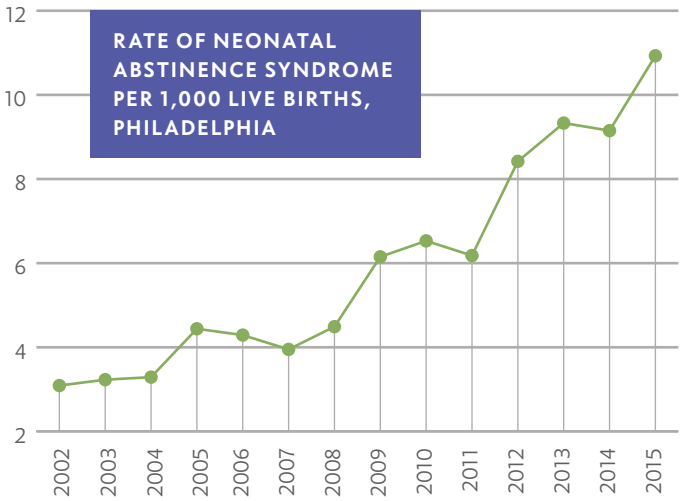


IMPACT ON FAMILIES

Opioids negatively impact not only the addicted user, but also the family around them, which may include parents, partners, children of any age, unborn children, siblings, and extended family.

Philadelphia families are burdened with grief and loss to overdose, stigma associated with opioid addiction, and the multigenerational dynamic of the disease of addiction. The consequences of alcohol and drug misuse that impact families include compromised physical health and mental health, increased health care costs, loss of productivity at school and/or work, reduced quality of life, increased crime and violence, as well as child abuse and neglect.[20]

Opioid use during pregnancy can lead to neonatal abstinence syndrome (NAS) and may interfere with a child's brain development and result in later consequences for mental functioning and behavior. In the United States, the incidence of NAS increased 383 percent during 2000–2012 along with increased opioid misuse.[21] In Philadelphia, the rate of NAS increased more than three-fold from 3 per 1,000 live births in 2002 to 11 per 1,000 live births in 2015 (see chart below).



Adverse childhood experiences (ACE) are stressful or traumatic events that are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse. The Philadelphia Urban ACE Study surveyed almost 2,000 Philadelphians in 2012–2013 for urban ACE indicators, one of which was growing up with substance abuse in the household. Among the findings was data that almost 40 percent of Philadelphians surveyed experienced greater than or equal to four ACEs and approximately 35 percent grew up with substance abuse in their household.[22]

Substance use becomes increasingly likely across adolescence, with rates peaking among people in their twenties, and declining thereafter. Youth and young adults are especially at risk. The majority of people with a substance use disorder started using substances during adolescence. Using substances during adolescence or young adulthood affects brain development which is not complete until a person reaching their mid-twenties. About three quarters (74 percent) of 18- to 30-year-olds admitted to substance use disorder treatment programs began using substances at the age of 17 or younger.[23]

NEONATAL ABSTINENCE SYNDROME

In Philadelphia, the rate of NAS increased more than three-fold from 2002 to 2015.

IMPACT ON THE CRIMINAL JUSTICE SYSTEM

People with substance use disorder interact with the criminal justice system in many ways. Prevalence of substance use disorder is higher among prison populations than among the general population.[24] Incarceration itself is also a risk factor for developing substance use disorder.[25] The Philadelphia Drug Treatment Court, established in 1997,[26] seeks to address some of these underlying causes of crime by directing some people to substance use disorder treatment instead of incarceration.

Substance use disorder in the criminal justice system

The Philadelphia Department of Prisons processes over 30,000 individuals for intake each year, averaging over 6,000 people per day. The incarcerated population has significant disease burden, including about 40 percent who participate in behavioral health treatment (primarily pharmacologic care), 17 percent who are seriously mentally ill, 14 percent who have Hepatitis C and three percent who are HIV positive. The Department of Prisons does not test for drug use on admission, but can estimate drug use among its population based on a 2014 study. Seventy-four percent of inmates tested positive for use of one or more drugs on admission to jail. Of those who tested positive for drug use, 14 percent tested positive for opioids (15 percent of females tested and 12 percent of males tested).[27]

The Department of Prisons generally does not initiate medication for individuals with opioid use disorder, although inmates who are already receiving methadone in the community can continue to receive it while incarcerated. However, pregnant women with opioid use disorder are started on methadone for the duration of their pregnancy. Together, about 300 inmates receive methadone in the prison system annually. In March 2017, the prison started maintaining inmates with opioid use disorder who enter prison on prescribed buprenorphine.

Beyond medication-assisted treatment, the Department of Prisons offers withdrawal management support (commonly referred to as detoxification or detox) and enrollment in its cognitive behavioral therapy treatment program, called Opportunities for Prevention and Treatment Interventions for Offenders Needing Support (OPTIONS). The Department of Prisons provides withdrawal management about 8,000 times annually; in the second half of 2016, about two-thirds of withdrawal management admissions included opioids. About 1,500 people also participate in substance use disorder counseling annually through the OPTIONS program. The risk related to withdrawal management in prison is that upon release into the community where opioids are widely available, inmates who participate in withdrawal management will experience reduced tolerance to opioids, and so are at greater risk for overdose. Resources to increase access to medication-assisted treatment during incarceration would address some of these risks for overdose, and have the broader benefit of enabling people to begin treatment while incarcerated.

WITHDRAWAL MANAGEMENT

The Department of Prisons provides withdrawal management about 8,000 times annually.

Incarceration history among people with substance use disorder

The prevalence of psychiatric disorders, including substance use disorder, is higher among inmates than in the general population. Early-onset substance use disorders increase risk of incarceration due to tendency to engage in drug-related criminalized behavior.[28] Substance use disorders that co-occur with other serious mental illness also increase likelihood of arrest for nonviolent or drug-related offenses.[29] In addition, incarceration may lead to onset of psychiatric disorders, including substance use disorders, due to challenges encountered during incarceration and post release.[30] In Philadelphia, of the 3,172 people who died of an unintentional drug overdose during 2010–15, 782 (25 percent) were incarcerated in the Philadelphia Department of Prisons at least once during the same time frame.[31]

Role of the Philadelphia Treatment Court

Philadelphia Treatment Court is a Municipal Court that addresses cases for the drug-involved criminal justice population. The court is designed to treat substance use disorder as a root cause of criminal activity, providing an alternative or supplement to normal legal proceedings. Treatment Court can offer post-plea deals that deliver a network of treatment and supportive services (such as recovery housing, vocational training, and employment placement) according to the needs of the participant. If appropriate, medication-assisted treatment (MAT) and trauma counseling is provided.[32]

Over twenty years, Philadelphia Treatment Court has enrolled more than 4,800 participants and has successfully graduated more than 3,100 participants. In the past five years, 890 participants have been accepted to Treatment Court, representing 74 percent of all referrals.

Treatment Court accepts individuals with primary diagnoses of substance use disorder who have been charged with nonmandatory felony drug offenses and have less than two nonviolent prior convictions. Self-reported opioid use among Treatment Court participants has increased from approximately 22 percent in 2015 to 37 percent as of March 2017.[33]

Most Treatment Court participants complete the program and are not convicted of another crime within a year of graduation. In 2016, 78 percent of participants successfully completed Treatment Court. Recidivism is low for all crimes (about 32 percent three years after last contact), but particularly for drug-related charges (18 percent three years after last contact).[34] Treatment courts have shown reduced recidivism when compared to traditional adjudication for drug offenders, reducing rates of re-arrest and re-conviction by approximately 6 percent to 26 percent.[35] However, Treatment Court cannot currently serve all of the people who could benefit from the program due to limited resources.

ACTIONS TAKEN BY DBHIDS IN RESPONSE TO THE OPIOID EPIDEMIC

- ☑ Required all halfway houses to accept individuals on all forms of medication-assisted treatment and psychiatric medications to decrease discrimination and increase access to this important treatment (effective June 1, 2017)
- ☑ Expanded the use of recovery houses and extended hours of some residential programs to take individuals after 5 p.m. and during weekends
- ☑ Started work on a web-based portal documenting treatment capacity. All residential providers are required to enter their availability daily and DBHIDS staff is assisting individuals directly with placement to improve timely access to treatment services when residential treatment is required
- ☑ Authorized higher levels of care in cases where there is significant or potential medical co-morbidity requiring residential treatment, decreasing delays in access for individuals in need
- ☑ Increased the availability of buprenorphine from approximately 100 slots to over 1,000 at the present time
- ☑ Mandated all opioid treatment programs to offer all forms of medication-assisted treatment, including methadone, buprenorphine and naltrexone in 2017. Three residential sites currently offer buprenorphine inductions and Naltrexone is now available in fourteen outpatient treatment sites and four residential sites.
- ☑ Initiated planning for the development of a 24/7 walk-in center where individuals can receive immediate stabilization in the outpatient setting and get access to further treatment. This center should be operational by the 3rd quarter in 2017.

TREATMENT SERVICES

> In Philadelphia, Community Behavioral Health (CBH) manages publicly funded treatment for mental health and addiction services.

CBH is a non-profit organization that is contracted by the City of Philadelphia and the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) to manage the behavioral health services for Philadelphia Medicaid beneficiaries. The Office of Behavioral Health manages care for uninsured Philadelphia residents.

CBH maintains a network of treatment providers to provide the continuum of care. These treatment providers include 13 opioid treatment programs, 36 residential treatment facilities, six halfway houses, 10 hospitals, five Crisis Resource Centers, one Behavioral Assessment Center, 59 outpatient facilities, 34 intensive outpatient programs, 14 prevention providers, and three drug and alcohol case management providers.

Approximately 25,000 individuals participated in care in Philadelphia's publicly funded drug and alcohol treatment system in 2016, 14,000 of whom received treatment for opioid use disorder. Eighty-four percent of these individuals received treatment not only for their addiction, but also for a co-occurring mental health diagnosis.[36]

Among uninsured Philadelphians, 27% reported heroin to be their preferred drug when being admitted to a treatment program in 2015, an increase from 17.6% in 2011. Consistent with the overall burden of opioid use disorder in Philadelphia, uninsured adults admitted to treatment programs for opioid use disorder are predominantly non-Hispanic whites, men and ages 26–44 years.

Across the public and private health care systems, thousands of Philadelphia residents receive medication-assisted treatment for opioid use disorder. Medication-assisted treatment, in which patients participate in counseling in addition to Federal Drug Administration (FDA) approved medications for opioid use disorder, has been shown to be effective in reducing illicit opioid use. Medication-assisted treatments (including methadone, buprenorphine and extended-release naltrexone) for opioid use disorder are considered evidenced based, and are supported as essential to treatment by multiple professional agencies, including the National Institute on Drug Abuse, Substance Abuse and Mental Health Services Administration, the National Institute on Alcohol Abuse and Alcoholism, Centers for Disease Control and Prevention, the American Academy of Addiction Psychiatry, the American Medical Association and the National Council. Multiple studies have proven that medication-assisted treatments in combination with psychosocial treatment are effective in reducing mortality, lessening illicit opioid use, increasing retention in treatment, lowering criminal justice consequences of substance use and diminishing overall health care and societal costs. While MAT for substance use disorders has been available for many years, SAMHSA reports that numerous studies have shown that MAT is grossly underused and access to MAT remains limited.[37]

In Philadelphia, increasing the availability and use of all forms of medication-assisted treatments (including methadone, buprenorphine and extended-release naltrexone), in conjunction with other forms of treatment is paramount. Across the public and private health care systems, thousands of Philadelphia residents participate in medication-assisted treatment for opioid use disorder. Nonetheless, despite the strong evidence to support the use of medication-assisted treatments in helping individuals with opioid use disorder, these are significantly underutilized due to stigmatization, regulatory barriers, as well as a lack of knowledge about them among treatment professions, prescribers and the community. Methadone remains an important medication-assisted treatment for opioid use disorder, with 13 clinics receiving city funding. In 2016, almost 6,000 individuals received methadone in conjunction with other treatments for their opioid use disorder. Treatment availability of other important forms of medication-assisted treatments, including buprenorphine and extended-release naltrexone, was also increased in 2015 and 2016.

While challenges exist, there is potential for the use of medication-assisted treatments to greatly expand in Philadelphia throughout the public and private behavioral health treatment system and in all medical settings where individuals present. Unlike methadone, which must be dispensed from licensed facilities when treating opioid use disorder, extended-release naltrexone and buprenorphine can be prescribed in primary care clinics and other medical settings. For these settings to be successful, however, policies, programs, and education to support and promote the use of medication-assisted treatments are needed at all levels of the health care system. Individuals with opioid use disorder may find themselves dissuaded from engaging in medication-assisted treatment by stigma, misinformation, and policies in their selected treatment settings, and these types of barriers need to be addressed to better serve the public.

CBH NETWORK OF TREATMENT PROVIDERS

RECOMMENDATIONS

Strategy 1: PREVENTION AND EDUCATION

Despite the magnitude of the opioid epidemic in Philadelphia, public awareness is low about the dangers of opioids and the need to recognize, intervene, and support people who may be opioid dependent. In addition, doctors and other prescribers still prescribe too many opioids. This strategy area focuses on developing recommendations to change behaviors around use of prescription opioids, including through mass media campaigns, education for doctors and other prescribers and insurance policies, as well as recommendations to increase public awareness about how to help people with opioid use disorder. Addressing stigma will be a core part of making prevention and education efforts successful, but also will ease the entire task of combatting the city's opioid epidemic.

1 Conduct a consumer-directed media campaign about opioid risks.

The City should implement a comprehensive, consumer-directed media campaign about the dangers of opioids, which addresses specific populations along the developmental life course (adolescents, young adults, adults, parents) and reflects the diversity of Philadelphia. The campaign should educate consumers about other ways to treat pain. It should also be available in multiple languages.

Prescription opioid pain medication continue to be prescribed at high rates, both nationally and in Philadelphia. However, the risks associated with these medications are poorly understood by the general public. Because these medications are prescribed by physicians and other health care providers, people who use them—both medically and recreationally—often perceive prescription opioids as safe or at least less dangerous than illicit drugs, such as heroin. In addition, a national survey indicated that more people blame prescription opioid misuse on individual behavior (such as lack of self-discipline) than on external factors such as physician prescribing.[38]

Large national studies have shown that nonmedical use of prescription opioid pain medication can begin as early as middle school.[39] However, many people also begin use of opioid pain medication when they are older and have been prescribed it by a health care provider for acute pain. Media campaigns have been effective in changing behaviors around other substances, including in preventing initiation of tobacco use among young people and increasing cessation of tobacco use among people of all ages.[40] A broad consumer-directed media campaign is needed to ensure the diverse adult population in Philadelphia is aware of the inherent risks of opioids.

2 Conduct a public education campaign about naloxone.

The City should launch a citywide public education campaign to increase knowledge, use, and access to naloxone, including awareness of legal protections (Good Samaritan law), awareness of statewide medical standing order, and availability of naloxone through various venues. The campaign should also be available in multiple languages.

Naloxone is a potentially life-saving medication that reverses opioid overdoses, including those from heroin and fentanyl. It can easily be given by people who are not medical professionals, and due to a statewide "standing order" issued by Pennsylvania's physician general, it can be obtained by any Pennsylvanian without the need for an individual prescription. However, many people are not aware of what naloxone is or how to access it. Evidence from Massachusetts shows that community-based overdose education and naloxone distribution programs are effective at reducing fatal overdoses.[41]

> **Community-based overdose education and naloxone distribution programs are effective at reducing fatal overdoses.**

3 Destigmatize opioid use disorder and its treatment.

The City should conduct public education to raise awareness about opioid use disorder as a chronic medical condition and to reduce the stigma of treatment for opioid use disorder. This effort should recognize it as affecting everyone in Philadelphia, and use existing programs and people with lived experiences to conduct individual and family education in multiple languages and targeted at specific populations. Because stigma is a major barrier to siting new services, the City should also partner with City Council, civic groups, and neighborhoods to plan for new treatment programs and recovery support services in key areas.

The stigma surrounding both drug use and treatment often prevents individuals and families from seeking help. Demeaning words such as "addict" and "junkie" and other depictions of drug users perpetuate the belief that a substance use disorder is a moral failing. Public education is needed to reframe the discussion such that a substance use disorder is seen as a chronic medical condition for which effective treatments are available.

The City should partner with existing organizations across Philadelphia who engage different populations and communities and who can help disseminate this message. Educational programs should employ peers and people with lived experiences, and should be able to connect people to treatment resources.

> **The stigma surrounding both drug use and treatment often prevents individuals and families from seeking help.**

4 Improve health care professional education.

Health care professional schools and provider organizations should require and have standards for broad, interdisciplinary competency-based training for all levels of health care professionals on pain, pain management and substance use disorder, and support evidence-based approaches that change behavior of doctors and other prescribers when combined with education, including prescriber detailing, outreach programs, and tailored small group learning. The City should continue to convene professional schools and provider organizations to discuss these efforts and encourage them to share their curricula on pain, pain management, and addiction.

Health care professionals have historically received limited education on substance use disorders. National survey data suggest that about half of primary care physicians are "very" concerned about the risk of substance use disorder or death related to opioid use, but fewer are concerned about other adverse effects, including tolerance, impaired cognition, and sedation.[42] Most physicians surveyed indicated that they are "moderately" or "very" confident in their clinical skills related to opioid prescribing, though this may reflect cognitive biases. These findings suggest that while physicians may be confident in their prescribing, they may not be fully aware of the range of risks associated with opioid use.

In recent years, education of health care professionals has increased attention to pain and opioid prescribing for pain. While medical schools are expanding curriculums to include pain, pain management, and substance use disorders, such education needs to be expanded to all health care professionals, including dentists, pharmacists, physical therapists, counselors and social workers. Professional schools, training programs, and health systems can adopt standards for such interdisciplinary education.

While education is necessary, alone it is unlikely to change provider prescribing behaviors, particularly among established clinicians. In order to reduce the liberal prescribing of opioid pain medication, the City should support evidence-based approaches to changing prescribing behavior. In 2015, the New York City health department conducted an academic detailing program on judicious opioid prescribing in Staten Island that showed a reduction in the prescribing of high-dose opioids.[43]

5 Establish insurance policies that support safer opioid prescribing and appropriate treatment.

Public and private insurers should

1) *require prior authorizations for opioid prescriptions;*
2) *increase access to alternative pain treatments;*
3) *make all FDA-approved medications in addiction treatment readily accessible; and*
4) *improve coordination of care by reducing the separation between physical and mental health services.*

Even as awareness of the opioid use epidemic has risen among health care providers, many continue to prescribe too many opioids, which suggests that provider education will be insufficient to change prescribing behavior. However, prescribing behavior can be altered through health insurer policies. In Massachusetts, when a commercial insurer implemented robust opioid policies that included a prior authorization requirement for new opioid prescription, the prescribing of short-acting opioids decreased by 16 percent.[44]

Additionally, health insurers have the opportunity to expand access to treatment for individuals already affected by opioid use disorder. This may be accomplished through the lowering of insurance barriers to medication-assisted treatment (including buprenorphine and extended-release naltrexone) and alternative pain treatments, and greater coordination of care between physical and mental health providers. Beyond lowering coverage barriers, insurers and managed care entities should develop disease management programs to achieve increases in the rates of identification and engagement of patients with opioid use disorder. The City cannot legally require insurers to make these changes, but can and should convene and urge them to do so.

Strategy 2: TREATMENT

Many barriers impede access to quality treatment for substance use, including a shortage of sites that provide medication-assisted treatment, gaps in services for special populations, restrictive hours of operation, antiquated treatment modalities, requirements of clients for state-issued identification cards, housing issues, workforce limitations, and the separation of behavioral health treatment from physical health care.

6 Increase the provision of medication-assisted treatment.

The City and substance use disorder treatment provider organizations should vigorously continue its efforts to increase the provision of medication-assisted treatment (MAT) in all forms as standard practice, and facilitate referral and/or provision of MAT at multiple sites including emergency departments, halfway houses, outpatient practices, residential treatment facilities, psychiatric facilities, medical facilities, primary care sites and prisons. All consumers should be offered all options of treatment available to them, including all FDA-approved versions of MAT. Treatment programs should introduce these agents and offer both agonist and antagonist medications, within the treatment program. Integrating MAT into all treatment settings will ease patients' burden of navigating the complex treatment system. All regulatory barriers to the use of MAT should be identified and reduced.

MAT is considered as a vital evidence-based treatment by numerous national professional organizations, as referenced previously in the Treatment Services section.

All consumers should be offered all options of treatment available to them, including all FDA-approved versions of medication-assisted treatment.

7 Expand treatment access and capacity.

The City should

1) *increase the number of sites in the city offering addiction treatment services;*
2) *expand weekend and evening operations for facilities at multiple levels of care;*
3) *identify gaps in substance use disorder treatment capacity for special populations and increase capacity of treatment slots and providers to engage these populations at all levels of care;*
4) *partner with the state to resolve identification issues that are barriers to accessing treatment;*
5) *create a web-based database for the general public and provider access to identify available treatment slots in real time;*
6) *integrate information on how to access treatment into public education campaigns;*
7) *expand the capacity of crisis centers and emergency departments in Philadelphia to assess and treat individuals with opioid use disorder;*
8) *improve the quality of assessments for individuals entering treatment by adopting ASAM Criteria; and*
9) *increase the use of peer recovery specialists to support individuals in their recovery throughout behavioral health and medical settings.*

An increase in sites offering addiction treatment services should include providers within the behavioral health treatment system as well as medical providers, early intervention programs, and important recovery support programs. Public education campaigns should emphasize all levels of care where individuals can access treatment, including outpatient and other nontraditional settings.

A requirement for determining treatment need is a multidimensional assessment. The adoption of the state of Pennsylvania of the American Society of Addiction Medicine Criteria and its requirement for utilization review purposes by the U.S. Centers for Medicare and Medicaid Services is an opportunity for the system to upgrade and standardize the assessment of patients' needs and outcomes.

It has been known for many years that the "treatment gap" is massive—that is, among those who need treatment for a substance use disorder, few participate in it.[45] The Drug Enforcement Agency and National Survey on Drug Use and Health estimated that there are between 122,000 and 150,000 Philadelphians in need of substance use disorder treatment.

The Drug Enforcement Agency and National Survey on Drug Use and Health estimated that there are between 122,000 and 150,000 Philadelphians in need of substance use disorder treatment.

8 Embed withdrawal management into all levels of care, with an emphasis on recovery initiation.

The City should require all substance use disorder treatment providers at every level of care to begin offering withdrawal management and place greater emphasis on developing comprehensive treatment approaches to increase the likelihood of continued engagement in treatment. Individuals who enter programs for withdrawal management should receive a comprehensive evaluation of potential psychiatric, medical and psychosocial complications, and informed consent around the evidence base for medication-assisted treatments (MAT). All individuals should be evaluated for the appropriateness of MAT, and programs should offer all forms of MAT or be able to link individuals to them. Integrated services within programs should include treatment of psychiatric disorders since the majority of individuals seeking treatment for substance use disorders have a co-occurring psychiatric diagnosis. Treatment facilities will also need to be able to address other substance use disorders that may be co-morbid with opioid use disorder. Psychosocial treatment and engagement of peer supports should be provided as early as possible to combine other evidenced based practices with MAT.

The current practice of detoxification programs as isolated levels of care and siloed programs, as well as being considered the major treatment entry point for individuals with opioid use disorder, is inconsistent with current evidenced based practice. Multiple individuals are entering detoxification alone without any continued engagement in treatments and other recovery support services. Individuals who receive detoxification alone without other treatments including evidenced-based MAT (agonist or antagonist) are at greater risk of relapse and death from overdose. According to ASAM criteria, withdrawal management is a medical intervention which can be offered in every level of care ranging from outpatient to hospital based services, so that the emphasis is placed on recovery initiation and engagement in sustained treatment. The emphasis on entry into detoxification programs also creates an unnecessary strain on the perceived availability of treatment slots. Expanding access to withdrawal management across the treatment system will reduce perceived unavailability of treatment slots.

9 Implement "warm handoffs" to treatment after overdose.

The City should ensure that people experiencing nonfatal overdoses revived in the field or in emergency departments have unfettered access to services including dedicated centralized coordinators, peers, removal of financial/ insurance barriers until services can be identified, and use of MAT as bridge. Hospitals and behavioral health providers should create systems and protocols for warm handoffs from emergency departments to treatment providers. This "warm handoff" starts with appropriate MAT induction in emergency departments and a take-home supply of medication.

A lack of coordination in response to nonfatal overdoses places those needing help at risk. Individuals who are discharged from emergency medical care following an opioid overdose have an increased risk for repeat overdoses.[46] MAT induction and care coordination in emergency departments would provide immediate access to treatment and resources.

Emergency departments throughout the city should develop protocols to induct individuals on buprenorphine when clinically appropriate, and should explore the development of hospital based urgent care clinics to provide immediate access to individuals needing stabilization with the goal of linkage to longer term treatments.

Hospitals and behavioral health providers should create systems and protocols for warm handoffs from emergency departments to treatment providers.

10 Provide safe housing, recovery, and vocational supports.

The City should work with other systems and elected officials to increase safe permanent supportive housing, recovery houses, vocational support, and recovery support services for individuals with substance use disorders, eliminate barriers to longer retention at treatment facilities, and eliminate housing discrimination against individuals enrolled in medication-assisted treatment and special populations. This expansion should include support for youth and young adults through recovery high schools and collegiate recovery infrastructure.

There is a shortage of safe housing and vocational supports to facilitate healthy and positive outcomes for individuals with substance use disorders. Without a safe, affordable place to live, it is almost impossible to achieve good health or to achieve one's full potential. Individuals with substance use disorders can be particularly vulnerable to becoming homeless or being precariously housed.[47]

Recovery support services empower individuals with substance use disorders to direct their own recovery. These support services are essential for special populations. NIMBY is a major barrier to siting new treatment programs and engagement of elected officials will be a necessary strategy. DBHIDS' recent policy changes for halfway houses, recovery houses and residential treatment programs support these objectives, but additional action is needed.

> **Recovery support services empower individuals with substance use disorders to direct their own recovery.**

11 Incentivize providers to enhance the quality of substance use disorder screening, treatment, and workforce.

The City should develop strategies to

1) *increase capacity and competency of non-substance use disorder (SUD) professionals in health care and other social services to identify SUDs and work with them and*
2) *incentivize qualified staff to work in the SUD workforce using the most current and supported evidence-based practices and requiring continuing education:*
    a) *incentivize a specialization in SUD Treatment,*
    b) *develop a standardized, uniformed, and mandatory training that will increase effectiveness across all SUD treatment providers,*
    c) *incorporate holistic offerings and alternative therapies into the scope of SUD treatment,*
    d) *develop city-wide standard rigorous training for certified recovery specialists and certified peer specialists and incorporate peers across private and public systems.*

The broader health care workforce does not have the capacity for integrated health care and is undertrained to deal with issues related to SUDs. Non-SUD professionals within health care and other social services (such as child welfare and criminal justice) need basic SUD competency so that SUD screening can take place outside of the formal treatment system. The SUD workforce shortage is exacerbated by the scarcity of providers who can provide culturally competent services to minority populations, a very high turnover rate, and recruitment challenges. As of June 2016, more than three-quarters of United States counties had severe shortages of psychiatrists and other types of health care professionals needed to treat mental health and SUDs.[48]

> **The broader health care workforce is undertrained to deal with issues related to substance use disorders.**

Strategy 3: OVERDOSE PREVENTION

Not all opioid users are able and willing to begin drug treatment. Until those persons do begin treatment, actions can be taken to increase use of health and treatment services and reduce fatalities, non-fatal overdoses, and the infectious complications (HIV, hepatitis B and C, infections) of drug use.

12 Expand naloxone availablity.

The City should develop a strategic plan to make naloxone readily available to reverse opioid overdoses. The plan should engage governmental agencies, community-based organizations, health care providers, pharmacies, and private citizens who may know individuals using opioids. The plan should prioritize supporting naloxone programs and activities that have the greatest likelihood of achieving overdose reversals.

Although many health care professionals and emergency services personnel are experienced in administering naloxone, laypeople can also be successfully trained to identify and respond to overdose. Use of naloxone by laypeople has been linked to reductions in overdose death rates. People who use opioids are at greatest risk of overdose, and are also motivated to protect themselves and others around them.

Naloxone should be readily available and/or administered to persons at risk of overdose through four major mechanisms:

1) governmental and quasi-governmental agencies, such as Fire, Police and Homeless Outreach;
2) harm-reduction programs;
3) take-home programs, including from hospital emergency departments, prison discharge, and opioid treatment programs; and
4) direct request at pharmacies.

The City should support the purchase of naloxone with public funds for specific distribution in supported programs. Because resources may limit ability to provide all persons and agencies with naloxone, the City should strategically select those who are most likely to encounter overdose victims. Distribution of naloxone has expanded in the city with some government and philanthropic investment, but additional distribution is needed.

All naloxone distribution programs should include specific training on recognition of overdose, administration of naloxone, treatment service availability, and other harm reduction messages.

13 Further explore comprehensive user engagement site(s).

The City and/or partner organizations should further explore the possibility of implementing one or more comprehensive user engagement sites (CUES), on a pilot basis, in which essential services are provided to reduce substance use and fatal overdose (including referral to treatment and social services, wound care, medically supervised drug consumption, and access to sterile injection equipment and naloxone) in a walk-in setting.

Safe consumption facilities (SCF) have a long record of success in reducing the health and social harms of drug use among persons injecting heroin and other opioids. SCFs have been in operation since 1988, beginning in Europe and extending to Australia and Canada. They have been shown to:

- Reduce overdose death, disease transmission (including HIV, hepatitis C, and hepatitis B), injection-related infections, and other adverse health outcomes associated with drug use.[49]
- Serve as an access point for drug and alcohol treatment, medical services, social services, and housing services that in turn reduce the burden on the Emergency Departments, Police and Fire.[50]
- Improve public order and neighborhood safety by reducing public drug consumption and improper disposal of drug use equipment.[51]

The continuing rise in opioid overdose, now driven in part by highly dangerous fentanyl products, has brought new salience to safe consumption as a potentially valuable intervention in the U.S. Seattle-King Country's overdose task force has recommended the opening of several facilities providing safe consumption and other services, and other U.S. cities hit hard by overdose are also considering the move. Deploying CUES in Philadelphia will require a serious process of planning and community engagement to fully assess the value proposition and secure public acceptance. In addition, there are serious legal impediments that would need to be addressed. The pilot program should be rigorously evaluated for health and community outcomes to guide future decisions on continuation or expansion.

14 Establish a coordinated rapid response to "outbreaks."

The City should develop a strategy for identifying (in real time) and responding to significant surges in the number of opiate overdoses ("outbreaks") in a non-coercive manner. The strategy should aim to prevent additional overdoses by increasing situational awareness, improving deployment of resources, and enhanced treatment services.

Illicit opioids often are mixed with harmful adulterants (for example, fentanyl and its analogs blended with or deliberately substituted for heroin or mixed with opioid analgesic combinations). Resultant outbreaks of fatal and nonfatal overdoses may impact opioid experienced or inexperienced individuals. The explosive occurrence of multiple overdoses should trigger a rapid response by public safety and medical communities to identify the substance and its source. Local agencies should respond to gather additional information, alert the public, confine the outbreak, and save lives where possible.

15 Address homelessness among opioid users.

The City should expand outreach and specialized programs to meet the unique needs of individuals with opioid use disorder who are homeless, such as the City's Safe Haven, Journey of Hope, and Housing First programs.

Housing First provides access to housing for homeless individuals without restriction for those suffering from substance use disorder. This strategy has been proven to reduce homelessness, shelter costs, and health care costs through emergency department utilization. In addition, it increases substance use disorder and mental health treatment among its participants.[52] Housing First has been used successfully in many cities across the United States and Canada, including in Philadelphia.

Strategy 4: # INVOLVEMENT OF THE CRIMINAL JUSTICE SYSTEM

Individuals in the justice system continuum, from arrestees to sentenced prisoners, with OUD who are not participating in adequate treatment services constitute a particularly risky population.[53] A change to a public health approach within the justice system is urgently needed,[54] however, members of the Justice System, Law Enforcement, and First Responders subcommittee reported systemic barriers and gaps in programming, resources, and training which must be addressed in Philadelphia to enable implementation of an evidence-based public health strategy.

16 Expand the court's capacity for diversion to treatment.

The City should collaborate with the court system, the District Attorney's office, the Defenders Association, and treatment providers to expand existing court-sanctioned treatment programs to increase capacity, including but not limited to Drug Treatment Court and the Accelerated Misdemeanor Programs.

Drug Treatment Court allows defendants with SUDs who are charged with nonviolent felony offenses an opportunity to participate in treatment and avoid conviction. The Accelerated Misdemeanor Programs (AMP 1 and AMP 2) are diversion programs that expedite the resolution of misdemeanor charges by allowing substance-using offenders to engage in treatment and avoid conviction. Across the United States, integration of court monitoring with clinical OUD care that includes MAT has achieved remarkable success rates, for both public health and public safety. At present, the number of participants is capped due to limited resources.

The judicial intervention of diverting offenders to treatment programs has been extensively studied, and can reduce recidivism, increase abstinence in closely supervised offenders, and improve retention in treatment. Philadelphia's system is cited as a best practice model by the National Association of Criminal Defense Lawyers.

The judicial intervention of diverting offenders to treatment programs... can reduce recidivism, increase abstinence in closely supervised offenders, and improve retention in treatment.

17 Expand enforcement capacity in key areas.

Federal, state and local law enforcement agencies should

1) *expand capacity for investigating those who divert prescription opioids, focusing on pharmaceutical companies and opioid prescription abuse by registrants, recognizing that there are DEA regulatory sanctions as well as state and federal criminal penalties that can be levied against registrants involved in the illicit distribution of prescription opioids; and*
2) *take action against drug dealers who prey on people trying to recover at clinics and treatment facilities.*

Philadelphia is following recommended best practices with regional coordination through the High-Intensity Drug Trafficking Area program and DEA 360 strategy; however, additional staffing resources are needed for complex investigations.[55] Federal funding may be available to leverage local funding for high-level investigation and interdiction.

18 Provide substance use disorder assessment and treatment in Philadelphia Department of Prisons.

The Philadelphia Department of Prisons should provide substance use disorder assessment to all inmates upon entry and comprehensive treatment during incarceration, with a continuum of care plan upon release, which includes a plan to obtain an identification card to facilitate treatment.

Treatment during incarceration increases the likelihood of engagement in treatment post-incarceration and correlates with positive outcomes such as reduced recidivism, increased abstinence, and decreased overdose morbidity in the weeks immediately after release.

In a well-designed study,[56] inmates who participated in medication-assisted treatment (MAT) during incarceration were more than twice as likely to engage in treatment upon re-entry than the control group. A large, multi-site study that included patients in Philadelphia found similar benefit for MAT in patients on parole or probation.[57] SAMHSA also recommends provision of MAT in jails.[58]

> **... inmates who participated in medication-assisted treatment during incarceration were more than twice as likely to engage in treatment upon re-entry,**

IMPLEMENTATION

This report makes 18 recommendations that together have the potential to turn the tide on the opioid epidemic in Philadelphia. However, the City will succeed only if a large number of organizations and individuals referenced in the recommendations implement these changes. The participating city government agencies that report to the mayor are committed to implementing these recommendations to the extent that resources and legal authority allow. The members of the Task Force strongly encourage all other organizations and individuals referenced in these recommendations do the same.

Implementation of these recommendations will require many actions steps, which will be more likely to occur if progress is reported publicly. The Task Force therefore recommends that governmental and nongovernmental entities charged with implementing specific recommendations report on their progress regularly to an appropriate oversight body. The Task Force co-chairs will work with the mayor to establish the body responsible for this oversight and the systems for reporting to this group.

MONITORING AND EVALUATION

In addition to monitoring progress around implementation, the City should increase its data collection and analysis efforts around key opioid use and overdose trends. The Data Analysis and Sharing subcommittee of the Task Force specifically reviewed city agencies' existing efforts to quantify and track the opioid epidemic, and made the following recommendations for how to improve data collection and analysis.

The City should establish a high-level substance use surveillance program that would:

a. *Develop an opioid epidemic data report to establish a baseline and monitor the epidemic;*
b. *Establish use of real-time data to support a rapid response plan;*
c. *Use data matched across departments to identify barriers and opportunities for optimal system interactions with individuals; and,*
d. *Develop an evaluation plan that assesses the progress and impact of actions and interventions undertaken as a result of the Mayor's Opioid Task Force Report.*

In developing this data collection and analysis plan, the data subcommittee drew on examples of effective surveillance programs in other locations. Jurisdictions that have made real and measurable success in addressing the opioid epidemic, such as New York City, Baltimore, and Rhode Island, have established surveillance programs within their local and state health departments. A permanent program with an organizational structure that is modeled on the structure of other "disease"-specific program areas within Philadelphia's health department would help ensure that the city remains accountable for the recommendations it puts forth and remains sustainable over the long term.

In the interim, the Data Analysis and Sharing subcommittee also produced a set of core metrics to monitor progress on the opioid epidemic (see table below). These metrics will be tracked on a quarterly basis. In addition, a draft list of metrics to evaluate Philadelphia's progress in implementing these recommendations is in Appendix IV.

METRIC
Opioid prescription rate per 1,000 population*
Buprenorphine prescription rate per 1,000 population*
Behavioral health treatment rate for patients with a primary diagnosis of opioid use disorder*
Medication-assisted treatment rate for patients with a primary diagnosis of opioid use disorder*
Doses of naloxone distributed
Doses of naloxone administered by first responders
Fatal overdoses
Nonfatal overdoses

** Medicaid-enrolled patients only*

APPENDIX I: GLOSSARY OF TERMS

12-Step Program: Group providing mutual support and fellowship for people recovering from addictive behaviors. Alcoholics Anonymous, the first 12-Step program was founded in 1935; an array of 12-step groups following a similar model have since emerged and are the most widely used mutual aid groups for maintaining recovery from substance use disorders. It is not a form of treatment.

Adverse Childhood Experience (ACE): Stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse.

American Society of Addiction Medicine (ASAM) Criteria: The ASAM treatment criteria provide separate placement criteria for adolescents and adults to create comprehensive and individualized treatment plans. Patients are assessed for treatment needs, obstacles, and liabilities as well as their own strengths, assets, resources, and support structure. Treatment plans are developed to cover five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided and the intensity of treatment services provided.

Benzodiazepines: A class of drugs primarily used for treating anxiety; also known as tranquilizers (e.g., Valium, Xanax).

Buprenorphine: Generic name of Suboxone, a treatment medication for opioid use disorder used in medication-assisted treatment.

Cognitive Behavior Therapy (CBT): CBT is a time-sensitive, structured, present-oriented psychotherapy directed toward solving current problems and teaching clients skills to modify dysfunctional thinking and behavior.

Certified Recovery Specialist (CRS): The CRS credential is for drug and alcohol peers in recovery who have been trained to help others move into and through the recovery process. Candidates must attest that he/she has personal, lived recovery experience in a continuous manner for a minimum of 18 months to be eligible.

Certified Peer Specialist (CPS): A person willing to self-identify as having a serious behavioral health condition (mental illness or co-occurring disorder) with lived experience. To be certified, the person must have received specific training in the role, functions, and skills of the CPS position. The purpose of a CPS is to support others in their recovery process.

Diversion: A voluntary, judicial intervention which provides an alternative to criminal-case processing for a defendant charged with a crime related to their substance use disorder (SUD); ideally, upon successful completion of a program /plan, diversion results in a dismissal of the charge(s).

Fentanyl: A synthetic, short-acting opioid analgesic with a potency 50 to 100 times that of morphine. Fentanyl carries a high risk of overdose. These drugs are sold illicitly for their heroin-like effects and may be mixed with heroin and/or cocaine as a combination product, with or without the user's knowledge. The biological effects of fentanyl are indistinguishable from those of heroin. Overdoses involving fentanyl increased six-fold from 2013 through 2015.

Implications: A higher dose or multiple doses of naloxone may be required to revive patients with overdoses involving fentanyl. Patients presenting to emergency departments with symptoms of opioid intoxication may be unaware that they have taken fentanyl. Providers should be mindful that fentanyl is not detected by standard urine toxicology screens.

Heroin: An opioid drug that is synthesized from morphine, a naturally occurring substance extracted from the seed pod of the Asian opium poppy plant. Heroin is a full opioid agonist.

Integration: The systematic coordination of general and behavioral health care. Integrating services for primary care and behavioral health together provides the most effective approach for supporting comprehensive health and wellness.

Intervention: A professionally delivered program, service, or policy designed to prevent substance misuse (prevention intervention) or treat a substance use disorder (treatment intervention).

Medication-Assisted Treatment (MAT): The use of medication in combination with therapy to treat substance use disorders.

Methadone: A medication used in medication-assisted treatment for opioid use disorder.

Naloxone hydrochloride: Generic name for the opioid overdose antidote; known as naloxone.

Naltrexone: Also known as Vivitrol®. A medication used in medication-assisted treatment for opioid-use disorder.

NIMBY: The acronym for "not in my backyard", which is used to express opposition by local citizens to the locating in their neighborhood of a civic project, such as a treatment program. Although needed by the larger community, it is considered unsightly, dangerous, or likely to lead to decreased property values.

Office of Mental Health and Substance Abuse Services (OMHSAS): The OMHSAS is an agency within Pennsylvania's Department of Human Services that is responsible for the mental health and substance abuse service system for the entire state of Pennsylvania.

Opioid: A compound or drug that binds to receptors in the brain involved in the control of pain and other functions, for example, morphine, heroin, fentanyl, hydrocodone, and oxycodone.

Opioid Treatment Program (OTP): SAMHSA-certified program, usually comprising a facility, staff, administration, patients, and services, that engages in supervised assessment and treatment, using methadone, buprenorphine, or naltrexone, of individuals who have opioid use disorders. An OTP can exist in a number of settings, including but not limited to intensive outpatient, residential, and hospital settings. Services may include medically supervised withdrawal and/or maintenance treatment, along with various levels of medical, psychiatric, psychosocial, and other types of supportive care.

Opioid Use Disorder (OUD): A medical illness characterized by a problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by assessing cognitive, behavioral, and psychological symptoms.

Prescription Drug Misuse: Use of a prescribed medication in any way a prescribing health care provider (including doctors, dentists, nurse practitioners, physician assistants, etc.) did not direct an individual to use it.

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Individuals with severe and chronic substance use disorders can, with help, overcome their substance use disorder and regain health and social function. "Being in recovery" is when those positive changes and values become part of a voluntarily adopted lifestyle. Although abstinence from all substance misuse is a cardinal feature of a recovery lifestyle, it is not the only healthy, pro-social feature.

Relapse: Breakdown or setback in a person's attempt to change or modify a particular behavior; an unfolding process in which the resumption of compulsive substance use is the last event in a series of maladaptive responses to internal or external stressors or stimuli.

Substance Abuse and Mental Health Services Administration (SAMHSA): The SAMHSA is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation.

Screening, Brief Intervention, and Referral to Treatment (SBIRT): A method for early intervention to identify, reduce, and prevent problematic use of and dependence on alcohol and illicit drugs.

Special Populations: Groups of individuals with unique circumstances requiring specific needs and alternate considerations for behavioral health treatment, for example, women, pregnant and parenting women, youth, young adults, LGBTQIA, and Spanish-speaking Latinos.

Substance Use Disorders (SUDs): A medical illness caused by repeated misuse of a substance or substances. SUDs are characterized in the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) by clinically significant impairments in health, social function, and impaired control over substance use and are diagnosed through assessing cognitive, behavioral, and psychological symptoms. Substance use disorders range from mild to severe and from temporary to chronic. They typically develop gradually over time with repeated misuse, leading to changes in brain circuits and executive functions. Severe substance use disorders are commonly called addictions.

Take Home Programs: Under the supervision of doctors and other prescribers, some forms of medication in addiction treatment can be dispensed to enrolled individuals to "take home" in multiple doses for future use as prescribed.

Tolerance: A condition in which higher doses of a drug are required to produce the same effect achieved during initial use; often associated with physical dependence. Alteration of the body's responsiveness to alcohol or a drug such that higher doses are required to produce the same effect achieved during initial use.

Withdrawal: Symptoms that occur after chronic use of a drug is reduced abruptly or stopped. A set of symptoms that are experienced when discontinuing use of a substance to which a person has been dependent or addicted, which can include negative emotions such as stress, anxiety, or depression, as well as physical effects such as nausea, vomiting, muscle aches, and cramping, among others. Withdrawal symptoms often lead a person to use the substance again.

APPENDIX II: SUBCOMMITTEE MEMBERS

PUBLIC EDUCATION AND PREVENTION STRATEGIES

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Randi McKeon
Andrea Stout
Catherine Williams

Recorders

Kelly Boettcher
Mary Figgatt
Lolita Griffin
Natalie Kotkin
Victoria Prisco

APPENDIX III: DETAILS ON TASK FORCE PROCESS

CHARGE FOR MAYOR'S TASK FORCE TO COMBAT THE OPIOID EPIDEMIC IN PHILADELPHIA

The task force met semi-monthly over three months, for a total of six meetings, kicking off with Mayor Kenney on January 11, 2017 and concluding on March 22, 2017. All Task Force Meetings were open for the public to attend. Fifteen minutes were set aside at the end of every Task Force meeting for public comment.

SUBCOMMITTEE CHARGES

The Task Force worked through five subcommittees:
1. Public Education and Prevention Strategies
2. Service Access, Best Practices, and Treatment Providers
3. Overdose Prevention and Harm Reduction
4. Justice System, Law Enforcement, and First Responders
5. Data Analysis and Sharing

Each subcommittee was led by two co-chairs and met five times for two hours, beginning on January 18, 2017 and concluding on March 20, 2017.

The five subcommittees were given the following overall charges, in addition to their specific topics to address:

- All subcommittee recommendations should take into consideration the general diversity of Philadelphia County, e.g., youth, LGBTQIA, pregnant and parenting women, race, ethnicity, gender, and so on.
- All subcommittees will thoroughly understand and analyze the key issues, needs, and priorities of the opioid epidemic as it impacts and relates to their subcommittee area.
- All subcommittees will submit a written report to the Task Force, summarizing their findings related to their specific subcommittee area and providing justification for their recommendations.

COMMUNITY PERSPECTIVES FROM THE LISTENING SESSIONS

Overview

The Task Force held four Community Listening Sessions over two weeks in January and February 2017. The Community Listening Sessions were held at the following locations on the following dates:

1. **Northwest Philadelphia**
   Monday, January 23, 2017
   Resources for Human Development (RHD)
   4700 Wissahickon Ave, 19144

2. **North Philadelphia**
   Wednesday, January 25, 2017
   Prevention Point Philadelphia (PPP)
   2913 Kensington Ave., 19134

3. **South and West Philadelphia**
   Tuesday, January 31, 2017
   Greater Philadelphia Health Action, Inc. (GPHA)
   1401 S 31st St., 19146

4. **Northeast Philadelphia**
   Thursday, February 2, 2017
   Counseling Or Referral Assistance (CORA)
   8540 Verree Rd., 19111

ATTENDANCE

The combined total attendance for all four Community Listening Sessions was 463 community members. On average, 116 people attended each session. Attendees came from all over the city, including at least 42 of Philadelphia's 47 populated zip codes. Of those surveyed, 86 percent of participants have been directly impacted themselves or know someone directly impacted by the opioid epidemic. Eighty four percent of surveyed participants felt they were seriously listened to by city officials and Task Force members on possible solutions to the opioid epidemic.

COMMON THEMES

There were several common themes expressed by attendees at the four Community Listening Sessions, including:

Opioid Prescribing

- Impose harsher restrictions on doctors illegally prescribing opioids
- Improve monitoring of doctors distributing and prescribing opioids

Public Education

- Increase early intervention and education opportunities for at-risk children and populations

Increasing Treatment Access and Availability

- Increase medication-assisted treatment (MAT) for opioid use disorder
- Increase the length of time that individuals remain engaged in treatment
- Increase financial investment from the state in substance use disorder treatment
- Make available innovative alternative treatments for pain management, such as acupuncture and EEG biofeedback

Public Safety

- Establish drug-free communities so persons in recovery do not have to be tempted by drug dealers while participating in or after returning from treatment

Government Coordination and Communication

- Facilitate a partnership between the City and its communities in fighting the opioid epidemic (with emphasis on communication)
- Increase understanding and partnership between the Department of Human Services (DHS) and recovering mothers

APPENDIX IV: COMPILED TASK FORCE METRICS

PREVENTION AND EDUCATION	1	Conduct a consumer-directed media campaign about opioid risks	• Estimated view of campaign messages • People using opioids in previous seven days
	2	Conduct a public education campaign about naloxone	• Estimated view of campaign messages • People trained
	3	Destigmatize opioid use disorder and its treatment	• People reached through community events
	4	Improve health care professional education	• Opioid pills sold
	5	Establish insurance policies that support safer opioid prescribing and appropriate treatment	• Opioid prescriptions • Buprenorphine prescriptions • People with public insurance or uninsured receiving methadone
TREATMENT	6	Increase the provision of medication-assisted treatment	• Publicly insured opioid use disorder clients participating in medication-assisted therapy
	7	Expand treatment access and capacity	• People treated for opioid use disorder in the public behavioral health system
	8	Embed withdrawal management into all levels of care, with an emphasis on recovery initiation	• Facilities using physical health stabilization protocol
	9	Implement "warm handoffs" to treatment after overdose	• Successful warm hand-offs
	10	Provide safe housing, recovery, and vocational supports	• Number of individuals housed that have opioid use disorder
	11	Incentivize providers to enhance the quality of substance abuse disorder screening, treatment, and workforce	• To be developed
OVERDOSE PREVENTION	12	Expand naloxone availiblity	• Doses of naloxone distributed, by agency • Doses of naloxone administered, by agency • Nonfatal drug overdoses treated in hospital emergency departments • Fatal drug overdoses
	13	Further explore comprehensive user engagement sites	• Community impact assessment
	14	Establish a coordinated rapid response to "outbreaks"	• Time from recognition of a surge in non-lethal overdoses to coordinated response
	15	Address homelessness among opioid users	• Individuals with opioid use disorder placed in Safe Havens and Housing First programs
INVOLVEMENT OF THE CRIMINAL JUSTICE SYSTEM	16	Expand the court's capacity for diversion to treatment	• People served by Drug Treatment Court • People in Accelerated Misdemeanor Program
	17	Expand enforcement capacity in key areas	• To be developed
	18	Provide substance abuse disorder assessment and treatment in the Philadelphia Department of Prisons	• Inmates treated for opioid use disorder while incarcerated • Inmates with opioid use disorder released with continuum of care plan

APPENDIX V: ADDITIONAL RECOMMENDATIONS FOR INVOLVEMENT OF THE CRIMINAL JUSTICE SYSTEM (STRATEGY #4)

In order to fully address the issues raised by the Justice System, Law Enforcement, and First Responders Subcommittee, this group wished to provide additional recommendations beyond those described in the main body of the report. These additional recommendations, listed below, complement the Subcommittee's three main recommendations and should be considered as expansions upon those recommendations.

SUBRECOMMENDATIONS FOR:

RECOMMENDATION #16

Expand the court's capacity for diversion to treatment

A. Create Access to Medication-assisted Treatment
Federal, state, and local law enforcement should align policies across the criminal justice system to create access to medication-assisted treatment (MAT) within each sector including jail, probation and parole, drug courts and other diversion programs, and housing programs.

B. Recovery Housing
Identify and address factors that hinder or enhance capacity of quality recovery housing (zoning, regulations, funding) for court referrals.

C. Gender Specific Needs
Federal, state, and local law enforcement must ensure that the appropriate resources are readily available for court referred men and women in need.

RECOMMENDATION #17

Expand enforcement capacity in key areas

A. Protocol Support
Federal, state, and local law enforcement should support law enforcement and fire department protocol changes to ensure that all overdose survivors are transported to sites for proper evaluation as a prelude to entering a continuum of care.

B. Pharmaceutical Representative Licensing
Federal, state, and local law enforcement should enact new laws requiring the licensing of pharmaceutical representatives to ensure practices adhere to ethical and professional standards.[59]

RECOMMENDATION #18

Provide substance use disorder assessment and treatment in the Philadelphia Department of Prisons

A. Cognitive Behavioral Therapy

Federal, state, and local law enforcement should specifically make cognitive behavioral therapy (CBT) available to all inmates.

B. Medication-Assisted Treatment

Federal, state, and local law enforcement should initiate medication-assisted treatment (MAT) in conjunction with community treatment programs during incarceration.

C. Mutual Aid Groups

Federal, state, and local law enforcement should create additional Mutual Aid Groups, such as Narcotics Anonymous, Alcoholics Anonymous, SMART Recovery, etc. for cell blocks and vastly increase the number of meetings.

D. Good Time/Earned Time

Federal, state, and local law enforcement should increase the "Good Time/Earned Time" credit for cognitive behavioral therapy (CBT) and general education development (GED) completion as an incentive for inmates to participate in these programs.

E. Assure Medical Assistance (Medicaid)

The City should work with state officials at the Office of Mental Health and Substance Abuse Services (OMHSAS) to revise Medical Assistance (Medicaid) policies so that coverage is suspended, rather than canceled, during incarceration; jails would then re-enroll detainees just prior to release.

F. Naloxone at Release

Federal, state, and local law enforcement agencies should train inmates and provide naloxone to them at the time of their release to mitigate the risk of fatal overdose, which is 15 to 29 times higher for released prisoners than for the general population in the first two weeks after release.[60]

G. Assure Government Issued Identification

The City should work with state officials at the Department of Motor Vehicles to provide non-driver photo licenses upon release.

APPENDIX VI: HOW TO GET HELP

ACCESS TREATMENT:

The Task Force encourages individuals who are actively using and at-risk for overdose to access treatment. To determine your eligibility for services and find the nearest assessment site, contact:

Community Behavioral Health (CBH) Member Services: (888) 545-2600

CBH Member Services operates a 24/7, 365 days a year hotline that directs people to available behavioral health resources, emergency services, and treatment programs.

ACCESS COMMUNITY SUPPORT:

The Task Force encourages individuals who may not be ready to enter treatment to access support in the community.

PRO-ACT's Philadelphia Recovery Community Center: (215) 223-7700

1701 W. Lehigh Ave., Philadelphia, PA 19132-2123
Hours of Operation:
Monday – Wednesday: 10 a.m. – 6 p.m.
Thursday – Friday: 11:30 a.m. – 7 p.m.

The Philadelphia Recovery Community Center is a resource for education, information, support, and socialization for those in recovery and their family and friends. It is meant to authenticate that recovery from the disease of addiction is possible. The basis of services and programming available through the Recovery Centers are Peer Recovery Support Services. These are non-clinical services focusing on removing barriers and providing invaluable resources to those who are seeking to achieve and maintain long-term recovery.

OTHER SUPPORTS:

The Task Force encourages individuals who may be grieving the loss of loved ones to seek support for themselves by using CBH Member Services; if they are not ready to access services, contact the DBHIDS Crisis Intervention Hotline or the Philadelphia Warmline to talk with someone for confidential support.

DBHIDS 24-Hour Suicide & Crisis Intervention Hotline: (215) 686-4420

DBHIDS operates a 24-hour telephone hotline to assist people and their families dealing with behavioral health emergencies. Compassionate, trained professionals are available 24 hours a day, 7 days a week, and 365 days a year. Callers will receive counseling, guidance and direction for receiving prompt evaluative and treatment services. Interpreter services are available for all languages and TTY services for those who are hearing impaired.

Philadelphia residents can call the DBHIDS Crisis Intervention Hotline if they (or someone they know):

- Are suffering from depression
- Have feelings or thoughts of wanting to harm themselves or others
- Have feelings of hopelessness
- Are having difficulty dealing with life stressors
- Suffer from intense anger or other emotional or substance abuse crises

The Philadelphia Warmline: (855) 507-3945

The Philadelphia Warmline is a non-judgmental "listening ear" operated by trained certified peer specialists to help individuals who may be experiencing anxiety, depression, loss, stress, and other life challenges.

thank you

ACKNOWLEDGMENTS

Co-Chairs Thomas Farley, MD, MPH, and Arthur Evans, PhD, gratefully acknowledge the roles of many people who made the work of the Task Force possible, including the Task Force members, the co-chairs of the Task Force's five subcommittees, and the members of the subcommittees. Each of these individuals have contributed meaningfully to the work of the Task Force, and helped to shape its recommendations. Their names are listed in Appendix II.

In addition, Co-Chairs Farley and Evans are grateful to the staff from DBHIDS and PDPH who supported the operations and logistics of the Task Force, including:

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Logistics Coordinators:
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Finally, Co-Chairs Farley and Evans extend their thanks to the members of the public who attended the Task Force's community listening sessions, Task Force meetings, and subcommittee meetings.

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Report references are available online at http://bit.ly/OTFPhilaReferences

City Announces Progress on Opioid Task Force Recommendations

For immediate release: January 23, 2018 | **Published by: Department of Public Health** , **Department of Behavioral Health and Intellectual disAbility Services** , **Office of the Mayor** |
Contact: Alicia Taylor **alicia.taylor@phila.gov** (215) 686-0334 | Ajeenah Amir **ajeenah.amir@phila.gov** (215) 686-6210

PHILADELPHIA – Philadelphia officials today provided **status updates** to the 18 recommendations made by **The Mayor's Task Force to Combat the Opioid Epidemic** in May 2017.

Led by the Philadelphia Department of Public Health and the Department of Behavioral Health and Intellectual disAbility Services, the City is currently implementing many of the recommendations presented by the Task Force. These include, but are not limited to:

- Increasing outreach and access to Medication-Assisted Treatment
- Developing "warm hand-offs" from Emergency Departments and the EMS system so that someone who has recently overdosed is connected as quickly as possible to treatment
- Distributing the opioid overdose antidote naloxone to first responders, people who use drugs and community members
- Providing "low-barrier" housing options that do not require sobriety
- Working with residents to mitigate the quality of life issues that have arisen in neighborhoods close to the epicenter of the opioid epidemic

Today, officials also announced that the City will encourage private-sector development of Comprehensive User Engagement Sites (CUES) for individuals experiencing a substance use disorder related to opioids.

"Philadelphia's fatal overdose rate is the worst in the nation among large cities, and incidents of overdose have steadily increased to an alarming degree," said Mayor Jim Kenney about the decision. "I applaud the work of the Task Force and city leadership in taking this bold action to help save lives."

CUES are medical interventions in which essential services are provided to reduce substance use, the harms associated with substance use, and fatal overdose. These services include referral to treatment and social services, wound care, medically supervised drug consumption, and access to sterile injection equipment and naloxone. The services are provided in a walk-in setting.

The development by a private-sector entity of one or more CUES is a harm reduction strategy, and taken together with multiple other strategies will move the City forward in addressing the opioid crisis by saving lives and reducing the public disorder caused by open air drug use.

"We cannot just watch as our children, our parents, our brothers, and our sisters die of drug overdose," said Dr. Thomas Farley, Philadelphia Health Commissioner. "We have to use every proven tool we can to save their lives until they recover from the grip of addiction."

In fully examining this recommendation raised by the task force (Recommendation #13), a delegation of city officials visited Vancouver, British Columbia and Seattle, Washington, in November 2017 to study similar facilities and efforts in those cities. A brief report on this visit is available **HERE.**

Eva Gladstein, Deputy Managing Director of Health and Human Services, stated, "Our visits to Vancouver and Seattle really hit home that establishing CUES is just one piece of the puzzle to address the opioid crisis. Our efforts to prevent addiction, help people access treatment, prevent overdoses in other ways, increase housing resources and address public safety concerns are already underway and must continue to grow and strengthen."

"Having Comprehensive User Engagement Sites – or CUES – as part of our continuum to treatment is just one of the ways in which we believe we can connect Philadelphians struggling with substance use disorders to lifesaving treatment," said DBHIDS Commissioner David T. Jones. "Of course, we will explore all opportunities that can provide people with the support and services they need, but we are confident that this option is a crucial step in helping people live healthier and happier lives."

Philadelphia officials also released a **scientific review** of studies of supervised injection facilities, which showed that these facilities reduce deaths from drug overdose; prevent HIV, hepatitis C, and other infections; and help drug users get into treatment. The report estimates that one site in Philadelphia could prevent up to 76 deaths from drug overdose each year.

The review also concluded that a CUES would also help clean up communities hit hard by drug use. Specifically, supervised injection facilities in other cities have been shown to reduce the number of littered syringes and other injection materials, the amount of drug injection in public, and neighbors' perception of disorder.

Moving forward, the City will actively encourage organizations like community nonprofits or medical organizations to operate and fund one or more CUES. While the city will not operate a CUES, agencies and officials will bring together key stakeholders and identify organizations that are interested in operating, funding, or offering a location for such a facility.

Further, working with elected officials, the city will educate and engage people about the opioid epidemic and how CUES fits into the larger solutions; and develop plans for coordinating or integrating other key services, particularly drug treatment, with the facility.

Other status updates to the Task Force recommendations include:

- Recommendation #1: In 2017, the Health Department recently launched the first phase of a consumer-directed media campaign about the risks of prescription painkillers – Don't Take the Risk – **www.donttaketherisk.org** . A second phase for this campaign is planned for 2018.
- Recommendation #4: Mayor Kenney met with the heads of all large health systems in Philadelphia asking that they reduce their prescribing of opioids and help addicted people get treatment. The Health Department and the Department of Behavioral Health have had follow-up meetings with each health system in the city to help them implement this request.
- Recommendation #5: The Health Department met with every health plan in the state of Pennsylvania and encouraged them to adopt policies that limit over-prescribing of opioids. Several plans have already adopted or are phasing in these policies
- Recommendation #12: City agencies will administer or distribute 35,000 doses of naloxone to persons who might witness and be able to treat overdoses.

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Press releases

PRESS RELEASE

Mayor Kenney's Public Schedule for Friday, May 24, 2019

May 23, 2019

PRESS RELEASE

Mayor Kenney's Public Schedule for Thursday, May 23, 2019

May 22, 2019

PRESS RELEASE

Mayor Kenney's Public Schedule for Wednesday, May 22, 2019

May 21, 2019

PRESS RELEASE

Statements on Apprehension of Michelle "Tamika" Washington's Killer

May 21, 2019

This content was last updated on June 28, 2018 by Department of Public Health , Department of Behavioral Health and Intellectual disAbility Services , Office of the Mayor .

What will the City do about CUES

- → Help to identify funders and operators interested in CUES
- → Work with elected officials & the public to educate about CUES
- → Develop plans to integrate CUES with other services, like treatment
- → Will NOT fund or operate a CUES

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA, Plaintiff, v. SAFEHOUSE, a Pennsylvania nonprofit corporation; JEANETTE BOWLES, as Executive Director of Safehouse, Defendants.	Civil Action No.: 2:19-cv-00519
SAFEHOUSE, a Pennsylvania nonprofit corporation, *Counterclaim Plaintiff,* v. UNITED STATES OF AMERICA, *Counterclaim Defendant,* and U.S. DEPARTMENT OF JUSTICE; WILLIAM P. BARR, in his official capacity as Attorney General of the United States; WILLIAM M. MCSWAIN, in his official capacity as U.S. Attorney for the Eastern District of Pennsylvania, *Third-Party Defendants*.	

DEFENDANT SAFEHOUSE'S ANSWER, AFFIRMATIVE DEFENSES, COUNTERCLAIMS TO PLAINTIFF'S COMPLAINT, AND THIRD-PARTY COMPLAINT

PRELIMINARY STATEMENT

"The opioid problem is perhaps the greatest public health crisis this city has faced in the last century."[1] Philadelphians and Americans are dying from opioid overdoses at unprecedented

[1] Tr. of Council of City of Phila., Comm. on Pub. Health & Human Servs., at 21:3-5 (Mar. 12, 2018) (Dr. Thomas Farley, Phila. Health Comm'r).

and alarming rates. In the last two years, more than 2,300 of our brothers, sisters, mothers, fathers, sons, daughters, and neighbors died of opioid overdoses in Philadelphia alone.[2] Philadelphia's overdose fatality rate is nearly four times its homicide rate.[3] The overdose crisis has intensified in the past several years due to the influx of fentanyl—a powerful and fast-acting opioid that was involved in 87% of the overdose deaths that occurred in Philadelphia in 2017.[4]

This is the stark reality: in an opioid overdose, a person loses consciousness, stops breathing, and then—absent intervention—will die. Fentanyl increases the risk of overdose, because it is 50-to-100 times more potent and faster-acting than heroin. A person overdosing on fentanyl can stop breathing in as little as 2-to-3 minutes. Opioid receptor antagonists (such as Naloxone) are a lifesaving treatment that will reverse the effects of an overdose—but only if timely medical assistance is available. Tragically, for thousands help arrived too late or not at all.

In Philadelphia, Safehouse intends to prevent as many of these deaths as possible through a medical and public health approach to overdose prevention. The Safehouse model will include medically supervised consumption and observation. Those who are at high risk of overdose death would stay within immediate reach of urgent, lifesaving medical care at the critical moment of consumption. Medical supervision at the time of consumption ensures that opioid receptor antagonists such as Naloxone, and other respiratory and supportive treatments like oxygen, will be immediately available in the event of an overdose. This intervention will not solve the opioid

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[2] *See* City of Phila., Dep't of Pub. Health, *Opioid Misuse and Overdose Report* (Nov. 29, 2018), https://www.phila.gov/media/20181129123743/Substance-Abuse-Data-Report-11.29.18.pdf; City of Phila., *Combating the Opioid Epidemic*, https://www.phila.gov/programs/combating-the-opioid-epidemic/reports-and-data/opioid-misuse-and-overdose-data/ (last visited Apr. 2, 2019); *see also* WHYY, *Fatal opioid overdoses expected to dip in Philly for first time in 5 years* (Dec. 24, 2018), https://whyy.org/articles/fatal-opioid-overdoses-expected-to-dip-in-philly-for-first-time-in-5-years/.

[3] City of Phila., Dep't of Pub. Health, *Philadelphia's Community Health Assessment: Health of the City 2018*, at 5, https://www.phila.gov/media/20181220135006/Health-of-the-City-2018.pdf (last visited Apr. 2, 2019).

[4] *See* City of Phila., Dep't of Pub. Health, *Opioid Misuse and Overdose Report* (Nov. 29, 2018), https://www.phila.gov/media/20181129123743/Substance-Abuse-Data-Report-11.29.18.pdf.

crisis, but it will provide a critical life raft. Safehouse's comprehensive model will also (i) encourage entry into drug treatment by engaging with participants when they are most receptive to counseling, (ii) reduce the transmission of communicable diseases such as HIV and Hepatitis C, (iii) treat and prevent life-threatening infections, (iv) provide primary medical care, and (v) offer a host of essential wraparound services. These measures are informed by medical science and public health data. And, consistent with their Judeo-Christian traditions, Safehouse's overdose prevention service is an exercise of the religious beliefs of its Board of Directors, who hold as core tenets preserving life, providing shelter to neighbors, and ministering to those most in need of physical and spiritual care.

The success of Safehouse's model has been confirmed by clinical and public health research that shows that medically supervised consumption sites save lives and prevent overdose deaths. Medically supervised consumption sites are not a new phenomenon; they have been in operation for more than 30 years. More than 120 sites operate openly worldwide, and *not a single fatal overdose* has been reported inside any similar facility. Extensive public health research of medically supervised consumption sites report a *decrease* in overdose deaths in their immediate vicinity, a *decrease* in the public use of drugs, a *decrease* in discarded drug paraphernalia waste, and a *decrease* in the transmission of infectious diseases. That research also shows that medically supervised consumption sites encourage long-term treatment for opioid addiction and do not contribute to increased crime.[5]

[5] *See* Beau Kilmer et al., Rand Corp., *Considering Heroin-Assisted Treatment and Supervised Drug Consumption Sites in the United States* 31-38 (2018), https://www.rand.org/content/dam/rand/pubs/research_reports/RR2600/RR2693/RAND_RR2693.pdf ("The existing reviews of scientific evaluation of [supervised consumption sites] report positive findings across a broad range of outcomes."); Chloe Potier et al., *Supervised injection services: What has been demonstrated? A systematic literature review*, 145 Drug & Alcohol Dependence, Results (2014) (concluding, after review of seventy-five relevant articles, that supervised consumption sites "were efficacious in promoting safer injection conditions, enhancing access to primary health care, and reducing overdose frequency," that they are "associated with reduced levels of public drugs injections or dropped syringes," and that such sites "were not found to increase drug injecting, drug trafficking or crime in the surrounding environments").

Overdose prevention services, including medically supervised consumption, are nationally and internationally recognized as an appropriate medical and public health measure by the American Medical Association, the American Public Health Association, AIDS United, the European Monitoring Centre for Drugs and Drug Addiction, the Infectious Diseases Society of America, the HIV Medicine Association, the International Drug Policy Consortium, and innumerable public health experts, physicians, and addiction researchers. This measure has locally been endorsed and encouraged by Philadelphia's Mayor, Health Commissioner, Commissioner of the Department of Behavioral Health and Intellectual disAbility Services, and the District Attorney, who all see the critical need for this intervention.

Despite this evidence, the U.S. Department of Justice ("DOJ") has threatened to prosecute Safehouse and seeks a declaratory judgment that Safehouse's proposed overdose prevention services would violate 21 U.S.C. § 856. Providing lifesaving medical services to individuals who are suffering from substance use disorder does not and constitutionally cannot violate Section 856. The DOJ's interpretation of Section 856 ignores Safehouse's planned comprehensive medical model. It is contrary to (i) the statutory regime adopted by Congress in the Controlled Substances Act ("CSA"), Pub. L. No. 91-513, 84 Stat. 1242 (21 U.S.C. § 801 *et seq.*), the Consolidated Appropriations Act, 2016 ("Appropriations Act of 2016"), Pub. L. No. 114-113, § 520, 129 Stat. 2327, and the Comprehensive Addiction and Recovery Act of 2016 ("CARA"), Pub. L. No. 114-198, 130 Stat. 695; (ii) the text, structure, purpose, and history of Section 856; (iii) well-settled canons of construction; (iv) foundational principles of federalism and limited federal government authority underlying the U.S. Constitution; and (v) the Religious Freedom Restoration Act of 1993 ("RFRA"), Pub. L. No. 103-141, 107 Stat. 1488 (42 U.S.C. § 2000bb *et seq.*). The DOJ now asks this Court to declare that the stark realities of the opioid crisis are irrelevant because "the law is

the law"—even though "the law" is not what DOJ claims it to be, and the DOJ has never enforced Section 856 in any analogous circumstance.

Section 856 does not address, much less prohibit, the legitimate, multifaceted, medical, and public health intervention that Safehouse intends to provide. Congress enacted Section 856 as an amendment to the CSA to target "crack houses" and "rave parties" where drug dealers established and maintained houses or temporary warehouses "for the purpose of" the manufacture, sale, and use of drugs in furtherance of their drug distribution and for-profit enterprises. Safehouse is nothing like a "crack house" or drug-fueled "rave." Nor is Safehouse established "for the purpose" of unlawful drug use. Rather, it is established for the exclusive purpose of providing urgent, lifesaving medical care to those at risk of drug overdose. The CSA does not regulate such a legitimate—indeed, critical—medical and public health intervention.

The DOJ claims that Safehouse's overdose prevention services violate federal law. It is wrong. To the contrary, Safehouse's comprehensive model is entirely consistent with the federal government's response to the opioid crisis. The services Safehouse will offer—clean injection equipment, Naloxone access, comprehensive medical services (primary care, wound care, HIV and Hepatitis C treatment), and immediate enrollment into drug treatment—are not only permitted by federal law, they are expressly endorsed by Congress and federal agencies. The U.S. Department of Health and Human Services ("HHS") and the Centers for Disease Control and Prevention ("CDC") expressly approve of comprehensive syringe exchange programs, which include the provision of clean needles, tourniquets, wipes, clean water for injections, and instruction on safer injection techniques. Recently, Congress clarified that federal law not only

permits syringe exchange programs, but now allows those programs to receive federal funding.[6] Congress and federal agencies likewise affirmatively have promoted the availability of Naloxone and other opioid receptor antagonists.[7]

Safehouse will bridge the short, but critical, gap—a matter of seconds to minutes—between the time a person receives a sterile syringe and other clean injection equipment and the need for immediate access to Naloxone and other medical treatment to reverse an overdose. The DOJ does not dispute that Safehouse may provide a person with syringes and consumption equipment and may have Naloxone at the ready. Yet, the DOJ suggests that Safehouse itself, as well as its leadership and personnel, would commit a 20-year felony unless it insists that a person leave the safety of its shelter—and potentially go to an alley, a public street or bathroom, or home alone—at the very moment when access to lifesaving medical supervision and care is most critical, that is, at the time of consumption. Contrary to the DOJ's Complaint, overdose prevention services, including Safehouse's proposed medically supervised consumption site in Philadelphia, will advance—not violate—federal law and policy.

The moral and religious imperative to save lives, medical ethics and practice, the public health data, and federal law all point to the same conclusion: Safehouse offers a lifesaving service that is not prohibited by Section 856. Federal criminal law does not require Safehouse to ignore this overdose crisis while people continue to die at a staggering rate. This Court should deny the DOJ's request for a declaration, and instead should hold that Section 856, under these circumstances, does not criminalize Safehouse's contemplated overdose prevention services.

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[6] CDC, *Program Guidance for Implementing Certain Components of Syringe Services Programs* (2016), https://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf.

[7] *See* CARA, § 107, 130 Stat. 703 (42 U.S.C. § 290dd-3).

Defendant Safehouse, by and through its counsel, answer the Complaint of Plaintiff United States of America ("Plaintiff") and aver as follows:

1. Safehouse admits that Plaintiff purports to seek a declaratory judgment under the Declaratory Judgment Act, as amended, 28 U.S.C. § 2201, and under the CSA, 21 U.S.C. § 843(f) (as made applicable by *id*. § 856(e)) and its implementing regulations, 21 C.F.R. § 1301 *et seq*., but denies that Plaintiff is entitled to such relief.

2. Admitted.

3. Admitted.

PARTIES

4. Admitted.

5. Admitted.

6. Denied as stated.

7. Denied.

FACTUAL ALLEGATIONS

8. Admitted. Despite the existence of such nonprofits providing services intended to reduce the harms of the opioid crisis, Philadelphians continue to die of overdoses at rates higher than nearly every other major city.[8]

[8] In 2016, Philadelphia had the second-highest rate of drug overdose deaths among counties with a population of more than one million residents. *See* Pew Tr., *Philadelphia's Drug Overdose Death Rate Among Highest in Nation* (Feb. 15, 2018), https://www.pewtrusts.org/en/research-and-analysis/articles/2018/02/15/philadelphias-drug-overdose-death-rate-among-highest-in-nation.

In 2017, Philadelphia had the highest overdose death rate (65/100,000 residents) of the counties in the top ten largest U.S. cities. Its overdose death rate was three times the rate of the second highest county (Cook County, 23/100,000 residents). *See* CDC, *CDC WONDER Online Database*: *About Underlying Cause of Death, 1999-2017*, https://wonder.cdc.gov/ucd-icd10.html (last visited Apr. 2, 2019).

9. Admitted in part and denied in part. Safehouse's mission, as stated on its website, "is to save lives by providing a range of overdose prevention services."[9] Also as stated, "[t]he leaders and organizers of Safehouse are motivated by the Judeo-Christian beliefs ingrained in [them] from [their] religious schooling, [their] devout families and [their] practices of worship. At the core of [their] faith is the principle that preservation of human life overrides any other considerations."[10] Safehouse will save lives by providing a range of overdose prevention services, including medically supervised consumption and observation. Exhibit A to the Complaint is a writing that speaks for itself. Any attempt by Plaintiff to characterize or interpret Exhibit A is therefore denied.

10. Denied as stated. Upon arrival at Safehouse, all participants must register and provide demographic information. A physical and behavioral health assessment will be conducted and a range of overdose prevention services offered. "[P]articipants will be directed to the medically supervised observation room," where they will be "offered on-site initiation of Medication Assisted Treatment (MAT), wound care, and referrals to primary care, social services, and housing opportunities."[11] Or participants may seek supervised consumption, in which case they "will be directed to the medically supervised consumption room and provided sterile consumption equipment and fentanyl test strips.[12] Participants will safely dispose of used

[9] Safehouse, *Frequently Asked Questions*, https://www.safehousephilly.org/about/faqs (last visited Apr. 2, 2019).

[10] *Id.*

[11] *Id.*

[12] The provision of sterile consumption equipment will reduce of the risk of transmission of infectious diseases. Fentanyl test strips are used to detect the presence of fentanyl prior to consumption. By alerting the participant to the presence of fentanyl and the increased risk of overdose, Safehouse would be practicing a harm reduction strategy that encourages a dosage adjustment to a safer level.

consumption equipment before leaving the supervised consumption area.[13] Under no circumstance will Safehouse make available any illicit narcotic or opioid. From the consumption area, participants will be directed to the medically supervised observation room and again offered opportunities for drug treatment, medical care, and social services .[14] Exhibit A is a printout of the Safehouse website as of February 2019. Exhibit A to the Complaint is a writing that speaks for itself. Any attempt by Plaintiff to characterize or interpret Exhibit A is therefore denied.

11. Admitted in part and denied in part. Paragraph 11 selectively quotes from the Safehouse website as of February 2019, as reflected in Exhibit A. Exhibit A to the Complaint is a writing that speaks for itself. Any attempt by Plaintiff to characterize or interpret Exhibit A is therefore denied.

12. Denied. The averments contained in Paragraph 12 constitute conclusions of law to which no response is required by the Federal Rules of Civil Procedure, and are therefore denied.

13. Denied. The averments contained in Paragraph 13 constitute conclusions of law to which no response is required by the Federal Rules of Civil Procedure, and are therefore denied.

14. Denied. The averments contained in Paragraph 14 constitute conclusions of law to which no response is required by the Federal Rules of Civil Procedure, and are therefore denied.

15. Denied. The averments contained in Paragraph 15 constitute conclusions of law to which no response is required by the Federal Rules of Civil Procedure, and are therefore denied. Safehouse's provision of overdose prevention services would not violate Section 856(a)(2).

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[13] The safe disposal of consumption equipment will reduce the risk of transmission of intravenous diseases, and will further the goals of city-sponsored programs like the Philadelphia Resilience Project, which aim to alleviate the public littering of consumption equipment that is prevalent in areas of Philadelphia with high drug use. *See* City of Phila., *Philadelphia Resilience Project*, https://www.phila.gov/programs/philadelphia-resilience-project/.

[14] *Id.* (footnotes added).

16. Denied. The averments contained in Paragraph 16 constitute conclusions of law to which no response is required by the Federal Rules of Civil Procedure, and are therefore denied. Safehouse's overdose prevention services would not fall within the scope of Section 856(a)(2).

17. Admitted in part and denied in part. Safehouse has publicly stated that its planned operations would not violate federal law. The remainder of Paragraph 17 is denied.

18. Admitted in part and denied in part. It is admitted that Safehouse received a letter from U.S. Attorney for the Eastern District of Pennsylvania, William M. McSwain, dated November 9, 2018. Exhibit B to the Complaint is a copy of that letter, which is a writing that speaks for itself. Any attempt by Plaintiff to characterize or interpret Exhibit B is therefore denied.

19. Admitted in part and denied in part. It is admitted that Safehouse sent a letter to U.S. Attorney for the Eastern District of Pennsylvania, William M. McSwain, dated November 26, 2018, explaining (among other things) that a proper and constitutional application of Section 856 does not prohibit Safehouse's overdose prevention services model that would combat the opioid crisis and prevent fatal overdoses. Exhibit C to the Complaint is a copy of that letter, which is a writing that speaks for itself. Any attempt by Plaintiff to characterize or interpret Exhibit C is therefore denied.

20. Admitted.

21. Admitted as stated.

22. Denied.

COUNT I

Violations of the Controlled Substances Act, 21 U.S.C. § 856(a)(2) – Declaratory Judgment

23. Safehouse incorporates by reference its responses to paragraphs 1 through 22 of Plaintiff's Complaint as if set forth fully herein.

24. Denied. The averments contained in Paragraph 24 constitute conclusions of law to which no response is required by the Federal Rules of Civil Procedure, and are therefore denied.

25. Denied. The averments contained in Paragraph 25 constitute conclusions of law to which no response is required by the Federal Rules of Civil Procedure, and are therefore denied.

26. Denied. The averments contained in Paragraph 26 constitute conclusions of law to which no response is required by the Federal Rules of Civil Procedure, and are therefore denied.

27. Denied. The averments contained in Paragraph 27 constitute conclusions of law to which no response is required by the Federal Rules of Civil Procedure, and are therefore denied.

28. Denied. The averments contained in Paragraph 28 constitute conclusions of law to which no response is required by the Federal Rules of Civil Procedure, and are therefore denied.

29. Denied. The averments contained in Paragraph 29 constitute conclusions of law to which no response is required by the Federal Rules of Civil Procedure, and are therefore denied.

30. Denied. The averments contained in Paragraph 30 constitute conclusions of law to which no response is required by the Federal Rules of Civil Procedure, and are therefore denied.

31. Denied. The averments contained in Paragraph 31 constitute conclusions of law to which no response is required by the Federal Rules of Civil Procedure, and is therefore denied.

PRAYER FOR RELIEF

Safehouse denies that Plaintiff is entitled to any relief in connection with the allegations set forth in its Complaint, including, but not limited to, the allegations set forth in Plaintiff's Prayer for Relief.

AFFIRMATIVE DEFENSES

As affirmative defenses to Plaintiff's Complaint, Safehouse asserts as follows without assuming the burden of proof or persuasion on matters for which it has no such burden. In doing

so, Safehouse specifically reserves the right to restate, re-evaluate, or recall any defenses and to assert additional defenses:

1. The cited provision of the CSA, 21 U.S.C. § 856(a)(2), does not apply to Safehouse's proposed conduct.

2. Safehouse's proposed conduct is justified by medical necessity to avoid imminent serious bodily injury and death.

3. The application of Section 856 to Safehouse is barred by RFRA, 42 U.S.C. § 2000bb *et seq.*

4. As applied to Safehouse, Section 856(a)(2) is unconstitutional under the Commerce Clause.

SAFEHOUSE'S COUNTERCLAIMS AND THIRD-PARTY COMPLAINT

Pursuant to Federal Rule of Civil Procedure 13, Counterclaim Plaintiff Safehouse asserts the following counterclaims against Counterclaim Defendant United States of America, and claims against Third-Party Defendants U.S. Department of Justice; William P. Barr, in his official capacity as U.S. Attorney General; and William M. McSwain, in his official capacity as U.S. Attorney for the Eastern District of Pennsylvania (collectively, "the DOJ"), and, by and through its counsel, alleges as follows:

INTRODUCTION

1. In this action, Safehouse seeks to have this Court declare 21 U.S.C. § 856 inapplicable to the establishment and carrying out of its overdose prevention services model, which includes medically supervised consumption and observation.

2. Safehouse further seeks a declaration by the Court that any prohibition on its operation of a medically supervised consumption room as part of its overdose prevention services model would violate the Religious Freedom and Restoration Act, 42 U.S.C. § 2000bb *et seq.*, by

substantially burdening the exercise of its religious beliefs that call its Board Members and Directors to provide lifesaving medical treatment to a vulnerable population. The federal government lacks any compelling interest in preventing Safehouse's proposed operation; nor would enforcement of Section 856 against Safehouse be the least restrictive means of advancing any such interest.

JURISDICTION AND VENUE

3. This action arises under 21 U.S.C. § 801 *et seq.* and 42 U.S.C. § 2000bb *et seq.* This Court has jurisdiction over this action pursuant to 28 U.S.C. §§ 1331 and 1346. Safehouse seeks remedies under 28 U.S.C. §§ 2201 and 2202.

4. Venue lies in the Eastern District of Pennsylvania pursuant to 28 U.S.C. § 1391(b), as the relevant events took place in this District.

DECLARATORY JUDGMENT

5. There is an actual controversy of sufficient immediacy and concreteness relating to the legal rights and duties of Safehouse to warrant relief under 28 U.S.C. § 2201.

6. The harm to Safehouse as a direct result of the actions and threatened actions of the DOJ is sufficiently real and imminent to warrant the issuance of a conclusive declaratory judgment.

7. The DOJ and its officials have asserted that Safehouse's overdose prevention services model, which includes medically supervised consumption and observation, would violate federal criminal law. The DOJ has threatened to commence criminal and civil enforcement proceedings at any time to prevent Safehouse from opening and becoming operational, and brought the instant action resulting in this counterclaim.

8. Safehouse, as well as its leaders and personnel, are thus threatened with federal civil and criminal enforcement unless Safehouse refrains from engaging in entirely lawful conduct in pursuit of its lifesaving mission.

9. Under these circumstances, judicial intervention is warranted to resolve a genuine case or controversy within the meaning of Article III of the U.S. Constitution regarding the proper interpretation and application of Section 856.

10. A declaration that Safehouse would not violate Section 856 once it becomes operational would definitively resolve that controversy for the parties.

THE PARTIES

11. Counterclaim Plaintiff Safehouse is a nonprofit corporation operating under the laws of the Commonwealth of Pennsylvania with a registered address at 1211 Chestnut Street, Suite 600, Philadelphia, Pennsylvania 19107.

12. Counterclaim Defendant is the United States of America.

13. Third-Party Defendant is the U.S. Department of Justice.

14. Third-Party Defendant William P. Barr is sued in his official capacity as U.S. Attorney General.

15. Third-Party Defendant William M. McSwain is sued in his official capacity as the United States Attorney for the Eastern District of Pennsylvania.

I. FACTUAL ALLEGATIONS

16. Safehouse hereby incorporates and re-alleges the Preliminary Statement and each of the factual allegations in its Answer to Plaintiff's Complaint. It further avers as follows:

The Opioid Epidemic in the City of Philadelphia

17. The City of Philadelphia is in the midst of an unprecedented public health emergency due to the opioid epidemic and the opioid overdose crisis.

18. In the last two years, more than 2,300 individuals died as a result of an opioid overdose in Philadelphia.[15] On average, Philadelphia is losing three of its citizens each day to opioid overdoses.

19. On October 3, 2018, the Mayor of Philadelphia issued an Opioid Emergency Response Executive Order declaring that "Kensington and its surrounding neighborhoods are in the midst of a disaster" due to the opioid crisis, and empowering city agencies and officials to lead efforts to reduce opioid deaths and transmission of disease and to increase entry into drug treatment.[16]

20. Since 2011, most opioid-related deaths in Philadelphia have been caused by heroin.[17] In the last several years, Philadelphia has experienced a dramatic increase in the number of deaths related to fentanyl.[18]

21. Fentanyl is a synthetic opioid that is now found in many of the opioids sold on the street in Philadelphia. Fentanyl is often sold to drug users who mistakenly believe that they are purchasing less lethal drugs.

22. Fentanyl is 50-to-100 times more potent than heroin, and its effects are felt within the human body much faster. In the event of an overdose, a person may stop breathing within ***2-***

[15] *See* City of Phila., Dep't of Pub. Health, *Opioid Misuse and Overdose Report* (Nov. 29, 2018), https://www.phila.gov/media/20181129123743/Substance-Abuse-Data-Report-11.29.18.pdf; City of Phila., *Combating the Opioid Epidemic*, https://www.phila.gov/programs/combating-the-opioid-epidemic/reports-and-data/opioid-misuse-and-overdose-data/ (last visited Apr. 2, 2019); *see also* WHYY, *Fatal opioid overdoses expected to dip in Philly for first time in 5 years* (Dec. 24, 2018), https://whyy.org/articles/fatal-opioid-overdoses-expected-to-dip-in-philly-for-first-time-in-5-years/.

[16] City of Phila., Office of the Mayor, *Executive Order No. 3-18 – Opioid Emergency Response Executive Order* (Oct. 3, 2018), https://www.phila.gov/ExecutiveOrders/Executive%20Orders/eo99318.pdf.

[17] *See id*.

[18] *See id*.

to-3 minutes after the consumption of fentanyl. Absent intervention, serious injury or death can occur as quickly as ***3-to-5 minutes*** from the time of consumption.

23. Every second counts in reversing an opioid overdose. When immediately available, the administration of Naloxone and similar opioid receptor antagonists provides lifesaving treatment. These interventions ***will resuscitate and keep a person alive with medical certainty***.

24. The time-sensitive nature of overdose prevention services is complicated by the fact that Philadelphia's Emergency Medical Services ("EMS") is inundated with calls to respond to overdoses, response times are variable, and for 46 percent of calls in 2017, more than 9 minutes elapsed before EMS arrived at the scene.[19]

25. In 2017, Philadelphia's EMS personnel administered Naloxone to more than 5,400 overdose victims.[20] This number has continued to increase in 2018.

26. Emergency rooms, moreover, frequently are not equipped to provide the wraparound services needed to overcome opioid addiction.[21]

27. As part of this growing crisis, the Mayor of Philadelphia created the Task Force to Combat the Opioid Epidemic in Philadelphia (the "Task Force"). The final report issued by the

[19] Adam Thiel, Fire Comm'r, *Philadelphia Fire Department Fiscal Year 2018 Budget Testimony*, at 6, http://phlcouncil.com/wp-content/uploads/2017/04/FY18-Fire-Budget-Testimony-final-version-4.12.17.pdf (last visited Apr. 2, 2019).

[20] *See* City of Phila., Dep't of Pub. Health, *Opioid Misuse and Overdose Report* (Nov. 29, 2018), https://www.phila.gov/media/20181129123743/Substance-Abuse-Data-Report-11.29.18.pdf; City of Phila., *Combating the Opioid Epidemic*, https://www.phila.gov/programs/combating-the-opioid-epidemic/reports-and-data/opioid-misuse-and-overdose-data/ (last visited Apr. 2, 2019)

[21] Hoag Levins, *Optimizing Heroin Users' Treatable Moments in the ER* (June 2017), https://ldi.upenn.edu/news/optimizing-heroin-users-treatable-moments-er (last visited Apr. 2, 2019).

Task Force recommended the implementation of overdose prevention services and expansion of treatment access and capacity.[22]

28. Safehouse would fulfill Philadelphia's dire need for overdose prevention services.

Formation of Safehouse

29. Safehouse, a privately funded nonprofit corporation, was established in 2018 with the mission to save lives by providing a range of overdose prevention services. Its proposed model is part of a broader harm reduction strategy to mitigate the catastrophic losses resulting from the opioid epidemic and overdose crisis in Philadelphia.

30. "Substance use disorder" or "Opioid use disorder" are defined by the CDC to be a medical condition diagnosed "based on specific criteria such as unsuccessful efforts to cut down or control use, or use resulting in social problems and a failure to fulfill obligations at work, school, or home, among other criteria."[23] The Office of the U.S. Surgeon General has reported that more than eleven million Americans use illicit drugs or misuse prescription drugs, but that only one out of four of those people seek specialized treatment for opioid use disorder.[24] In 2016, the Mayor's Task Force reported that more than 14,000 Medicaid recipients in Philadelphia sought treatment for opioid use disorder—a small fraction of those actually suffering from that condition—and estimated that more than 70,000 Philadelphians are active heroin users.[25]

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[22] *See* City of Phila., *The Mayor's Task Force To Combat The Opioid Epidemic in Philadelphia: Final Report and Recommendations* (May 19, 2017), https://dbhids.org/wp-content/uploads/2017/04/OTF_Report.pdf ("*Task Force Report*").

[23] CDC, *Commonly Used Terms: Opioid Overdose*, https://www.cdc.gov/drugoverdose/opioids/terms.html (last visited Apr. 3, 2019).

[24] HHS, *Facing Addiction in America: The Surgeon General's Spotlight on Opioids* 6 (Sept. 19, 2018), https://addiction.surgeongeneral.gov/sites/default/filesfiles/Spotlight-on-Opioids_09192018.pdf.

[25] *Task Force Report* 7-8.

31. "Harm reduction" is an umbrella term for interventions that aim to reduce problematic or otherwise harmful effects of certain behaviors. In the context of substance and opioid use disorders, such interventions are necessary to reduce harm for individuals "who, for whatever reason, may not be ready, willing, or able to pursue full abstinence as a goal." Harm reduction strategies are an essential aspect of public health initiatives. Harm reduction can include reducing the frequency of substance use, preventing diseases caused by substance use (such as HIV and Hepatitis C), providing syringe exchange, and offering medication-assisted treatments, overdose prevention, and wound care. Harm reduction strategies are necessary in light of the psychology of addiction and substance use disorder, and seek to help individuals engage in treatments to reduce, manage, and stop their substance use when appropriate.[26]

32. Safehouse will combat the opioid crisis through the use of a comprehensive harm reduction strategy.

33. Safehouse's overdose prevention services include the assessment of an individual's physical and behavioral health status, provision of sterile consumption equipment, provision of drug testing (*i.e.*, fentanyl test strips), medically supervised consumption and observation, overdose reversal, wound care and other primary care services, on-site education and counseling, on-site MAT and recovery counseling, distribution of Naloxone, and access to wraparound services such as housing, public benefits, and legal services.

34. Safehouse's overdose prevention services model provides those at highest risk of an opioid overdose with immediate access to medical care, including overdose reversal agents. Under this model, Safehouse can offer assurance, to a medical certainty, that people within its care will not die of a drug overdose.

[26] *See* Diane E. Logan & G. Alan Marlatt, *Harm Reduction Therapy: A Practice-Friendly Review of Research,* 66 J. Clinical Psychol. 201 (2010).

35. Safehouse will not provide any illicit drugs for consumption, nor will it tolerate any sale of illicit drugs or drug sharing at its facility.

36. Safehouse's comprehensive services will encourage entry into drug treatment, reduce the burden on emergency services and first responders, prevent the transmission of infectious diseases, and create a safer community by reducing public consumption of illicit drugs and discarded needles and other consumption equipment.

37. Safehouse will save lives by preventing and averting overdose deaths. It will also save lives by preventing death and serious health complications caused by infections and disease transmitted by intravenous drug use.

38. Studies estimate that an overdose prevention site like Safehouse could reduce overdose deaths annually by 30% in the site's immediate vicinity.[27]

Threat of Prosecution

39. On November 9, 2018, the U.S. Attorney for the Eastern District of Pennsylvania, William M. McSwain, sent a letter to Safehouse declaring the DOJ's intent to pursue "appropriate legal remedies" for a purported "violation of the CSA." A true and correct copy of the November 9, 2018 letter is attached as Exhibit B to the Complaint.

40. Similarly, in a widely published op-ed, U.S. Deputy Attorney General Rod Rosenstein argued that safe injection facilities violate federal law and could result in "up to 20 years in prison."[28]

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[27] Sharon Larson et al., *Supervised Consumption Facilities – Review of the Evidence* 20 (2017), https://dbhids.org/wp-content/uploads/2018/01/OTF_LarsonS_PHLReportOnSCF_Dec2017.pdf ("*Supervised Consumption Facilities*").

[28] *See* Rod J. Rosenstein, *Fight Drug Abuse, Don't Subsidize It,* N.Y. Times (Aug. 27, 2018), https://www.nytimes.com/2018/08/27/opinion/opioids-heroin-injection-sites.html.

41. On February 5, 2019, the DOJ filed a complaint for a declaratory judgment that Safehouse's medically supervised consumption room would violate 21 U.S.C. § 856(a)(2).

42. Violation of 21 U.S.C. § 856(a)(1) or (a)(2) carries with it severe criminal and civil penalties, including fines of up to $2,000,000 and imprisonment for up to twenty years. *See* 21 U.S.C. § 856(b) and (d).

II. SAFEHOUSE'S OVERDOSE PREVENTION SERVICES ARE ENTIRELY CONSISTENT WITH FEDERAL LAW AND POLICY

43. Efforts to expand drug treatment have been at the heart of the CSA, 21 U.S.C. § 801 *et seq*. since its passage in 1970. In the bill enacting the CSA, Congress identified "increased efforts in drug abuse prevention and rehabilitation of users" as one of three important objectives of the CSA. *See* H.R. Rep. No. 91-1444, *as reprinted in* 1970 U.S.C.C.A.N. 4566, 4567; *see also* Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. No. 91-513, 84 Stat. 1236.

44. Under the CSA, health care practitioners licensed by the U.S. Drug Enforcement Administration ("DEA") may lawfully dispense or prescribe controlled substance "in the course of professional practice." 21 U.S.C. § 802(21); 21 C.F.R. § 1306.04. The CSA does not generally "regulate the practice of medicine," except "insofar as it bars doctors from using their prescription-writing powers as a means to engage in illicit drug dealing and trafficking as conventionally understood." *Gonzales v. Oregon*, 546 U.S. 243, 270 (2006). Outside of those delineated spheres, the CSA does not limit the appropriate medical response to the risk of drug overdose.

45. Federal law permits, and indeed encourages, a facility like Safehouse to provide safe and clean equipment for intravenous drug users, notwithstanding 21 U.S.C. § 863, and to provide them with medical treatment, including immediate access to Naloxone and other opioid reversal agents.

46. Safehouse's overdose prevention services model allows those at high risk of overdose death to stay within immediate reach of urgent, lifesaving medical care at the critical moment of consumption. Medical supervision and direct access to treatment can reverse an overdose with medical certainty and ensures that participants in Safehouse's care will stay alive.

47. It would be entirely inconsistent with the CSA, recent Congressional changes to federal law, and federal agency policy to find that Section 856 requires doctors, nurses, and medically trained volunteers to turn their backs on patients at their most vulnerable moment. Section 856 does not prohibit overdose prevention services, including the medical supervision of drug consumption designed to provide immediate access to lifesaving care and to encourage entry into long-term drug treatment.

A. *The CSA Does Not Regulate Medical Treatment or Overdose Prevention Measures.*

48. Although the CSA creates a comprehensive statutory and regulatory regime regarding the manufacture, distribution, and possession of controlled substances, it does not regulate medical treatment or the practice of medicine. *See Oregon*, 546 U.S. at 270 ("[T]he statute manifests no intent to regulate the practice of medicine generally.").

49. Under Subchapter I of the CSA, a medical professional licensed by the DEA is empowered to administer controlled substances in accordance with its schedules and regulations. *See id.* § 829 (setting forth registration requirements for manufacture and distribution of controlled substances). Moreover, DEA regulations implementing Subchapter I of the CSA permit the dispensing, prescribing, and administering of non-Schedule I controlled substances "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." *See* 21 C.F.R. § 1306.04.

50. Neither the CSA nor the DEA regulate medical practitioners (or others providing wraparound services, counseling, or volunteer support) who are not dispensing, prescribing, or distributing controlled substances.

51. Section 856 does not dictate the appropriate means of preventing and treating opioid overdoses.

52. Safehouse's health care professionals and other volunteers will not distribute, dispense, prescribe, or administer controlled substances as part of its medically supervised consumption service. Safehouse will not administer any illicit drugs. Safehouse's health care professionals will supervise consumption with the singular goal of assessing and reversing overdoses using Naloxone and other opioid reversal agents (which are not prohibited or regulated by the CSA), with respiratory support, and by providing other lifesaving care.

53. In addition, Safehouse will provide comprehensive overdose prevention services including medical care, provision of sterile consumption equipment, education, counseling, and wraparound services such as housing, access to public benefits, and legal services. None of those activities are addressed by the CSA.

54. The CSA does not prohibit medical practitioners from supervising and remaining proximate to individuals at risk of overdose and death with the goal of providing immediate lifesaving care.

55. Section 856 accordingly does not prohibit Safehouse from providing urgent medical treatment through its proposed overdose prevention services, including medically supervised consumption.

B. ***Federal Law Endorses and Funds Syringe Exchange Programs.***

56. Recent changes in federal law demonstrate official federal approval of certain harm reduction strategies to address the opioid crisis.

57. In 2011, amid growing evidence of the positive effect of syringe exchange programs in treating drug abuse, the U.S. Surgeon General issued a determination "that a demonstration needle exchange program . . . would be effective in reducing drug abuse and the risk of infection."[29]

58. In pertinent part, the U.S. Surgeon General recognized that syringe exchange programs promote entry into treatment and can reduce a drug user's injections. The determination relied upon a 2000 study, which concluded that:

> [N]ot only were new [syringe services program] participants five times more likely to enter drug treatment than non-[syringe exchange program] participants, former [syringe exchange program] participants were more likely to report significant reduction in injection, to stop injecting altogether, and to remain in drug treatment.[30]

59. In 2012, the CDC implemented summary guidance to prevent HIV infection, viral hepatitis, sexually transmitted diseases, and tuberculosis for drug users. This guidance recommended the implementation of integrated prevention services that would enable drug users to receive comprehensive care at the time they participate in clean syringe exchange.[31] The CDC

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[29] *Determination That a Demonstration Needle Exchange Program Would be Effective in Reducing Drug Abuse and the Risk of Acquired Immune Deficiency Syndrome Infection Among Intravenous Drug Users,* 76 Fed. Reg. 10038 (Feb. 23, 2011).

[30] *Id.* (citing Holly Hagan et al., *Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors*, 19 J. of Substance Abuse Treatment 247–252 (2000)).

[31] *See* CDC, *Morbidity And Mortality Weekly Report: Integrated Prevention Services For Hiv Infection, Viral Hepatitis, Sexually Transmitted Diseases, And Tuberculosis For Persons Who Use Drugs Illicitly: Summary*

guidance provided that "a comprehensive service program" may include "[p]rovision of sterile needles, syringes and other drug preparation equipment (purchased with non-federal funds) and disposal services" and "[p]rovision of Naloxone to reverse opioid overdoses."[32]

60. Federal law now permits federal funding of most elements of local- and state-sponsored syringe exchange programs, notwithstanding the criminalization of interstate distribution of drug paraphernalia in 21 U.S.C. § 863. In 2016, Congress drastically relaxed a nearly thirty-year ban on the use of federal funds for state and local programs that furnish "sterile needles or syringes for the hypodermic injection of any illegal drug." *See* Appropriations Act of 2016, § 520, 129 Stat. 2652. That same year, HHS adopted the CDC's 2012 Guidance to support the implementation of new federal funding for syringe exchange programs.[33]

61. Safehouse will provide comprehensive overdose protection services that are entirely consistent with the CDC and HHS guidelines, and will provide sterile syringes, other sterile consumption equipment, syringe disposal services, Naloxone, primary care, and wraparound services. Although Safehouse is not a local or state entity seeking federal funding, it is indisputable that its comprehensive syringe exchange and Naloxone services are entirely legal under, and indeed, encouraged by federal law.

62. Yet, under the DOJ's rationale, a syringe exchange program is transformed from a legal, federally endorsed public health measure into a 20-year felony simply by allowing participants to remain within the same facility and under the supervision of its medical practitioners at the critical moment of consumption when death is most likely to occur. That is the

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Guidance From Cdc And The U.S. Department Of Health And Human Services (2012), Https://Www.Cdc.Gov/Mmwr/Preview/Mmwrhtml/Rr6105a1.Htm (last visited Apr. 3, 2019).

[32] CDC, *Program Guidance for Implementing Certain Components of Syringe Services Programs* (2016), https://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf.

[33] *See* HHS, *Implementation Guidance to Support Certain Components of Syringe Services Programs* (Mar. 29, 2016), https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs.

very moment when proximity to urgent medical care may mean the difference between life and death.

63. It cannot be that compassionate and conscientious medical providers may establish a clinic, well-stocked with emergency overdose reversal medication, staff the clinic with trained medical practitioners, and provide individuals with sterile consumption equipment (all plainly permitted by federal law) only to confront a stark choice: cast those individuals away from lifesaving medical care or else suffer serious criminal liability. That is not a reasonable interpretation of federal law.

64. The DOJ's interpretation of Section 856 cannot be reconciled with the medical facts recognized by Congress, the CDC, and federal health policy—syringe exchange programs and overdose prevention services save lives, decrease disease transmission, and reduce the harms of this opioid crisis.

65. Safehouse's modest extension of already-endorsed harm reduction measures will close a short, but critical gap in care at the time of drug consumption.

66. Medical supervision for those at risk of overdose advances federal policy and does not violate federal law.

C. *The Federal Government and Pennsylvania State Law Encourage Access to Naloxone to Combat the Opioid Crisis.*

67. Safehouse's overdose prevention model is entirely consistent with federal and state laws and policies that have expanded access to Naloxone and other opioid reversal agents.

68. Opioid receptor antagonists, like Naloxone, are highly effective—if given in time and in sufficient quantity, they will reverse an otherwise fatal overdose with medical certainty.

69. Naloxone can only work if someone is close by to administer it. A person experiencing an overdose loses consciousness and therefore cannot self-administer Naloxone.

Once a person loses respiratory function, which can occur within minutes of consumption, time is of the essence in providing respiratory support and Naloxone. The more time that elapses, the greater the risk of serious injury and death.

70. Naloxone is designed to be easily administered as an intra-nasal spray. It has been widely dispensed, with the help of federal, state, and local funding. At times, however, a single dose of Naloxone is not sufficient to reverse an overdose. Multiple doses or intramuscular injections of Naloxone are sometimes required. Oxygen and respiratory support may also be beneficial, and can serve as an alternative first-line treatment. Outside of a medically supervised environment, even when help does arrive for an overdose victim, first responders, family members, and Good Samaritans sometimes lack sufficient doses of Naloxone or lack training in other respiratory support required to resuscitate that person.

71. Congress recognized the importance of Naloxone access when it enacted the Comprehensive Addiction and Recovery Act. *See* CARA § 101, 130 Stat. 697. CARA established a coordinated, public health-focused strategy to address the opioid crisis, including increased funding for education and awareness campaigns and improved access to overdose treatment.

72. CARA also amended the CSA to expand prescribing privileges for MAT, like buprenorphine and suboxone, to nurses and physicians assistants. *See id.* § 303(a)(l)(C)(v)-(iv), 130 Stat. 720-723.

73. CARA includes several measures that expand and encourage access to opioid reversal agents such as Naloxone. Title I, Section 107 of CARA empowers HHS to award grants to eligible entities providing overdose reversal treatment, including Naloxone. *See id.* § 107, 130 Stat. 703 (42 U.S.C. § 290dd-3). Section 703 of CARA requires evaluation of state Good Samaritan laws that provide civil and criminal immunity to individuals who administer Naloxone

to an individual experiencing an overdose. *See id.* § 703, 130 Stat. 741. CARA also directs that "[t]he Secretary shall maximize the availability of opioid receptor antagonists, including [N]aloxone, to veterans." *See id.* § 911, 130 Stat. 759 (38 U.S.C. § 1701).

74. Pennsylvania state law similarly recognizes the importance of Naloxone access. In light of the growing opioid crisis, in 2010, the Pennsylvania General Assembly amended its state drug law (the Controlled Substance, Drug, Device and Cosmetic Act, 35 P.S. § 780–101 *et seq.*) by enacting the Drug Overdose Response Immunity statute ("the Good Samaritan Statute"). That statute provides immunity from prosecution for persons who call authorities to seek medical care for a suspected overdose victim. *See id.* § 780–113.7. The Good Samaritan Statute also provides criminal, civil, and professional immunity to anyone who, in good faith, administers Naloxone to an individual experiencing an overdose.[34] Former Governor of Pennsylvania, Tom Corbett, stated the Good Samaritan statute "will save lives and ensure those who help someone in need aren't punished for doing so."[35]

75. On April 18, 2018, the Pennsylvania Physician General issued Standing Order DOH-002-2018, providing a statewide prescription for eligible persons to obtain Naloxone. The purpose of the Order is to "ensure that residents of the Commonwealth of Pennsylvania who are at risk of experiencing an opioid-related overdose, or who are family members, friends or other persons who are in a position to assist a person at risk of experiencing an opioid-related overdose

[34] To date, forty States and the District of Columbia have enacted some form of a Good Samaritan statute or law that provides criminal immunity when an individual experiencing an opioid-related overdose or witnesses an opioid-related overdose calls 911, administers Naloxone, or seeks medical assistance. *See* Nat'l Conf. of State Legis., *Drug Overdose Immunity and Good Samaritan Laws* (June 5, 2017), http://www.ncsl.org/research/civil-and-criminal-justice/drug-overdose-immunity-good-samaritan-laws.aspx.

[35] *See* David Wenner, *Pa. Painkiller-Heroin Crisis: Corbett Signs Bill Intended To Save Lives*, PennLive (Sept. 30, 2014), https://www.pennlive.com/midstate/2014/09/corbett_heroin_good_samaritan.html.

. . . , are able to obtain Naloxone."[36] The Pennsylvania Physician General has continued to renew this Standing Order, consistent with Pennsylvania Governor Tom Wolf's Proclamation and as the opioid crisis continues in Pennsylvania.

76. Safehouse's medically supervised consumption spaces will be staffed at all times by medically trained practitioners supplied with sufficient doses of Naloxone and able to provide other forms of respiratory support. This model permits proximity and access to Naloxone during and immediately after the time of use—which is the moment when Naloxone is most needed.

77. The Safehouse model is entirely consistent with CARA, federal policy, and Pennsylvania state law, all of which include strong measures to increase Naloxone access.

III. SECTION 856 DOES NOT PROHIBIT SAFEHOUSE'S PROPOSED OVERDOSE PREVENTION MODEL

78. Despite the federal endorsement of a public health-focused strategy to combat the opioid crisis, the DOJ seeks to prohibit Safehouse's overdose prevention services model under 21 U.S.C. § 856. The history, purpose, and text of Section 856 confirm that it has no application to Safehouse's proposed medical and public health response to the opioid crisis.

A. *Section 856 Was Enacted to Target Crack Houses and Rave Parties, Not Legitimate Medical Interventions to Prevent Drug Overdoses.*

79. The DOJ's proposed application of Section 856 to Safehouse's overdose prevention services model would be an unprecedented expansion of that discrete statutory provision.

80. Congress enacted Section 856 to target drug dealers and party promoters who established locations for manufacture, distribution, and use of illicit drugs to facilitate their for-profit enterprises.

[36] Pa. Dep't of Health, Standing Order DOH-002-2016: Naloxone Prescription for Overdose Protection, https://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Documents/SN%20-%20Naloxone%20Prescription%20for%20Overdose%20Prevention%20(Standing%20Order%20DOH-002-2016).pdf.

81. The federal government has never sought to use Section 856 to prosecute or enjoin any public health measure or legitimate medical activity remotely analogous to Safehouse's proposed overdose prevention model.

82. In 1986, Congress enacted Section 856 as part of the Anti-Drug Abuse Act of 1986 ("1986 Act"), Pub. L. No. 99-570, 100 Stat. 3207. The 1986 Act established a comprehensive scheme that not only expanded federal drug enforcement and interdiction measures, but also sought "to provide strong Federal leadership in establishing effective drug abuse prevention and education programs," and "to expand Federal support for drug abuse treatment and rehabilitation effort[t]s." 132 Cong. Rec. S26473 (daily ed. Sept. 26, 1986).

83. The passage of Section 856 was intended to authorize federal prosecution of "crack houses" and similar premises. The Senate Report stated that Congress's purpose in enacting Section 856 was to "[o]utlaw[] operation of houses or buildings, so-called 'crack houses', where 'crack' cocaine and other drugs are manufactured and used." *See* 132 Cong. Rec. at S26474. In legislative debate on the 1986 Act, sponsoring Senator Lawton Chiles noted that this provision would address law enforcement's difficulties in arresting "crack house" operators: "When police raid these crack houses, the dealers and users can easily dispose of the drugs, thus avoiding arrest. This bill makes it a felony to operate such a house, to be present at the house." *See* 132 Cong. Rec. at S26447 (statement of Sen. Chiles).

84. Likewise, in 2003, Congress amended Section 856 to add subsection (a)(2), "after holding a series of hearings regarding the dangers of Ecstasy [*i.e.*, MDMA, a synthetic drug with combined stimulant and hallucinogenic effects] and the rampant drug promotion associated with some raves." 149 Cong. Rec. S10606 (daily ed. July 31, 2003) (statement of Sen. Biden); Illicit Drug Anti-Proliferation Act of 2003 ("2003 Amendment"), Pub. L. No. 108-21, 117 Stat. 691.

("Rave," in this context, refers to commercial dance parties, popular in the 1990s, featuring electronic "club" music and often involving widespread drug use, in particular MDMA.) Senator Biden, who sponsored the 2003 Amendment, noted that the new provision clarified that Section 856 prohibited not only the operation of premises with ongoing drug distribution activities, but also "'single-event' activities, including an event where the promoter has as his primary purpose the sale of Ecstasy or other illegal drugs." *Id.* Thus, Senator Biden stated that it was appropriate under the amendment "to prosecute rogue rave promoters who profit off of putting kids at risk," by "knowingly and intentionally hold[ing] an event for the purpose of drug use, distribution or manufacturing." *See id.*

85. Plainly, Safehouse's lifesaving medical and public health mission is far from the concerns that led Congress to originally enact Section 856 or the 2003 amendment. Nothing in Section 856's legislative history suggests Congress ever contemplated that Section 856 would be used to prosecute medical professionals, public health workers, and volunteers who seek to prevent opioid overdoses, reduce disease transmission, encourage drug treatment, and provide urgent lifesaving care, as Safehouse now proposes to do.

B. *Section 856 Does Not Apply Where Conduct Is "Authorized by this Subchapter," Which Permits Legitimate Medical Practice.*

86. Section 856 expressly exempts conduct "authorized by [Subchapter I]" from its criminal and civil penalties. Section 856 does not regulate the practice of medicine nor does it dictate the appropriate means of preventing and treating opioid overdoses. Neither the CSA nor the DEA regulate medical practitioners (or others providing wraparound services, counseling, or volunteer support) who are not dispensing, prescribing, or distributing controlled substances.

87. In any event, DEA regulations implementing Subchapter I of the CSA expressly permit the dispensing, prescribing, and administering of non-Schedule I controlled substances "for

a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." *See* 21 C.F.R. § 1306.04.

88. Safehouse's overdose prevention services are a legitimate medical and public health measure that have been recognized and endorsed by prominent national and international medical and public health associations including American Medical Association, the American Public Health Association, AIDS United, the European Monitoring Center for Drugs and Drug Addiction, the Infectious Diseases Society of America, the HIV Medical Association, the International Drug Policy Consortium, and innumerable public health experts, physicians, and addiction researchers.

89. Safehouse's overdose prevention model is also a measure that has been endorsed and encouraged by Philadelphia's Public Health Commissioner and its Commissioner of the Department of Behavioral Health and Intellectual disAbility Services, who have announced that overdose prevention, including supervised consumption, is a critical medical and public health intervention.

90. Safehouse's overdose prevention services are legitimate medical services that fall under Section 856's express exemption.

C. *Section 856 Does Not Apply to Safehouse Because It Will Not Operate "For The Purpose Of" Illegal Drug Use.*

91. The CSA, 21 U.S.C. § 856(a) states:

> Except as authorized by this subchapter, it shall be unlawful to—
>
> (1) knowingly open, lease, rent, use, or maintain any place, whether permanently or temporarily, ***for the purpose of*** manufacturing, distributing, or using any controlled substance;
>
> (2) manage or control any place, whether permanently or temporarily, either as an owner, lessee, agent, employee, occupant, or mortgagee, and knowingly and intentionally rent,

> lease, profit from, or make available for use, with or without compensation, the place ***for the purpose of*** unlawfully manufacturing, storing, distributing, or using a controlled substance.

Id. (emphasis added).

92. Safehouse's singular purpose is to provide lifesaving medical treatment, primary care, and wraparound services to a vulnerable population at high risk of overdose death and complications from opioid use disorder.

93. Safehouse will not provide these services "for the purpose" of unlawful drug use within the meaning of Section 856—they are for the purpose of providing immediate, proximate access to lifesaving medical care to those at high risk of overdose death.

94. Safehouse's legitimate and urgent medical and public health mission and purpose removes its proposed activities from Section 856's scope.

D. *The CSA Does Not Define "Unlawful . . . Use" of Controlled Substances.*

95. Section 856(a)(2) prohibits management or control of a place for the purpose of "***unlawfully*** manufacturing, storing, distributing, or ***using a controlled substance***." 21 U.S.C. § 856(a)(2) (emphases added). Although the CSA elsewhere expressly defines and prohibits the unauthorized manufacture, storage, or distribution of controlled substances (*see generally id.* §§ 802 (definitions), 841(a) (prohibition of manufacture, possession and distribution)), nowhere does it define or proscribe "unlawful[] . . . us[e]." It is unclear from either Section 856 or the CSA as a whole what "unlawful[] . . . us[e]" means.

96. Safehouse will not manufacture, store, or distribute any controlled substances. The only possible portion of Section 856(a)(2) that could apply is the prohibition against providing a place for "unlawful[] . . . us[e]"—an undefined term that does not plainly encompass Safehouse's

medically supervised consumption services model, which allows drug use in its facility only for the purpose of enabling access to a critical medical intervention.

E. *The Rule of Lenity Forecloses the DOJ's Expansive Interpretation of Section 856.*

97. The DOJ's unprecedented interpretation of Section 856 cannot be reconciled with several canons of construction, including the rule of lenity and the clear statement canon.

98. If the Court is left with "any doubt about the meaning of" Section 856 it should invoke the rule that "ambiguity concerning the ambit of criminal statutes should be resolved in favor of lenity"—*i.e.*, in favor of a criminal defendant. *Yates v. United States*, 135 S. Ct. 1074, 1088 (2015) (citation omitted); *see United States v. Flemming*, 617 F.3d 252 (3d Cir. 2010).

99. The rule of lenity favors adopting Safehouse's interpretation of a criminal statute where both interpretations of the government and the defendant are "plausible." *Flemming*, 617 F.3d at 270. Similarly, when a "choice has to be made between two readings of what conduct Congress has made a crime, it is appropriate, before we choose the harsher alternative, to require that Congress should have spoken in language that is clear and definite." *United States v. Universal C.I.T. Credit Corp.*, 344 U.S. 218, 221–22 (1952); *Yates*, 135 S. Ct. at 1089.

100. The phrases "except as authorized by," "for the purpose of," and "unlawful[]. . . us[e]" in Section 856 are ill-defined and cast substantial doubt on the statute's application to Safehouse's proposed overdose prevention services.

101. That doubt is only magnified when Section 856 is examined in the context of the CSA as a whole. Because a court's "duty . . . is 'to construe statutes, not isolated provisions,'" the Supreme Court instructs that "when deciding whether the language is plain, we must read the words 'in their context and with a view to their place in the overall statutory scheme.'" *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015) (citations omitted). The Supreme Court thus observed that

"oftentimes the 'meaning—or ambiguity—of certain words or phrases may only become evident when placed in context.'" *Id.* (citation omitted).

102. Here, the words of Section 856 must be read in the context of the CSA as a whole, its purpose, and its history, which evince no intent to criminalize Safehouse's medical and public health intervention to prevent overdose deaths, much less do so unambiguously.

103. Section 856 must also be interpreted in harmony with other federal statutes, including CARA and the Appropriations Act of 2016, which endorse and provide federal funding to a continuum of overdose prevention and harm reduction services. *See Food & Drug Admin. v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) ("A court must . . . interpret [a] statute 'as a symmetrical and coherent regulatory scheme,' and 'fit, if possible, all parts into an harmonious whole.' Similarly, the meaning of one statute may be affected by other Acts, particularly where Congress has spoken subsequently and more specifically to the topic at hand." (citations omitted)).

104. The DOJ's incongruous interpretation of Section 856 would criminalize the provision of medical care in the short gap between otherwise legal and federally endorsed syringe exchange services and overdose reversal administration. That result would be entirely inconsistent with the federal scheme established by the CSA, CARA, and HHS and CDC federal guidance and policy.

105. The rule of lenity therefore strongly counsels in favor of Safehouse's proposed interpretation of Section 856.

IV. APPLICATION OF SECTION 856 TO REGULATE LOCAL, NON-COMMERCIAL CONDUCT WOULD EXCEED THE AUTHORITY GRANTED BY THE COMMERCE CLAUSE AND UNCONSTITUTIONALLY UPSET THE BALANCE BETWEEN FEDERAL AND STATE AUTHORITY.

106. The DOJ's proposed interpretation of Section 856, as applied to Safehouse, exceeds the bounds of Congress's constitutional authority to regulate interstate commerce.

107. Congress lacks a general police power. *See United States v. Morrison*, 529 U.S. 598, 618–19 (2000); *Jones v. United States*, 529 U.S. 848, 850 (2000). Such power is granted only to the States. While "[t]he States have broad authority to enact legislation for the public good" through their "police power," the "Federal Government, by contrast, has no such authority." *Bond v. United States*, 572 U.S. 844, 854 (2014).

108. "[T]he regulation of health and safety matters is primarily, and historically, a matter of local concern." *Hillsborough Cty. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985); *Bond*, 572 U.S. at 853–54.

109. In light of those limits on federal authority, the Supreme Court found that the CSA "manifests no intent to regulate the practice of medicine generally," and observed, "[t]he silence is understandable given the structure and limitations of federalism, which allow the States 'great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons.'" *Oregon*, 546 U.S. at 269–70 (quoting *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996)).

110. Through this action, however, the DOJ interprets Section 856 in a way that would create a general police power for Congress.

111. Safehouse's proposed conduct has no substantial effect on interstate commerce. It is not activity that is economic in nature.

112. Safehouse is a non-profit corporation. Its operation will charge no fees, and will produce no revenue. Safehouse's facility will be entirely local and will not be engaged in facilitating commerce of any kind. Safehouse will not charge participants for its harm reduction and overdose prevention services; will not manufacture, sell, or administer unlawful drugs; will not permit the distribution or sale of drugs on site; will not provide any of its services across state lines; will not permit the exchange of any currency; will not allow participants to share consumption equipment or help another person consume drugs; and will not allow staff to handle illegal drugs or help participants consume drugs. No link therefore exists between Safehouse's proposed conduct and interstate commerce.

113. The operation of Safehouse's overdose prevention services will have no adverse impact on the legitimate CSA goal of suppressing the interstate market for illegal drugs. In fact, studies show that medically supervised consumption sites actually reduce drug use.

114. Section 856 lacks a jurisdictional element to ensure that the reach of the law has an explicit connection with or effect on interstate commerce.

115. Congress has never found that any conduct remotely similar to Safehouse's proposed model affects interstate commerce. In particular, while Congress found in 21 U.S.C. § 801(2) that "illegal importation, manufacture, distribution, and possession *and improper use* of controlled substances have a substantial and detrimental effect on *the health and general welfare* of the American people," its finding in Section 801(3) with respect to the effect on interstate commerce of local drug activities extends only to "manufacture, local distribution, and possession," *not* "use." *See id*. § 801(3) (emphases added). Similarly, the findings in Sections 801(4), (5) and (6) concerning the interstate impact of local drug activities conspicuously omit

"use" from the listed activities. The application of Section 856 to entirely local and noncommercial "use" is therefore of doubtful constitutionality.

116. States and localities, under our constitutional regime, are laboratories of experimentation that may develop new and innovative solutions to pressing issues of public health and policy. Safehouse attempts to employ such a solution to a pressing local health crisis.

117. Local officials, including the Philadelphia's Mayor, Public Health Commissioner, Director of the Department of Behavioral Health, and District Attorney, support Safehouse's efforts to mitigate the opioid crisis.

118. Similar overdose prevention efforts have proven to be effective in other countries and by clinically sound data.

119. Serious federalism concerns are raised by the DOJ's extension of federal law to interfere with traditionally local activities and to exercise powers traditionally reserved to the State, such as the regulation of volunteer medical treatment.

120. This Court should avoid an interpretation of Section 856 that implicates these serious constitutional concerns. "[S]o long as the statute is found to be susceptible of more than one construction"—one of which "raises a serious doubt as to its constitutionality"—the constitutional avoidance canon applies. *Guerrero-Sanchez v. Warden York Cty. Prison*, 905 F.3d 208, 223 (3d Cir. 2018) (citation and internal quotation marks omitted). But the DOJ seeks to disrupt the traditional balance of federal and state authority over public health initiatives, without any clear indication that Congress intended to thwart the traditional rights of States and localities.

121. To preserve these principles of federalism, "it is incumbent upon the federal courts to be *certain* of Congress' intent before finding that federal law overrides the usual constitutional balance of federal and state powers." *Bond*, 572 U.S. at 858 (citation and internal quotation marks

omitted). No such certainty exists with respect to Section 856, however, because the CSA "manifests no intent to regulate the practice of medicine generally." *Oregon*, 546 U.S. at 270.

122. Because the government's proposed interpretation of Section 856 would significantly disrupt the traditional balance of state and federal authority in the realm of public health, this Court should reject the government's unprecedented interpretation of Section 856. *See Jones*, 529 U.S. at 858 (explaining that, where Congress enacts criminal law that touches on areas traditionally falling within the authority of the States, courts will assume—"unless Congress conveys its purpose clearly"—that Congress "will not be deemed to have significantly changed the federal-state balance in the prosecution of crimes." (citation and internal quotation marks omitted)).

123. This Court could avoid these constitutional concerns about federalism and the scope of Congress's power to regulate commerce by rejecting the DOJ's interpretation of Section 856 and declaring that Section 856 does not prohibit Safehouse's provision of urgent, lifesaving medical treatment.

V. SAFEHOUSE'S LIFESAVING MISSION IS AN EXERCISE OF ITS FOUNDERS' AND DIRECTORS' RELIGIOUS BELIEFS

124. Safehouse's board members are adherents of religions in the Judeo-Christian tradition. For example:

i. Frank A. James III is a Christian and President of Missio Seminary (formerly known as Biblical Theological Seminary).

ii. Chip Mitchell is an adherent of and Lead Evangelist at the Greater Philadelphia Church of Christ.

iii. Board President José Benitez was raised and educated as a Roman Catholic; his entire professional life, including as Director of Prevention Point, has been an exercise in living out that faith and those teachings.

iv. Board Vice President Ronda Goldfein was raised with strong Jewish values and still worships in the small South Jersey synagogue cofounded by her grandfather; her entire professional life, including as Executive Director of the AIDS Law Project of Pennsylvania, has been an exercise in living out that faith and those teachings.

125. The board members' religious beliefs have been ingrained in them by their religious schooling, their devout families, and their practices of worship.

126. At the core of all board members' faith is the principle that the preservation of human life is paramount and overrides any other considerations.

127. This principle is rooted in scripture, and appears throughout the Old and New Testaments. For example:

i. According to the Shulchan Aruch, the Code of Jewish Law, "the Torah has granted the physician permission to heal, and it is a religious duty which comes under the rule of saving an endangered life. If he withholds treatment, he is regarded as one who sheds blood." Shulchan Aruch, Yoreh De'ah 336:1.

ii. The Book of Leviticus contains the clear commandment: "You shall not go up and down as a talebearer among your people; neither shall you stand idly by the blood of your neighbor: I am the Lord." Leviticus 19:16.

iii. In Deuteronomy, Moses conveys God's commandment: "You shall open wide your hand to your brother, to the needy and to the poor, in your land." Deuteronomy 15:11.

iv. The Talmud teaches: "It was for this reason that man was first created as one person [Adam], to teach you that anyone who destroys a life is considered by Scripture to have destroyed an entire world; and anyone who saves a life is as if he saved an entire world." Mishnah Sanhedrin 4:5

v. In the Gospel of John, Jesus refused to condemn to death a woman who had sinned, and cautioned fellow believers, "[l]et any one of you who is without sin be the first to cast a stone." John 8:7-11.

vi. The Gospel of John also counsels Christians: "The way we came to know love was that [Jesus] laid down his life for us; so we ought to lay down our lives for our brothers. If someone who has worldly means sees a brother in need and refuses him compassion, how can the love of God remain in him? Children, let us love not in word or speech but in deed and truth." 1 John 3:16-18.

vii. Matthew 25:34-40 directs believers to take in and care for the sick: "Then the king will say to those on his right, 'Come, you who are blessed by my Father. Inherit the kingdom prepared for you from the foundation of the world. For I was . . . ill and you cared for me. . . . Amen, I say to you, whatever you did for one of the least brothers of mine, you did for me.'"

viii. And in his Epistle to the Galatians, Paul the Apostle instructs Christians to "[b]ear one another's burdens, and so fulfill the law of Christ." Galatians 6:2.

128. The board members' religious beliefs obligate them to take action to save lives in the current overdose crisis, and thus to establish and run Safehouse in accordance with these tenets. Specifically, the board members believe that the provision of overdose prevention services

effectuates their religious obligation to preserve life, provide shelter to our neighbors, and to do everything possible to care for the sick.

129. The DOJ's threats and the initiation of a lawsuit against Safehouse burdens Safehouse by forcing it to choose between the exercise of its founders' and directors' religious beliefs and conformity with the DOJ's interpretation of Section 856.

130. The DOJ's interest in enforcement of Section 856 against Safehouse furthers no legitimate, much less a compelling interest, and the DOJ will be unable to meet its burden under RFRA to prove that it does.

131. To the contrary, enforcement of Section 856 against Safehouse will result in preventable deaths.

132. The government will also not be able to meet its burden of proving that preventing Safehouse from opening is the least restrictive means of fostering any compelling interest it may invoke.

133. Declaring Safehouse to be illegal will not reduce the manufacture, distribution, or possession of illegal drugs. Rather, when Safehouse does open, the demand for illegal drugs will decrease because some of its beneficiaries will seek and be provided with drug treatment.

CAUSES OF ACTION

COUNT I
Declaratory Judgment Regarding the Application of Section 856 to Safehouse

134. Safehouse repeats and re-alleges Paragraphs 1 through 133 as if fully set forth herein.

135. The CSA provides, in pertinent part:

> Except as authorized by this subchapter, it shall be unlawful to—

> (1) knowingly open, lease, rent, use, or maintain any place, whether permanently or temporarily, ***for the purpose of*** manufacturing, distributing, or ***using*** any controlled substance;
>
> (2) manage or control any place, whether permanently or temporarily, either as an owner, lessee, agent, employee, occupant, or mortgagee, and knowingly and intentionally rent, lease, profit from, or make available for use, with or without compensation, the place ***for the purpose of unlawfully*** manufacturing, storing, distributing, or ***using*** a controlled substance.

21 U.S.C. § 856(a) (emphases added).

136. Safehouse will not make its premises available "for the purpose of unlawfully . . . using a controlled substance."

137. Safehouse will operate only for the purpose of providing lifesaving medical treatment and critical wraparound services to a vulnerable population at risk of overdose death and complications from substance use disorder.

138. Safehouse will furnish legitimate and urgent medical services, which are not prohibited under 21 U.S.C. § 856.

139. Accordingly, pursuant to 28 U.S.C. § 2201, Safehouse is entitled to a declaration that it will not violate 21 U.S.C. § 856(a) by operating in accordance with its overdose prevention services model.

140. Safehouse is also entitled to a permanent injunction preventing the U.S. Attorney General from enforcing 21 U.S.C. § 856 against Safehouse.

COUNT II
Violation of the Religious Freedom Restoration Act, 42 U.S.C. § 2000bb *et seq.*

141. Safehouse repeats and re-alleges Paragraphs 1 through 140 as if fully set forth herein.

142. Allowing individuals at risk of an overdose to remain under medical supervision and in close proximity to urgent medical care is an exercise of the religious belief of Safehouse

and its board members that the preservation of human life is paramount and overrides other considerations. In the exercise of their religion, Safehouse and its principals intend to open and operate Safehouse as described above in this Counterclaim, as they are called to do.

143. The DOJ's interpretation of 21 U.S.C. § 856, and in particular its present effort to enforce that interpretation, substantially burdens Safehouse's exercise of its religious commitments.

144. The DOJ's threat to prosecute Safehouse substantially burdens Safehouse's exercise of its religion.

145. The DOJ's ongoing litigation against Safehouse substantially burdens Safehouse's exercise of its religion.

146. Counterclaim Defendant and Third-Party Defendants will not be able to carry its burden of proof to show that their attempts to prevent Safehouse's religious exercise are in furtherance of a compelling governmental interest.

147. Counterclaim Defendant and Third-Party Defendants will not be able to carry their burden of proof to show that these attempts are the least restrictive means of furthering any compelling governmental interest.

148. The DOJ's actions violate Safehouse's right to free religious exercise guaranteed by RFRA, 42 U.S.C. § 2000bb *et seq*.

149. Without injunctive and declaratory relief against the government, Safehouse has been and will continue to be harmed.

PRAYER FOR RELIEF

Safehouse respectfully requests that this Court enter judgment in its favor and grant the following relief:

i. A declaration that Safehouse's establishment and proposed operation of its overdose prevention services model will not violate 21 U.S.C. § 856;

ii. A declaration that a prohibition or penalizing of Safehouse's establishment and proposed operation of its overdose prevention services model will violate 42 U.S.C. § 2000bb;

iii. A declaration that 21 U.S.C. § 856, as applied to Safehouse, violates the Commerce Clause of Article I of the U.S. Constitution;

iv. An injunction permanently enjoining the Third-Party Defendants from enforcing or threatening to enforce 21 U.S.C. § 856 against Safehouse;

v. An order awarding such additional relief as the Court may deem appropriate and just under the circumstances.

Dated: April 3, 2019

Respectfully submitted,

DLA PIPER LLP (US)

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CERTIFICATE OF SERVICE

I hereby certify that on April 3, 2019, the foregoing document was electronically filed with the Clerk of Court using the CM/ECF system.

Notice will be sent to all CM/ECF registrants in this action via the CM/ECF system. Pursuant to Federal Rule of Civil Procedure 4(i), a copy of the foregoing was also sent via USPS certified mail to:

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Safe Injection Sites and the Federal "Crack House" Statute

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SAFE INJECTION SITES AND THE FEDERAL "CRACK HOUSE" STATUTE

ALEX KREIT

SAFE INJECTION SITES AND THE FEDERAL "CRACK HOUSE" STATUTE

ALEX KREIT*

Abstract: Safe injection sites have become the next battlefield in the conflict between state and federal drug laws. A safe injection site is a place where injection drug users can self-administer drugs in a controlled environment under medical supervision. They have been operating in other countries, including Canada, for decades, and a wealth of evidence suggests that they can help to reduce overdose deaths. To date, however, no United States city or state has sanctioned a safe injection site. Until recently, safe injection sites were politically untenable, seen as a form of surrender in the war on drugs. This dynamic, however, has changed over the past few years. Prominent politicians from across the political spectrum have called for an end to the drug war, and the opioid epidemic has grown increasingly dire. Efforts to start safe injection sites are currently underway in at least thirteen United States cities and states. Five cities—Denver, New York, Philadelphia, San Francisco, and Seattle—have gone so far as to announce plans to open an injection site. There is just one small problem: the site proposals appear to violate the federal crack house statute, which makes it a crime to maintain drug-involved premises. The Department of Justice has not yet taken a formal position on safe injection sites, but in a *New York Times* editorial, Deputy Attorney General Rod Rosenstein threatened that "cities and states should expect the Department of Justice to meet the opening of any injection site with swift and aggressive action." Surprisingly, this looming conflict has gone almost entirely overlooked by legal academics. Meanwhile, the public debate has assumed that safe injection sites are clearly forbidden by federal law. This Article argues that assumption is wrong. Despite the crack house statute, an obscure provision of the federal Controlled Substances Act (CSA) might allow states and localities to establish government-run safe injection sites. Buried in the CSA is a provision that im-

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munizes state and local officials who violate federal drug laws in the course of "the enforcement of any law or municipal ordinance relating to controlled substances." This provision was almost surely intended to protect state and local police officers that possess and distribute drugs in connection with undercover operations. Nevertheless, this Article argues, the text of the immunity provision and the scarce case law interpreting it suggest it could shield government-run safe injection sites from federal interference.

INTRODUCTION

The first government-sanctioned safe injection site opened in Berne, Switzerland in 1986.[1] In the years since, approximately one hundred safe injection sites have been established in ten countries, including Canada, but not the United States.[2] This may soon change, at least if the choice is left up to local decision makers. As of July 2018, there were at least thirteen U.S. cities and states beginning efforts to open supervised injection sites.[3] In February 2018, the director of San Francisco's Department of Public Health announced that the city hoped to become the first in the nation to permit safe injection facilities, with plans to have two open around the beginning of July 2018.[4] When July 2018 came, however, the city backed away from its original plan. Instead, it opened a non-operational prototype facility for four days in late August as an exhibition for interested community members.[5]

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[1] *Drug Consumption Rooms: An Overview of Provision and Evidence*, EUR. MONITORING CTR. FOR DRUGS & DRUG ADDICTION (July 6, 2018), http://www.emcdda.europa.eu/attachements.cfm/att_239692_EN_Drug%20consumption%20rooms_update%202016.pdf [https://perma.cc/XK7Z-KKK6].

[2] Alex H. Kral & Peter J. Davidson, *Addressing the Nation's Opioid Epidemic: Lessons from an Unsanctioned Supervised Injection Site in the U.S.*, 53 AM. J. PREVENTATIVE MED. 919, 919 (2017) (reporting that approximately ninety-eight supervised injection sites are currently operating in sixty cities in Australia, Canada, Denmark, France, Germany, Luxembourg, the Netherlands, Norway, Spain, and Switzerland). Although no U.S. city has permitted safe injection sites, at least one unsanctioned facility has been operating in "an undisclosed urban area" in the United States since September 2014. *Id*.

[3] Bobby Allyn, *Cities Planning Supervised Drug Injection Sites Fear Justice Department Reaction*, NPR (July 12, 2018), https://www.npr.org/sections/health-shots/2018/07/12/628136694/harm-reduction-movement-hits-obstacles [https://perma.cc/WM6C-37SX].

[4] Heather Knight, *SF Safe Injection Sites Expected to Be First in Nation, Open Around July 1*, S.F. CHRON., (Feb. 5, 2018), https://www.sfchronicle.com/news/article/SF-safe-injection-sites-expected-to-be-first-in-12553616.php [https://perma.cc/5TH8-FHJD].

[5] Laura Waxmann, *Mock Safe Injection Site Opens in SF Amid Threat of Federal Prosecution*, S.F. EXAMINER (Aug. 29, 2018), http://www.sfexaminer.com/mock-safe-injection-site-opens-sf-amid-threat-federal-prosecution/ [https://perma.cc/CZ2D-K8MG]. Safe injection sites are referred to by a number of different names, including supervised injection facilities, safer consumption services, and overdose prevention sites. This Article uses these terms interchangeably. *See generally,* Colleen L. Barry et al., *Language Matters in Combatting the Opioid Epidemic: Safe*

Safe injection sites are places where individuals can safely use their own drugs under the supervision of trained professionals.[6] They are a harm reduction measure, aimed at allowing people to use drugs safely and reducing public disturbances caused by people using drugs on the streets or in public bathrooms.[7] A wealth of evidence suggests that, if properly implemented, safe injection facilities succeed in achieving these goals. Safe injection sites have been shown to reduce overdose deaths, increase participation in drug treatment programs, and lessen injection drug use in public.[8]

Despite strong empirical support for safe injection facilities, U.S. policymakers have traditionally been resistant to them. Like many other public health-oriented drug strategies—from needle exchange to heroin-assisted treatment[9]—safe injection sites were long considered to be off-limits in the United States simply because they were incompatible with the war on drugs.[10] Through the lens of the drug war, these sort of harm reduction measures were seen as a "form[] of surrender"[11] and rejected out of hand. The dynamic has begun to change over the past decade, however, as a number of prominent politicians from across the political spectrum have called for an end to the war on drugs.[12] At the same time, the opioid epidemic has grown increasingly dire. With more than 52,000 drug overdose deaths in 2015—up over 300% since 2000—our country is arguably "in the worst drug-related crisis in its history."[13]

This convergence of events has led, somewhat suddenly, to serious efforts in a number of U.S. cities to establish safe injection facilities. Less than one month before San Francisco announced its intention to become the first city with a safe injection site, officials in Philadelphia gave the go-

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Consumption Sites Versus Overdose Prevention Sites, 108 AM. J. PUB. HEALTH 156 (2018) (discussing the lack of uniformity about the names used to refer to these sites).

[6] Kral & Davidson, *supra* note 2, at 919.

[7] *Id.*

[8] *See infra* notes 32–51 and accompanying text (providing an overview of empirical evaluations of safe injection sites).

[9] For an overview of needle exchange programs (also called syringe exchange programs), see generally Steven R. Salbu, *Needle Exchange, HIV Transmission, and Illegal Drug Use: Informing Law and Public Policy with Science and Rational Discourse,* 33 HARV. J. ON LEGIS. 105 (1996). For an overview of heroin-assisted treatment, see, for example, Dan Werb, *Heroin Prescription, HIV, and Drug Policy: Emerging Regulatory Frameworks*, 91 OR. L. REV. 1213 (2013).

[10] *See* Alex Kreit, *Drug Truce*, 77 OHIO ST. L.J. 1323, 1336–37 (2016) (discussing the impact of drug war politics on the pursuit of harm reduction measures in the United States).

[11] William J. Bennett, *The Drug War Worked Once; It Can Again*, WALL STREET J. (May 15, 2001), https://www.wsj.com/articles/SB989884118310019941 [https://perma.cc/EP6V-34PA].

[12] Kreit, *supra* note 10, at 1324–26.

[13] Leo Beletsky & Corey S. Davis, *Today's Fentanyl Crisis: Prohibition's Iron Law, Revisited*, 46 INT'L J. DRUG. POL'Y 156, 156 (2017).

ahead to open a facility.[14] In late 2017, the Seattle City Council passed a budget that included $1.3 million for a safe injection site.[15] Other locales that are considering permitting safe injection sites include Boston, Denver, New York City, and the State of Vermont.[16]

With so many interested cities, it seems like only a matter of time before government-sanctioned safe injection sites are open in the United States. There is just one small problem: they appear to violate federal law.

Because safe injection site operators do not handle drugs themselves, it is unlikely the facilities would run afoul of federal laws criminalizing drug possession and distribution.[17] But they would almost certainly violate the so-called federal crack house statute. Passed in the mid-1980s, the crack house statute makes it a crime to make property available to others "for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance."[18] Because safe injection site clients would be at the property for the purpose of using illegal drugs, facility operators—including

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[14] Elana Gordon, *What's Next for 'Safe Injection' Sites in Philadelphia?*, NPR (Jan. 24, 2018), https://www.npr.org/sections/health-shots/2018/01/24/580255140/whats-next-for-safe-injection-sites-in-philadelphia [https://perma.cc/DJ5S-W842].

[15] *Seattle Budget Includes Money for Safe-Injection Site*, ASSOCIATED PRESS (Nov. 21, 2017), https://www.usnews.com/news/best-states/washington/articles/2017-11-21/seattle-budget-includes-money-for-safe-injection-site [https://perma.cc/5XNQ-7WUW].

[16] *See infra* notes 52–85 and accompanying text (providing an overview of efforts to establish safe injection facilities).

[17] One does not need to touch an item to possess it. A person can constructively possess contraband if she has the "power and intent" to exercise dominion and control over it. Henderson v. United States, 135 S. Ct. 1780, 1784 (2015) ("Constructive possession is established when a person, though lacking such physical custody, still has the power and intent to exercise control over the object."). Under this formulation, knowing presence near contraband is insufficient to establish constructive possession. *See* United States v. Richard, 696 F.2d 849, 856 (10th Cir. 1992) ("[M]ere proximity to illegal drugs, mere presence on the property where they are located, or mere association with persons who do control them, without more, is insufficient to support a finding of possession."). As a result, it does not appear that safe injection site operators would be in possession of illegal drugs that were on their premises. Nor would they be likely to be accomplices to drug possession. Assuming *arguendo* that a safe injection facility facilitates the possession of a controlled substance, accomplice liability attaches only to those who act "with the intent of facilitating the offense's commission." Rosemond v. United States, 572 U.S. 65, 71 (2014). Safe injection operators do not intend to help users possess drugs; their purpose is to provide medical services to injection drug users. *See* Scott Burris et al., *Federalism, Policy Learning, and Local Innovation in Public Health: The Case of the Supervised Injection Facility*, 53 ST. LOUIS U. L.J. 1089, 1133 (2009) ("An SIF is providing a space for use of controlled substances not for its own sake or for profit, but in order to promote drug treatment, prevent disease, and avoid overdose mortality.").

[18] 21 U.S.C. § 856(a) (2012).

employees—would almost certainly be susceptible to charges for maintaining drug-involved premises.[19]

The United States Department of Justice (DOJ) has not yet taken a formal position on safe injection facilities, but early signs suggest that the Trump administration is unlikely to defer to states and cities on this issue. The Drug Enforcement Administration (DEA) has stated that it believes safe injection sites would violate the crack house statute.[20] The United States Attorneys for the districts of Colorado, Massachusetts, and Vermont have announced that if safe injection sites were established in their states, they would consider bringing criminal charges against facility employees.[21] In August 2018, Deputy Attorney General Rod Rosenstein penned a *New York Times* editorial in opposition to safe injection sites in which he warned that "cities and counties should expect the Department of Justice to meet the opening of any injection site with swift and aggressive action."[22] Last but not least, shortly before this article went to press, the United States Attorney for the Eastern District of Pennsylvania filed a lawsuit against Safehouse, a nonprofit that has been working with the city of Philadelphia to open a safe

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[19] *See infra* notes 173–277 and accompanying text (analyzing how the crack house statute would apply to safe injection sites).

[20] Tony Pugh, *Supervised Injection Sites Aimed at Cutting Opioid Overdoses Risk the Wrath of the DEA and Prosecutors*, PITT. POST-GAZETTE, (Mar. 20, 2018), http://www.post-gazette.com/news/nation/2018/03/20/Supervised-injection-sites-aimed-at-cutting-opioid-overdoses-risk-the-wrath-of-the-DEA-and-prosecutors/stories/201803190215 [https://perma.cc/TP5K-JP7S]; *see also* Dominic Holden, *The Trump Administration Says Proposed Heroin Injection Sites Could Face "Legal Action,"* BUZZFEED NEWS (Feb. 14, 2018), https://www.buzzfeed.com/dominicholden/the-trump-administration-says-proposed-heroin-injection?utm_term=.tuAJ4jDxk#.faGGEvldP [https://perma.cc/558K-BBJY] (quoting a Drug Enforcement Agency (DEA) spokeswoman that "[s]upervised injection facilities, or so-called safe injection sites, violate federal law").

[21] U.S. ATTORNEY'S OFFICE DIST. OF CO., JOINT-STATEMENT OF THE U.S. ATTORNEY'S OFFICE AND THE DENVER FIELD OFFICE OF THE DRUG ENFORCEMENT ADMINISTRATION REGARDING THE CITY AND COUNTY OF DENVER'S PROPOSAL TO CREATE SUPERVISED LOCATIONS TO INJECT HEROIN AND OTHER ILLEGAL DRUGS (Dec. 4, 2018), https://www.justice.gov/usao-co/pr/joint-statement-us-attorney-s-office-and-denver-field-office-drug-enforcement [https://perma.cc/G32H-87DA]; U.S. ATTORNEY'S OFFICE DIST. OF VT., STATEMENT OF THE U.S. ATTORNEY'S OFFICE CONCERNING PROPOSED INJECTION SITES (Dec. 13, 2017), https://www.justice.gov/usao-vt/pr/statement-us-attorney-s-office-concerning-proposed-injection-sites [https://perma.cc/P97H-FEBK]; Associated Press, *Prosecutor: Feds Won't Recognize Injection Sites in Mass.,* BOSTON.COM (July 19, 2018), https://www.boston.com/news/local-news/2018/07/19/prosecutor-feds-wont-recognize-injection-sites-in-mass [https://perma.cc/4N4U-ESS5] ("The top federal prosecutor in Massachusetts says supervised injection sites for drug users would violate U.S. law and could lead to criminal charges.").

[22] Rod J. Rosenstein, *Fight Drug Abuse, Don't Subsidize It*, N.Y. TIMES (Aug. 27, 2018), https://www.nytimes.com/2018/08/27/opinion/opioids-heroin-injection-sites.html [https://perma.cc/UE9N-4EYR].

injection site. Citing the crack house statute, the lawsuit seeks a declaratory judgment to stop Safehouse from going through with its plans.[23]

To date, the debate over supervised injection facilities has largely assumed that their status under federal law is clear and the only question is whether federal prosecutors will "turn a blind eye, as it's largely done with marijuana, or bring states to court."[24] This Article raises the possibility that, contrary to conventional wisdom, an obscure provision of the federal Controlled Substances Act (CSA) might already allow states and localities to establish safe injection facilities. Buried in the CSA is a provision that grants immunity from civil or criminal liability to "any duly authorized officer of any State, territory, political subdivision thereof, the District of Columbia, or any possession of the United States, who shall be lawfully engaged in the enforcement of any law or municipal ordinance relating to controlled substances."[25] This provision was likely intended to immunize state and local police officers that violate federal drug laws in connection with undercover operations. Nevertheless, the plain text of the provision, and the scant case law that exists interpreting it, suggests that it could shield government-run safe injection facilities from federal interference. Indeed, it is even possible that the provision could immunize a privately-run facility, if the operators were deputized as "duly authorized officer[s]"[26] in connection with a state or local safe injection law.

Although there is an extensive literature on safe injection sites in the fields of public health and public policy, legal academics have almost entirely overlooked the subject. Only a handful of articles have examined the legal implications of safe injection facilities.[27] None have considered the immunity provision that is the focus of this Article.

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[23] Complaint for Declaratory Judgment, United States v. Safehouse, 2:19-cv-00519-GAM (E.D. Pa. 2019), https://www.courthousenews.com/wp-content/uploads/2019/02/SAFEHOUSE.pdf [https://perma.cc/WCM2-3TXZ]; *see also* Bobby Allyn, *U.S. Prosecutors Sue to Stop Nation's First Supervised Injection Site for Opioids*, NPR (Feb. 6, 2019), https://www.npr.org/sections/health-shots/2019/02/06/691746907/u-s-prosecutors-sue-to-stop-nation-s-first-supervised-injection-site [https://perma.cc/ARK4-JTVP].

[24] The Editorial Board, *Let Cities Open Safe Injection Sites*, N.Y. TIMES (Feb. 24, 2018), https://www.nytimes.com/2018/02/24/opinion/sunday/drugs-safe-injection-sites.html [https://perma.cc/EWQ6-5RAJ].

[25] 21 U.S.C. § 885(d) (2012).

[26] *Id.*

[27] Burris et al., *supra* note 17, at 1133 (examining safe injection sites and arguing that courts should adopt a narrow interpretation of the crack house statute in order to allow them to be established in the United States); Christine Bulgozdi, *Supervised Injection Facilities: Fighting the Prescription Overdose Epidemic*, 26 ANNALS HEALTH L. ADVANCE DIRECTIVE 118, 128–29 (2017) (proposing that lawmakers consider establishing a combined program of prescription drug monitoring and safe injection sites in order to fight overdoses, but acknowledging that federal law would currently block such a program); Cylas Martell-Crawford, *Safe Injection Facilities: A Path*

Part I of this Article introduces the safe injection sites in more detail. It includes an overview of some of the evidence that supports them and the current efforts to establish them in the United States.[28] Part II addresses the primary roadblock standing in the way of safe injection sites: the federal crack house statute.[29] It also explains why previously proposed strategies for circumventing that law are unlikely to be successful. Part III argues that an often-overlooked provision of the Controlled Substances Act—its immunity provision—should allow cities and states to open government-run safe injection sites without federal interference.[30] Part IV situates the looming conflict between cities and the federal government over safe injection sites within the broader debate about the future of the war on drugs.[31] Part V concludes.

I. EFFORTS TO ESTABLISH SAFE INJECTION FACILITIES IN THE UNITED STATES

A. Evidence Supporting Safe Injection Facilities

Although serious discussion of safe injection facilities is new to the United States, they have been operating in other countries for decades. Safe injection facilities are founded on the principle of harm reduction, which "[i]n much of the developed world . . . is recognized as one of the four pillars of drug control, alongside enforcement, treatment, and prevention."[32] Harm reduction programs are designed "to aid dependent drug users without attempting to curtail their use."[33] The idea is to reduce the negative consequences associated with drug use, both to the user and to the public, without necessarily reducing drug use itself. Consistent with this strategy, the first sanctioned safe injection site, which opened in Berne, Switzerland in

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to Legitimacy, 11 ALB. GOV'T L. REV. 124, 141 (2018) (considering whether states and cities could raise a constitutional challenge to federal laws that block safe injection sites on the theory that the "DOJ's failure to exempt safe injection facilities [from the CSA] infringes upon drug addict's equal protection to treatment").

[28] *See infra* notes 32–86 and accompanying text.

[29] *See infra* notes 87–172 and accompanying text.

[30] *See infra* notes 173–277 and accompanying text.

[31] *See infra* notes 278–297 and accompanying text.

[32] Jonathan P. Caulkins & Peter Reuter, *Dealing More Effectively and Humanely with Illegal Drugs*, 46 CRIME & JUST. 95, 117 (2017). Harm reduction principles are not limited to the drug control setting but are used in connection with other activities that can carry negative health consequences, such as risky sexual activity. Melissa Vallejo, Note, *Safer Bathrooms in Syringe Exchange Programs: Injecting Progress into the Harm Reduction Movement*, 118 COLUM. L. REV. 1185, 1190 n.37 (2018).

[33] Caulkins & Reuter, *supra* note 32, at 117. Although reduced drug use is not a primary goal of harm reduction, harm reduction policies are not necessarily incompatible with the goal of use reduction. Indeed, some evidence suggests that safe injection facilities can help to reduce drug use by serving as an entry point for users to seek addiction treatment.

1986, was intended to "reduc[e] the nuisance associated with public injecting as well as public health problems such as HIV transmission and drug overdose."[34] Today, supervised injection sites are operating in sixty-six cities in ten different countries (Australia, Canada, Denmark, France, Germany, Luxembourg, the Netherlands, Norway, Spain, and, of course, Switzerland).[35]

Safe injection sites can differ from one another in their operational specifics. They "embrace[] a range of types of service[s], delivered in differing ways, targeting different populations, within different contexts."[36] Despite these differences, supervised injection facilities share a number of similarities.[37] At the broadest level, all supervised injection facilities are designed to provide a safe space to use a drug with medical personnel on hand.[38] They also share common goals, namely to lower disease and death rates from drug use, decrease drug usage in public, and improve public amenities in high drug use areas.[39] Safe injection sites do not make or distribute illegal drugs, nor do they encourage drug use. Instead, users bring drugs they have purchased elsewhere to use under the watch of medical personnel with hygienic instruments.[40] Safe injection facility staff members, including trained medical personnel, are on site to intervene if there is a possible overdose by administering the overdose reversal drug Naloxone.[41] Supervised injection facilities often offer other services, including educa-

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[34] Garth Davies, *A Critical Evaluation of the Effects of Safe Injection Facilities*, 1 J. GLOBAL DRUG POL'Y & PRAC. 1, 1 (2007).

[35] Kral & Davidson, *supra* note 2, at 919.

[36] Mehmet Zülfü Öner, *An Overview of Drug Consumption Rooms*, 4 HUM. RTS. REV. 87, 92 (2014). Indeed, although often referred to as injection sites, some facilities permit the use of drugs more broadly, and it is increasingly common to see them referred to as "drug consumption rooms." *Id.*

[37] *Id.* (noting that many injection facilities share "basic common elements"). For an overview and comparison of safe injection sites, see, for example, EBERHARD SCHATZ & MARIE NOUGIER, INTERNATIONAL DRUG POLICY CONSORTIUM, DRUG CONSUMPTION ROOMS EVIDENCE AND PRACTICE 5–6 (2012), https://www.drugsandalcohol.ie/17898/1/IDPC-Briefing-Paper_Drug-consumption-rooms.pdf [https://perma.cc/BX6R-YUDA]; S.F. DEP'T OF PUB. HEALTH, HARM REDUCTION SERVICES IN SAN FRANCISCO ISSUE BRIEF 16–20 (2017) [hereafter SAN FRANCISCO ISSUE BRIEF], https://www.sfdph.org/dph/files/SIStaskforce/IssueBrief-06202017.pdf [https://perma.cc/X7CB-6NXE].

[38] Bulgozdi, *supra* note 27, at 121.

[39] *Drug Consumption Rooms: An Overview of Provision and Evidence*, *supra* note 1 (noting that safe injection facilities are intended to "to reduce morbidity and mortality by providing a safe environment for more hygienic drug use . . . [and] to reduce drug use in public and improve public amenity in areas surrounding urban drug markets").

[40] Bulgozdi, *supra* note 27, at 121 (noting that drug users are "under medical supervision using clean instruments provided by the facility").

[41] *Id.*

tion, equipment, and counseling.[42] Many of these add-on services are standard at safe injection facilities that follow the so-called "integrated" model, which is the most common type of safe injection facility.[43] Under the integrated model, the safe injection site is one part of a broader, connected group of other important health and social services located in a larger facility.[44]

Although there remains some debate about the overall strength of the empirical evidence in support of safe injection sites, a number of studies have found that they improve public health and safety outcomes for both users and the community on a range of measures. A 2014 systematic review of the literature that examined seventy-five studies found that the studies all "converged to find that [safe injection sites] were efficacious in attracting the most marginalized [people who inject drugs], promoting safer injecting conditions, enhancing access to primary health care, and reducing the overdose frequency."[45] The same literature review revealed that safe injection sites "generate public benefits such as a decrease in the number of [people] injecting [drugs] in public and a reduction of dropped syringes in public places. Contrary to what was feared, [safe injection sites] do not promote drug use and do not increase crime or drug trafficking or the number of [people who inject drugs]."[46] Perhaps most notably—particularly in light of the current overdose crisis in the United States—the 2014 literature review observed that all of the studies that had evaluated overdose-induced mortality suggested that safe injection sites were effective at reducing overdose deaths.[47] A study of the safe injection facility in Vancouver, Canada, for example, concluded that overdose deaths in the vicinity of the facility dropped by 35% after it opened while the overdose rate in the city as a whole decreased by 9.3% during that same period.[48]

A 2018 review of the evidence by the RAND Corporation likewise found existing studies to be encouraging but struck a much more cautious

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[42] Öner, *supra* note 36, at 93 (noting that safe injection sites often provide "sterile injection supplies and safe disposal, education about safer drug use and communicable disease prevention, support, counseling, [and] referrals to health and social services").

[43] *Id.* at 94.

[44] SAN FRANCISCO ISSUE BRIEF, *supra* note 37, at 21 tbl.4. The other two models of safe injection sites are the "specialized" model, under which the facility focuses exclusively on safe injection services and does not provide other services in-house, and the "mobile" model, which are "specially outfitted vans that provide space for 1–3 injection booths inside." *Id.*

[45] Chloé Potier et al., *Supervised Injection Services: What Has Been Demonstrated? A Systematic Literature Review*, 145 DRUG & ALCOHOL DEPENDENCE 48, 48 (2014).

[46] *Id.* at 65.

[47] *Id.* at 62.

[48] Brandon D.L. Marshall et al., *Reduction in Overdose Mortality After the Opening of North America's First Medically Supervised Safer Injection Facility: A Retrospective Population-Based Study*, 377 LANCET 1429, 1433 (2011).

tone than the 2014 literature review.[49] The RAND report warned against drawing any firm conclusions about safe injection sites because, "[o]verall, the scientific evidence about the effectiveness of [supervised consumption sites] is limited in quality and the number of locations evaluated."[50] As a result, the report concluded that although there is evidence that supervised drug consumption "reduce[s] the risk of disease transmission and other harms associated with unhygienic drug use practices . . . there is uncertainty about the size of the overall effect."[51]

B. Safe Injection Facilities as a Response to the Opioid Crisis

While more research may be needed to reach a definitive conclusion about the effectiveness of safe injection sites, the available evidence is strong enough that a number of state and local lawmakers have begun to seriously consider them. Interest in bringing safe injection sites to the United States is not entirely new. Drug policy reform advocates have been lobbying for their adoption for decades, occasionally piquing the curiosity of local officials. In 2007, San Francisco became the first U.S. city to explore the issue when its public health department co-sponsored a symposium on Vancouver's safe injection site.[52] According to San Francisco's director of HIV prevention at the time, the conference was meant to help city officials "figure out whether this is a way to reduce the harms and improve the health of our community."[53] The idea was politically untenable, however. In the context of the war on drugs, a safe injection site was viewed as "a form of giving up,"[54] as an Office of National Drug Control Policy official ar-

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[49] BEAU KILMER ET AL., RAND CORPORATION, RESEARCH REPORT: CONSIDERING HEROIN-ASSISTED TREATMENT AND SUPERVISED CONSUMPTION SITES IN THE UNITED STATES (2018), https://www.rand.org/content/dam/rand/pubs/research_reports/RR2600/RR2693/RAND_RR2693.pdf [https://perma.cc/79CX-DDUS].

[50] *Id.* at x.

[51] *Id.* at xi.

[52] Lisa Leff, Associated Press, *San Francisco Considers Safe-Injection Site for Drug Addicts*, USA TODAY (Oct. 18, 2007), http://usatoday30.usatoday.com/news/health/2007-10-18-sf-injections_N.htm [https://perma.cc/2F7K-QXA6].

[53] *Id.*

[54] *Id.* In an interview in 2015, one of the organizers of San Francisco's 2007 conference said that the effort "just kind of crashed and burned. The country wasn't ready for this conversation." Beth Schwartzenfel, *Is America Ready for Safe Injection Rooms?*, VICE (Nov. 6, 2015), https://www.vice.com/en_us/article/4wb5yb/is-america-ready-for-safe-injection-rooms-1106 [https://perma.cc/7RFM-59GK]. In 2009, supervised injection site advocates held a similar conference in New York City, although this time without any backing from city officials. The New York City conference did not lead to any serious interest in safe injection facilities from local policymakers. psmith, *Feature: Effort to Bring Safe Injection Facility to New York City Getting Underway*, STOPTHEDRUGWAR.ORG (May 29, 2009, 11:00PM), https://stopthedrugwar.org/chronicle/2009/may/29/feature_effort_bring_safe_inject [https://perma.cc/3HB7-DEW7].

gued at the time, and therefore unacceptable. Even then-Mayor of San Francisco Gavin Newsom, known for being boldly ahead of the political curve on other progressive issues like marriage equality and marijuana legalization, declined to back the effort.[55]

In the decade-or-so since the first effort to establish a supervised injection site in San Francisco fell flat, two developments have resulted in a dramatic shift in the political landscape: a mounting opioid epidemic and the abandonment of the war on drugs. First, problematic opioid use has become an urgent public health crisis.[56] Although the beginning of the opioid epidemic pre-dates this decade,[57] it took on a new dimension in recent years. In 2010, the crisis entered a new "phase . . . [a]fter remaining relatively stable for years, heroin overdose deaths spiked, tripling between 2010 and 2015."[58] The rise in drug overdose deaths has continued: between 2015 and 2016, drug overdose death rates rose among all age groups, ranging from a 29% increase for 25 to 34 year-olds to a 7% increase for those over 65.[59] In late 2017, the federal government went so far as to officially declare the crisis a public health emergency.[60] Prior to the federal declaration, a number of states had already issued their own public health emergency orders in response to the crisis.[61] Not surprisingly, this state of affairs has given elected officials an incentive to think creatively about how to combat opioid abuse. As San Francisco Mayor London Breed put it in a 2017 report

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[55] *See* C.W. Nevius, *Support for Supervised Injection Is Growing*, SFGATE.COM (Oct. 15, 2007), https://www.sfgate.com/bayarea/article/C-W-Nevius-Support-for-supervised-drug-2518428.php [https://perma.cc/KK44-6XS6] ("Asked for comment from Mayor Gavin Newsom, spokesman Nathan Ballard said, '[t]he mayor is not inclined to support this approach, which quite frankly may end up creating more problems than it addresses.'").

[56] *See* Beletsky, *supra* note 13 (arguing that the epidemic is "the worst drug-related crises in [U.S.] history").

[57] Nabarun Dasgupta et al., *Opioid Crisis: No Easy Fix to Its Social and Economic Determinants*, 108 AM. J. PUB. HEALTH 182, 182 (2018); *see also* Ameet Sarpatwari et al., *The Opioid Epidemic: Fixing a Broken Pharmaceutical Market*, 11 HARV. L. & POL'Y REV. 463, 464–77 (2017) (providing a brief history of the emergence of the opioid epidemic, suggesting that the epidemic has "roots . . . that are deeper than popular narrative suggests").

[58] Dasgupta, *supra* note 57, at 182.

[59] HOLLY HEDEGAARD ET AL., U.S. DEP'T OF HEALTH & HUM. SERV., DRUG OVERDOSE DEATHS IN THE UNITED STATES, 1999–2016 (Dec. 2017), https://www.cdc.gov/nchs/data/databriefs/db294.pdf [https://perma.cc/D3EJ-5JWS].

[60] Brianna Ehley, *Trump Administration Extending Opioid Emergency Declaration*, POLITICO (Jan. 19, 2018), https://www.politico.com/story/2018/01/19/trump-opioids-emergency-declaration-extension-300590 [https://perma.cc/5WSN-BCFZ].

[61] James G. Hodge, Jr. et al., *Redefining Public Health Emergencies: The Opioid Epidemic*, 58 JURIMETRICS 1, 3 (2017).

on safe injection services, "this is too big of an issue for us to rule out any possible solutions."[62]

Second, during roughly this same period, the political consensus in favor of the war on drugs gave way to an emerging consensus that the drug war strategy should be abandoned.[63] Politicians from Chris Christie, the conservative former Republican governor of New Jersey, to Cory Booker, the progressive Democratic Senator from the same state, have branded the drug war a "failure" and called for its end.[64] Both of President Barack Obama's drug czars, Gil Kerlikowske and Michael Botticelli, expressed similar views, even going so far as to refer to the drug war in the past tense.[65] To be sure, the developing anti-drug war consensus is not yet nearly as cohesive as was support for the drug war in the 1980s, 1990s, or even 2000s, and the Trump administration has taken steps to revive the war on drugs.[66] But political backing for a public health-oriented approach to drug policy has nevertheless changed the tenor of the discussion. In the context of the opioid epidemic, for example, the Obama administration released a 2011 report that "broke with decades of tradition to shift the agency's rhetorical focus toward a more evidence-based, proactive approach to what had previously been termed the 'War on Drugs,' and announced the agency's goal of decreasing unintentional opioid deaths in the United States by 15% within five years."[67] At first glance, announcing a goal to reduce overdose deaths may not seem especially noteworthy. But the move was a genuine break from the strategy of the drug war, which has had a single-minded focus on "the consumption of the prohibited substance rather than any secondary consequences,"[68] such as overdose deaths.

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[62] S.F. DEP'T OF PUB. HEALTH, S.F. SAFE INJECTION SERVS. TASK FORCE, FINAL REPORT 5 (2017), https://www.sfdph.org/dph/files/SIStaskforce/SIS-Task-Force-Final-Report-2017.pdf [https://perma.cc/E56V-JFR3].

[63] *See* Kreit, *supra* note 10, at 1324–26 (discussing this trend).

[64] *Id.* at 1325–26 (noting that Gavin Newsom and Rand Paul have made similar remarks).

[65] *Id.* at 1324 (discussing Kerlikowski's and Boticelli's criticisms of the drug war, including Kerlikowski's statement in 2011 that the administration had "ended the drug war now almost two years ago").

[66] *See* James Cooper, *The United States, Mexico, and the War on Drugs in the Trump Administration*, 25 WILLAMETTE J. INT'L L. & DISP. RESOL. 234, 281–91 (2018) (discussing the Trump administration's interest in renewing the drug war).

[67] Corey Davis et al., *Action, Not Rhetoric, Needed to Reverse the Opioid Overdose Epidemic*, 45 J. L. MED. & ETHICS 20, 20 (2017).

[68] FRANKLIN E. ZIMRING & GORDON HAWKINS, THE SEARCH FOR RATIONAL DRUG CONTROL 9 (1992).

At the federal level, the emerging drug truce has been mostly rhetorical and has not resulted in much in the way of significant concrete change.[69] The story is a bit different at the local level. On issues from marijuana legalization to the repeal of mandatory minimum drug sentencing laws, states and cities across the country have begun to translate rhetoric into real reform.[70] In response to the opioid crisis, states and cities have enacted a number of harm reduction-oriented policies. As of mid-2017, forty states and the District of Columbia had passed a "Good Samaritan" law.[71] While the specifics of these laws vary from state to state, they generally give immunity from prosecution to people who call 911 to report a drug overdose for specified offenses like drug possession.[72] Similarly, states have enacted a range of laws to increase access to the anti-overdose drug Naloxone.[73]

Some state and local lawmakers have also begun to give serious thought to more far-reaching reforms like safe injection sites that were, until just a few years ago, considered to be political nonstarters. Lawmakers in a number of states including Colorado, Massachusetts, and Vermont have discussed safe injection sites.[74] They have also attracted support from influen-

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[69] Kreit, *supra* note 10, at 1345–49 (discussing efforts to reform federal drug laws during the Obama administration and their lack of success). Federal criminal justice reform efforts finally bore fruit at the very end of 2018, with the passage of the First Step Act. First Step Act of 2018, Pub. L. No. 115-391, 132 Stat. 5194 (2018). Although not as far reaching as some of the failed legislative proposals put forward during the Obama administration, the First Step Act includes meaningful reforms to federal drug sentencing laws. *See* Erin McCarthy Holliday, *President Trump Signs Criminal Justice Reform First Step Act into Law*, JURIST.ORG (Dec. 21, 2018), https://www.jurist.org/news/2018/12/president-trump-signs-criminal-justice-reform-first-step-act-into-law/ [https://perma.cc/LS6U-THCR] (discussing the First Step Act).

[70] Kreit, *supra* note 10, at 1345–46.

[71] *Drug Overdose Immunity and Good Samaritan Laws*, NAT'L CONFERENCE OF STATE LEGISLATURES (June 5, 2017), http://www.ncsl.org/research/civil-and-criminal-justice/drug-overdose-immunity-good-samaritan-laws.aspx [https://perma.cc/583D-AES6].

[72] *See* Kelsey Bissonnette, Note, *Anti-Death Legislation: Fighting Overdose Mortality from a Public Health Perspective,* 23 TEMP. POL. & CIV. RTS. L. REV. 451, 464–68 (2014) (providing an overview of Good Samaritan laws in place as of 2014).

[73] Jing Xu et al., *State Naloxone Access Laws are Associated with an Increase in the Number of Naloxone Prescriptions Dispensed in Retail Pharmacies*, 189 DRUG & ALCOHOL DEPENDENCE 37, 37 (2018). State efforts to expand naloxone access have received some support from federal agencies. *See* Christopher T. Creech, Note, *Increasing Access to Naloxone: Administrative Solutions to the Opioid Overdose Crisis*, 68 ADMIN. L. REV. 517, 524–25 (2016) (outlining the limited federal assistance). Of course, not all state and local responses to the opioid epidemic have followed a harm reduction strategy. In a number of states, some prosecutors have adopted a "get tough" approach by increasingly pursuing drug-induced homicide charges in cases of overdoses. *See* Valena E. Beety, *The Overdose/Homicide Epidemic*, 34 GA. ST. U. L. REV. 983, 990–91 (2018) (providing an overview of drug-induced homicide statutes and prosecutions).

[74] Mattie Quinn, *Drug Addicts Could Soon Get Their First Safe Haven in America*, GOVERNING (Jan. 8, 2018), http://www.governing.com/topics/health-human-services/gov-supervised-injection-2018.html [https://perma.cc/WVM8-FPLS].

tial organizations like the American Medical Association.[75] In a handful of cities—Denver, New York, Philadelphia, San Francisco and Seattle—officials have gone so far as to formally outline plans to open safe injection facilities. In January 2017, Seattle Mayor Ed Murray and King County Executive Dow Constantine jointly announced that the city and county would partner to open two safe injection sites.[76] Just one year later, the Philadelphia Health Commissioner declared the city's intent to encourage a private organization to open "the nation's first supervised injection site."[77] One month after that, in February 2018, San Francisco officials said that their city would become "the first in the country" to house a safe injection site and that two were scheduled to open by July 1, 2018.[78] In May 2018, New York City Mayor Bill de Blasio sent a letter to the state "asserting its intention to open four injection centers"—which would be called Overdose Prevention Centers—and seeking permission from the State Department of Health.[79] Most recently, in November 2018, the Denver City Council approved a supervised injection site to operate on a trial basis for two years, subject to approval from the state legislature.[80] Although each of these proposals was sincere and well thought out, none of them have come to fruition as of publication of this Article.[81]

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[75] Press Release, Am. Med. Ass'n, AMA Wants New Approaches to Combat Synthetic and Injectable Drugs, (June 12, 2017), https://www.ama-assn.org/ama-wants-new-approaches-combat-synthetic-and-injectable-drugs [https://perma.cc/SUC6-QZSV] ("In an effort to consider promising strategies that could reduce the health and societal problems associated with injection drug use, the AMA today voted to support the development of pilot facilities where people who use intravenous drugs can inject self-provided drugs under medical supervision.").

[76] David Gutman, *Seattle, King County Move to Open Nation's First Safe Injection Sites for Drug Users*, SEATTLE TIMES (Jan. 28, 2017), https://www.seattletimes.com/seattle-news/crime/seattle-king-county-move-to-create-2-injection-sites-for-drug-users/ [https://perma.cc/DNA4-CTPV] (noting that the legislators aimed to "create two safe-consumption rooms for drug users, the first of their kind in the county, as part of an effort to halt the surge of prescription opioid overdose deaths in the region").

[77] Gordon, *supra* note 14.

[78] Knight, *supra* note 4.

[79] William Neuman, *De Blasio Moves to Bring Safe Injection Sites to New York City*, N.Y. TIMES (May 3, 2018), https://www.nytimes.com/2018/05/03/nyregion/nyc-safe-injection-sites-heroin.html [https://perma.cc/WRH6-P5MJ].

[80] Blair Miller, *Denver City Council Approves Supervised Injection Site Pilot, Which Still Needs Legislative Approval*, THE DENVER CHANNEL (Nov. 26, 2018), https://www.thedenverchannel.com/news/politics/denver-city-council-approves-supervised-injection-site-pilot-which-still-needs-legislative-approval [https://perma.cc/X2KY-QRBN].

[81] Although there are no sanctioned safe injection sites operating openly in the United States, there is at least one unsanctioned safe injection site operating in secret somewhere in the country. Davidson & Kral, *supra* note 2. In addition, in an effort to combat overdoses, some syringe exchange programs have begun to make their on-site bathrooms safer for drug use by equipping them with hazardous materials disposal boxes. Vallejo, *supra* note 32, at 1202. Although these so-called "safer bathrooms" are a much more modest reform than safe injection sites, they may also

The reason for the disconnect between words and actions is simple. Federal law appears to make it a crime to operate a safe injection facility. As a result, and as discussed in more detail below, if a city were to open a facility, its managers and employees would be at risk of being sent to federal prison.[82] This fact has not stopped elected officials from continuing to make bold pronouncements about their plans for safe injection sites. In late August 2018, for example, after California lawmakers passed a bill to authorize San Francisco to open up a safe injection site, Mayor London Breed told reporters, "I am committed to opening one of these sites here in San Francisco, no matter what it takes, because the status quo is not acceptable."[83] In October 2018, former Pennsylvania Governor Ed Rendell announced he had incorporated a nonprofit to open a safe injection site in Philadelphia. In response to a question about the possibility of federal prosecution, Rendell said, "I'm the incorporator of the safe injection site nonprofit and they can come and arrest me first."[84] But despite statements like these, it is hard to imagine a safe injection site opening while the risk of federal prosecution looms. After all, the first mover could easily find its city employees charged with serious federal crimes. As Professor Scott Burris observed, while a number of cities have said they want to be the first to open a safe injection site, "my guess is that you have a lot of cities who are actually racing to be second."[85]

Is there a way around this impasse? The next Part examines the federal law that stands as the chief obstacle to safe injection sites and explains why it has proven to be such a difficult hurdle for cities and states to overcome.[86]

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be at risk of prosecution under the crack house statute. *See id.* at 1205–07 (discussing application of the crack house statute to syringe exchange programs with "safer bathrooms"). The case for applying the crack house statute to a safer bathroom is weaker than for a safe injection site, however. *See id*. at 1215–17 (arguing against the crack house statute's application to "safer bathrooms").

[82] *See infra* note 168 and accompanying text.

[83] Keri Blakinger, *Safe Injection Sites Get Green Light from California Lawmakers*, THE FIX (Aug. 27, 2018), https://www.thefix.com/safe-injection-sites-get-green-light-california-lawmakers [https://perma.cc/795H-6W4W]. Governor Jerry Brown vetoed the bill, citing Deputy Attorney General Rod Rosenstein's threat to prosecute safe injection site operators. German Lopez, *The Trump Administration's Threat Against Safe Injection Sites Is Working*, VOX (Oct. 2, 2018), https://www.vox.com/policy-and-politics/2018/10/2/17927864/safe-injection-site-trump-jerry-brown-california [https://perma.cc/69EK-QHHT].

[84] German Lopez, *Former PA Governor Calls-out Trump Administration on Safe Injection Sites: "Come and Arrest Me,"* VOX (Oct. 12, 2018), https://www.vox.com/policy-and-politics/2018/10/12/17967920/philadelphia-safe-injection-sites-ed-rendell-rod-rosenstein [https://perma.cc/2A6J-DKNP].

[85] Allyn, *supra* note 3.

[86] *See infra* notes 87–172.

II. THE "CRACK HOUSE" STATUTE

The biggest legal hurdle to states and cities that want to establish safe injection sites is the federal crack house statute. It contains two subsections that make it unlawful to:

> (a)(1) knowingly open, lease, rent, use, or maintain any place, whether permanently or temporarily, for the purpose of manufacturing, distributing, or using any controlled substance;
> (a)(2) manage or control any place, whether permanently or temporarily, either as an owner, lessee, agent, employee, occupant, or mortgagee, and knowingly and intentionally rent, lease, profit from, or make available for use, with or without compensation, the place for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance.[87]

Although formally titled "maintaining drug-involved premises," the statute is often referred to as the crack house statute because it was passed in response to concerns about "so-called 'crack-houses,' where 'crack', cocaine and other drugs are manufactured or used."[88]

The crack house statute was enacted as part of the Anti-Drug Abuse Act of 1986,[89] near the height of the drug war and during the moral panic surrounding crack cocaine.[90] Though clearly inspired by concerns about property owners who allow their houses to be used as crack houses, the statute sweeps much more broadly, as early decisions applying it make clear. For example, in the 1991 Ninth Circuit case *United States v. Tamez*, the defendant was prosecuted under the crack house statute for drug distribution that occurred at his used car dealership.[91] He argued that the statute should not apply to his case because it "was intended only to apply to 'crack

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[87] 21 U.S.C. § 856 (2012).

[88] 132 CONG. REC. 26,474 (1986) (excerpt of Senate Amendment No. 3034 to H.R. 5484).

[89] *See* United States v. Sturmoski, 971 F.2d 452, 462 (10th Cir. 1992) (discussing the legislative history of the crack house statute).

[90] *See* Erik Luna & Paul G. Cassell, *Mandatory Minimalism*, 32 CARDOZO L. REV. 1, 25 (2010) (discussing the moral panic surrounding crack cocaine in the context of the Anti-Drug Abuse Act of 1986). The Anti-Drug Abuse Act of 1986 was the same bill that instituted a 100-to-1 sentencing disparity in the treatment of crack and powder cocaine, meaning it took 100 times the amount of powder cocaine as crack cocaine to trigger the same mandatory minimum sentence. *Id*. The 100-to-1 disparity was widely criticized and is one of the very few federal drug war measures to have been amended or repealed. In 2010, the disparity was reduced to 18-to-1. *See* Sarah Hyser, Comment, *Two Steps Forward, One Step Back: How Federal Courts Took the "Fair" Out of the Fair Sentencing Act of 2010*, 117 PENN. ST. L. REV. 503, 504 (2012) (discussing reduction of the crack/powder cocaine disparity under the Fair Sentencing Act).

[91] United States v. Tamez, 941 F.2d 770 (9th Cir. 1991).

houses' or manufacturing operations."[92] The Ninth Circuit quickly rejected Tamez's theory, citing the plain language of the statute. "Although . . . the Congressional Record synopsis refer[s] to manufacturing and crack houses," the court explained, "the words of the statute clearly imply more expansive coverage."[93]

The statute's reach was further expanded in the early 2000s, this time based on fears about teenage ecstasy use at raves.[94] In 2003, Congress passed an amendment to the crack house statute, initially named the RAVE Act,[95] "to cover more relationships between persons and property" than the original statute.[96] When it was passed in 1986, the crack house statute was limited to permanent locations. The 2003 RAVE Act amendment extended the crack house statute to apply to permanent or temporary places, allowing it to reach indoor or outdoor venues and one-off events.[97] It also added declaratory and injunctive relief as remedies for violations of the law.[98] The statute has remained unchanged since the 2003 amendment.

Federal prosecutors rarely bring charges under the crack house statute. In 2017, maintaining a drug-involved premise was the primary offense of conviction for only twenty-four defendants who received federal sentenc-

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[92] *Id.* at 773.

[93] *Id.*

[94] Christina L. Sein, Note, *The Agony and the Ecstasy: Preserving First Amendment Freedoms in the Government's War on Raves*, 12 S. CAL. INTERDISC. L.J. 139, 139 (2002) (describing raves as "all-night dance part[ies] where electronically synthesized music is played"). For more on concerns about ecstasy use at raves in the early 2000s, see, for example, Michael H. Dore, Note, *Targeting Ecstasy Use at Raves*, 88 VA. L. REV. 1583, 1584 (2002) (noting that in 2000, the *New York Times* "described ravers as 'probably the most significant and innovative American youth dance culture today'"). Today, raves seem to have mostly faded as a cultural phenomenon. *See* Jacob A. Epstein, Note, *Molly and the Crack House Statute: Vulnerabilities of a Recuperating Music Industry*, 23 U. MIAMI BUS. L. REV. 95, 102 (2014) ("Although raves were distinctive in the late 1990s and the early 2000s, largely because of the electronic music and 'underground' nature of such events, today such music has migrated from the fringes of society to the mainstream music culture.").

[95] The amendment was originally introduced as the RAVE (Reducing Americans' Vulnerability to Ecstasy) Act, but it died in Congress in 2002 in the face of opposition to the bill, including concerns about "the findings section of the bill, which accused property owners and rave promoters of being intentional profiteers of illicit drug use." Epstein, *supra* note 94, at 104. A "slightly modified version" of the law was reintroduced by then-Senator Joe Biden under a different name in 2003, the Illicit Drug Anti-Proliferation Act, and passed in conjunction with the Amber Alert Bill. *Id.* at 104–105.

[96] Michael V. Sachdev, *The Party's Over: Why the Illicit Drug Anti-Proliferation Act Abridges Economic Liberties*, 37 COLUM. J. L. & SOC. PROBS. 585, 603 (2004).

[97] Prosecutorial Remedies and Tools Against the Exploitation of Children Today Act of 2003 (PROTECT Act), Pub. L. No. 108-21, § 608, 117 Stat. 650, 691 (2003); *see also* Epstein, *supra* note 94, at 103–104 (discussing the changes made by the amendment).

[98] PROTECT Act § 608.

es.[99] By comparison, a total of 19,750 federal drug offenders were sentenced in 2017.[100] In cases when the crack house statute is employed, it appears that federal prosecutors have used it mostly to target property owners with close ties to the drug activities occurring on their property.[101] The statute has the potential to apply to individuals with no direct connection to drugs, however.

A 2013 Eighth Circuit case, *United States v. Tebeau*, demonstrates the potential reach of the crack house statute.[102] James Tebeau owned 300 acres of land in rural Missouri that he sometimes used to hold weekend music festivals, with the number of attendees ranging between 3,600 and 8,000.[103] At some point, law enforcement officials became concerned that drug sales were taking place at Tebeau's music festivals. They proceeded to conduct a year-and-half long investigation, sending undercover officers to ten festivals between April 2009 and August 2010 and making "more than 150 controlled purchases of illegal drugs including marijuana, psychedelic mushrooms, ecstacy [sic], cocaine, LSD, MDMA, opium, and moonshine liquor."[104] The undercover officers also witnessed extensive drug use at the festivals.[105]

The Government charged Tebeau with maintaining a drug-involved premises, under subsection (a)(2) of the statute. Recall that under that provision, it is a crime to "manage or control any place whether permanently or temporarily, either as an owner, lessee, agent, employee, occupant, or mortgagee, and knowingly and intentionally rent, lease, profit from, or make available for use, with or without compensation, the place for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled sub-

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[99] U.S. SENTENCING COMM'N, 2017 SOURCEBOOK OF FEDERAL SENTENCING STATISTICS, S-41 tbl.17 (2017). Courts applied the sentencing guideline for crack house statute convictions—U.S.S.G. § 2D1.8—in an additional seventy-one cases. *Id.*

[100] *Id.* at S-104 tbl.33.

[101] *See* Sachdev, *supra* note 96, at 596 (discussing crack house statute prosecutions). The crack house statute's most common use might actually be as a plea negotiation tool, rather than as a charge pursued by a prosecutor at trial. This is because the crack house statute is not subject to the mandatory minimum penalties triggered by most other federal drug offenses. Ronald Weich, *Plea Agreements, Mandatory Minimum Penalties and the Guidelines*, 1 FED. SENT'G REP. 266, 267 (1988); *see also* Gerald W. Heaney, *Response to William W. Wilkins, Jr., Chairman of the Sentencing Commission*, 4 FED. SENT'G REP. 236, 237–38 (1992) (comparing a possible sentence to an offender convicted of violating the crack house statute to that of an offender who engages in similar conduct but is convicted of possession with intent to distribute).

[102] United States v. Tebeau, 713 F.3d 955 (8th Cir. 2013).

[103] *Id.* at 957–58.

[104] *Id.* at 958. Although the court listed ecstasy and MDMA as two separate drugs, they are the same drug; ecstasy is one of the informal terms for MDMA (3,4 methylenedioxymethamphetamine). United States v. David, 681 F.3d 45, 47 (2d Cir. 2012).

[105] *David*, 681 F.3d at 47.

stance."[106] After Tebeau's motion to dismiss the indictment was denied, he pled guilty but reserved his right to appeal the denial of his motion.[107]

On appeal, Tebeau acknowledged that he was aware of drug sales at the festivals and that he oversaw a medical site on the grounds, known as "Safestock," where festival-goers were treated if they overdosed.[108] He argued, however, that proof that he knew others were using his property for the purpose of selling and using drugs was not enough to violate the statute. Instead, Tebeau claimed that the crack house statute "should be read to require the government to show that *he* had the specific intent to store, distribute, manufacture, or use drugs" on his property.[109] Consistent with the other appellate courts that have considered this issue,[110] the Eighth Circuit rejected Tebeau's reading of the statute and held "that § 856(a)(2) only requires that a defendant has the purpose of maintaining property where drug use takes place, and not that the defendant intends the drug use to occur."[111] As a result, a "defendant may be liable if he manages or controls a building that others use for an illicit purpose, and he either knows of the illegal activity or remains deliberately ignorant of it."[112]

Based on decisions like *Tebeau*, a theoretical case against safe injection sites under the crack house statute would seem to be fairly straightforward. Safe injection facilities are a place for people to use illegal drugs in a supervised environment. To be sure, safe injection facilities serve a much different purpose than crack houses or jam band music festivals. They are not meant to promote recreational drug use but to serve a medical purpose[113] by providing counseling to people with a substance use disorder, preventing overdoses, and stopping the use of dirty needles.[114] However, as noted in *Tabeau*, section "856(a)(2) only requires that a defendant has the purpose of maintaining property where drug use takes place, and not that

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[106] 21 U.S.C. § 856 (2012).

[107] *Tebeau*, 713 F.3d at 957.

[108] *Id.* at 958.

[109] *Id.* at 958–59.

[110] *Id.* at 959–60 (reviewing cases).

[111] *Id.* at 960.

[112] *Id.* at 961 (quoting 8th Cir. Model Crim. Jury Instr. § 6.21.856B (2011), https://www.rid.uscourts.gov/sites/rid/files/documents/juryinstructions/otherPJI/8th%20Circuit%20Model%20Criminal%20Jury%20Instructions.pdf [https://perma.cc/E6QL-J3FM]).

[113] Burris et al., *supra* note 17, at 1133.

[114] PHS Cmty. Servs. Soc'y v. Att'y General of Canada, [2008] B.C.S.C. 661, ¶ 136 (Can.) ("While users do not use Insite [a safe injection facility in Canada] to directly treat their addiction, they receive services and assistance at Insite which reduce the risk of overdose that is a feature of their illness, they avoid the risk of being infected or of infecting others by injection, and they gain access to counseling and consultation that may lead to abstinence and rehabilitation. All of this is health care.").

the defendant intends the drug use to occur."[115] As a result, knowledge that clients are coming to the facility to use illegal drugs would likely constitute a violation.[116]

To date, advocates for safe injection sites appear to have focused their energies on three different strategies for overcoming the crack house statute. First, if courts were to embrace a narrower construction of the crack house statute, it might not apply to safe injection sites.[117] Second, some have suggested localities consider advancing a federalism-based defense of safe injection facilities.[118] Finally, if federal prosecutors could be persuaded to adopt a non-enforcement policy with respect to safe injection sites—similar to the current approach to state marijuana legalization laws—then localities could move forward in opening them, even if they are technically illegal under federal law.[119] Under a different administration, this last strategy might well be a viable option. At present, however, none of these three approaches seem likely to succeed in shielding safe injection facilities from federal interference. Each one is considered in turn.

A. A Narrow Reading of the Crack House Statute

A caveat to the above analysis of safe injection facilities and the crack house statute is that the Supreme Court has not yet considered the interpretive argument made by the defendant in *Tebeau*. If the Supreme Court were to find that section (a)(2) of the crack house statute requires the defendant to maintain property with "the express purpose . . . that drug related activity take place,"[120] safe injection site operators might well be excluded from its reach. Four scholars made this argument in a 2009 article that provides the most thorough scholarly analysis of the legal status of safe injection sites under federal law to date.[121] They contended that the crack house statute should be read to require a drug-related purpose on the *defendant's* part. If the statute were so construed, arguably it would not apply to safe injection site operators. This is because, "[j]ust as a hospital is operated to treat patients, not to facilitate the use of controlled substances, and a methadone

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[115] *Tebeau*, 713 F.3d at 960.

[116] United States v. Chen, 913 F.2d 183, 190 (5th Cir. 1990) ("Based on our reading of the statute, § 856(a)(2) is designed to apply to the person who may not have actually opened or maintained the place for the purpose of drug activity, but who has knowingly allowed others to engage in those activities by making the place 'available for use . . . for the purpose of unlawfully' engaging in such activity.").

[117] *See infra* notes 120–125 and accompanying text.

[118] *See infra* notes 126–140 and accompanying text.

[119] *See infra* notes 141–170 and accompanying text.

[120] *Chen*, 913 F.2d at 190.

[121] Burris et al., *supra* note 17, at 1133.

clinic is operated to treat drug dependency, not to facilitate the use of controlled substances, [a safe injection facility] is operated to reduce the individual and social costs of drug injection, not to facilitate the use of controlled substances."[122] While there is a solid case that allowing the use of illegal substances is not the ultimate purpose[123] of a safe injection site, there is little reason to think that the Supreme Court will find that an illicit purpose on the part of the defendant is required to violate section (a)(2) of the crack house statute.

This is not an issue that has divided lower courts. Every circuit to address the question has held "[t]he phrase 'for the purpose,' as used in this provision, references the purpose and design *not* of the person with the premises, but rather of those who are permitted to engage in drug-related activities there."[124] These courts have relied on both the plain language of the section 856(a)(2) as well as the conclusion that interpreting that provision to require purpose on the part of the defendant would render section 856(a)(1) "superfluous" because the two provisions would then criminalize essentially the same conduct.[125] As a result, although safe injection facilities might be on solid legal ground *if* the federal crack house statute were construed more narrowly, they appear to fall squarely within its reach under the prevailing interpretation.

B. The Federalism Defense

In search of a different way around federal law, some safe injection facility advocates have floated the possibility of a federalism-based challenge to the crack house statute. Specifically, some commentators have suggested that a 2006 Supreme Court decision regarding the CSA and Oregon's assist-

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[122] *Id.* at 1131.

[123] *Id.* at 1133 ("Allowing drug use is not the purpose, but the means to achieve other purposes—just as the 'purpose' of using morphine in a hospital is not the use of morphine but the relief of pain.").

[124] United States v. Wilson, 503 F.3d 195, 197–98 (2d Cir. 2007)*; see also Tebeau*, 713 F.3d at 960 (collecting cases). Interestingly, circuits are split on the meaning of the crack house statute's other provision, § 856(a)(1). All agree that in this portion of the statute, in contrast to (a)(2), "the phrase *for the purpose of* applies to the person who opens or maintains the place for the illegal activity." *Chen,* 913 F.2d at 190. The circuits disagree on whether the defendant's primary purpose in maintaining the property must be as a place for drug activity or if it need only be a significant purpose, a more than incidental purpose, or something else. *See* Matthew P. Fitzsimmons, *Primary, Significant, or Merely More Than Incidental: What Level of Intent Does the Federal Drug-Involved Premises Statute Really Require?*, 35 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 177, 179–80 (2009) (discussing this circuit split).

[125] *Wilson*, 503 F.3d at 198; *cf. Chen*, 913 F.2d at 190 (interpreting section (a)(1) as requiring a purpose on the part of the defendant because "any other interpretation would render § 856(a)(2) essentially superfluous").

ed-suicide law, *Gonzales v. Oregon*,[126] might shield safe injection facilities from federal prosecution.[127] The theory seems to have attracted the attention of at least one local official: Dan Satterberg, the Prosecuting Attorney for King County, Washington (where Seattle is located), told a reporter in February 2018 that if the Justice Department threatened to block safe injection sites in Seattle, "we think it will be an opportunity to convince the court that local public health powers are superior to criminal statutes that ban private drug dens run for profit."[128] Although Oregon's physician-assisted suicide law and safe injection facilities both implicate federalism concerns, the Supreme Court's decision in *Gonzales* does not stand for the principle that local public health powers trump federal law.

In *Gonzales*, the Supreme Court struck down a rule issued by the Attorney General that had prohibited doctors from prescribing drugs for use in physician-assisted suicide.[129] The Attorney General's rule rested on the DEA's authority to license physicians to dispense controlled substances with medical uses. It provided that "using controlled substances to assist suicide is not a legitimate medical practice and that dispensing or prescribing them for this purpose is unlawful under the CSA."[130] The rule was in effect a threat to revoke the license to prescribe controlled substances (referred to in the CSA as a registration) of any doctor who prescribed them to assist suicide.[131] The Court held that the CSA did not grant the Attorney General the power to regulate medical practice in this way, in an opinion that relied heavily on the premise that "regulation of health and safety is 'primarily, and historically, a matter of local concern.'"[132]

If read out of context, parts of the decision in *Gonzales* might seem to suggest that the CSA gives states broad deference on matters of public health in all settings. The Court, for example, criticized the Attorney General's interpretive rule as being based on the false "assumption that the CSA impliedly authorizes an Executive officer to bar a use [of a controlled sub-

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[126] 546 U.S. 243 (2006).

[127] *See* Burris et al., *supra* note 17, at 1134–39 (arguing that *Gonzales v. Oregon* might provide a degree of legal protection to safe injection facilities).

[128] Holden, *supra* note 20. Satterberg went so far as to say that "a face-off with Jeff Sessions" on the issue "could be a lot of fun"—a comment that likely has more to do with the electoral benefits to a Seattle politician of battling the Trump administration in court than Satterberg's view of the merits of his position. *Id*.

[129] 546 U.S. 243 (2006). The case arose in the context of the Oregon Death With Dignity Act (ODWDA), ORE. REV. STAT. § 127.800 *et seq*. (2003).

[130] *Gonzales,* 546 U.S. at 249.

[131] *See* KENNETH BAUMGARTNER, CONTROLLED SUBSTANCES HANDBOOK, at Part 1301 (2015) (providing an overview of the CSA's registration provisions).

[132] *Gonzales,* 546 U.S. at 271 (quoting Hillsborough Cty. v. Automated Med. Labs., Inc, 471 U.S. 707, 719 (1985)).

stance] simply because it may be inconsistent with one reasonable understanding of medical practice."[133] Elsewhere in the opinion, the Court described Oregon's assisted suicide law—which had prompted the Attorney General's order—as "an example of the state regulation of medical practice that the CSA presupposes"[134] and discussed elements of Oregon's law that some have argued compare favorably with safe injection facilities.[135]

Gonzales's deference to state and local lawmakers regarding medical practice would do little on its own to protect safe injection sites, however. The Attorney General's physician-assisted suicide rule claimed the authority to dictate how the substances that are legal to distribute as medicines—meaning substances in Schedules II through V of the CSA—can be used.[136] As a result, the validity of the rule turned on whether the Attorney General had the statutory authority to determine what constitutes legitimate use of an approved medicine within the context of the CSA.[137] Schedule I substances like heroin[138] are not considered medicines at all, and they therefore cannot be prescribed or used in medical practice. By placing a substance in Schedule I, the DEA has made an "express determination that [the substance] ha[s] no accepted medical use," which would "foreclose[] any argument about statutory coverage of drugs available by a doctor's prescription."[139] Moreover, application of the crack house statute to safe injection sites would not rest on the validity of an interpretive rule, as was the case in *Gonzales*. The crack house statute, which already accounts for places that are maintained for the lawful use of medicines in Schedules II and below,[140]

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[133] *Id*. at 272–73; *see id*. at 270 (stating that the CSA "manifests no intent to regulate the practice of medicine generally").

[134] *Id.* at 271.

[135] *See* Burris et al., *supra* note 17, at 1124, 1135 (arguing that "the Crack House Statute can only be applied to a [safe injection facility] through the sort of regulatory over-reaching by the federal government that the Supreme Court rejected in the Oregon Death with Dignity case" and the "*Gonzales* Court was emphatic about the limited scope of the CSA in relation to medical practice").

[136] *Gonzales*, 546 U.S. at 273–74 (discussing the CSA's scheduling process and noting that the Attorney General's interpretive rule rested on a reading of the CSA's prescription requirement).

[137] *Id*. at 248–49 ("The question before us is whether the Controlled Substances Act allows the United States Attorney General to prohibit doctors from prescribing regulated drugs for use in physician-assisted suicide, notwithstanding a state law permitting the procedure.").

[138] 21 C.F.R. § 1308.11(c)(11) (2018).

[139] *Gonzales*, 546 U.S. at 269 (distinguishing *Gonzales* from the Supreme Court's decision in *United States v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483 (2001), holding that the CSA did not recognize a medical necessity defense to the use or distribution of marijuana).

[140] The statute begins with the proviso that it does not criminalize activity that is "authorized by this subchapter." 21 U.S.C. § 856. This "is why the broad language of § 856 does not sweep in hospitals and doctors' offices and the landlords that rent to them." Burris et al., *supra* note 17, at 1124.

does not call for a determination about the medical value of safe injection facilities. For these reasons, the statutory limits on the Attorney General's power over the practice of medicine that was at issue in *Gonzales v. Oregon* would have no bearing on the application of the crack house statute to a place where Schedule I substances like heroin are being used.

C. Non-Enforcement Policies

Of course, as the recent experience with state marijuana legalization highlights, federal law only stands as a barrier to state and local drug policy reform if it is enforced. After spending more than a decade actively fighting the implementation of state medical marijuana laws, the Department of Justice (DOJ) adopted an advisory marijuana non-enforcement policy following the passage of the first legalization laws in Colorado and Washington state. Under the policy, issued in late 2013 but rescinded by Attorney General Jeff Sessions in early 2018,[141] federal prosecutors were advised not to use their limited resources to prosecute people who are operating in compliance with state marijuana laws.[142] The DOJ's non-enforcement policy effectively allowed states to implement wide-ranging marijuana legalization laws without federal interference.[143] As a result, even though it remains a crime to manufacture, distribute, and even simply possess marijuana under federal law, nine states have legalized the possession, manufacture, and retail sale of marijuana[144] and thousands of marijuana businesses are openly operating

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[141] Memorandum from Jefferson B. Sessions, III, Att'y Gen., to all United States Attorneys, (Jan. 4, 2018) [hereinafter Sessions Memo], https://www.justice.gov/opa/press-release/file/1022196/download [https://perma.cc/6FRY-GQL9].

[142] Memorandum from James M. Cole, Deputy Att'y Gen., to all United States Attorneys (Aug. 29, 2013) [hereinafter Cole Memo], https://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf [https://perma.cc/GZ4H-6AQA].

[143] Although the non-enforcement policy has allowed states to implement legalization laws without active opposition, the federal ban on marijuana continues to present challenges for state marijuana businesses on issues ranging from banking to trademarks. *See generally* Julie Anderson Hill, *Banks, Marijuana, and Federalism*, 65 CASE W. RES. L. REV. 597 (2015) (discussing how federal law has resulted in a lack of access to banking services for marijuana businesses); Sam Kamin & Viva R. Moffat, *Trademark Laundering, Useless Patents, and Other IP Challenges for the Marijuana Industry*, 73 WASH. & LEE L. REV. 217 (2016) (discussing intellectual property and marijuana law).

[144] In 2012, Colorado and Washington were the first states to pass legalization laws, with Oregon and Alaska following suit in 2014. *See* Colo. Const. art. XVIII, § 16; ALASKA STAT. § 17.38.060 (2015) (codifying Ballot Measure No. 2); Control and Regulation of Marijuana Act, OR. REV. STAT. §§ 475B.010–.395 (2015); Initiative Measure No. 502, WASH. REV. CODE § 69 (2018). California, Maine, Massachusetts, and Nevada all passed ballot measures legalizing marijuana in November 2016. *See* Christopher Ingraham, *Marijuana Wins Big on Election Night*, WASH. POST (Nov. 8, 2016), https://www.washingtonpost.com/news/wonk/wp/2016/11/08/medical-marijuana-sails-to-victory-in-florida/ [https://perma.cc/Y252-8QYN] (reporting on the election results). In 2018, Michi-

without any significant fear of federal prosecution.[145] Some safe injection site advocates have expressed hope that the DOJ might take a similar approach to safe injection sites.[146]

If federal officials could be persuaded to adopt a non-enforcement policy for safe injection facilities, states and cities could move forward with them, regardless of their legal status under federal law. At first blush, there would seem to be a good case for the federal government to give the same degree of deference to states for safe injection facilities as they have for marijuana legalization. Safe injection facilities are much less likely to impact neighboring states or implicate federal enforcement concerns than state marijuana legalization laws.[147] Safe injection facilities do not manufacture or distribute controlled substances, nor do they expressly encourage people to possess controlled substances. Even if safe injection sites impliedly "encourage and normalize heroin use,"[148] as some of their critics contend, any conceivable impact of permitting a handful of cities to establish safe injection facilities on the market for controlled substances would be negligible in comparison to marijuana legalization.

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gan voters passed a marijuana legalization ballot measure. *See* Kathleen Gray, *Legal Marijuana in Michigan: What You Need to Know*, DET. FREE PRESS (Nov. 7, 2018), https://www.freep.com/story/news/marijuana/2018/11/07/michigan-marijuana-results-election-legalization/1835297002/ [https://perma.cc/A577-ZSGP] (reporting that Michigan's marijuana legalization ballot measure passed by a 56–44 margin). In addition to these states, Vermont and Washington, D.C. have legalized the possession and personal cultivation, although not the commercial distribution, of marijuana. *See* D.C. CODE § 48-904.01 (2015); Jeff Smith, *Vermont Now Allows Adult-Use Marijuana, but MJ Sales Not Permitted*, MARIJUANA BUS. DAILY (July 2, 2018), https://mjbizdaily.com/vermont-now-allows-adult-use-marijuana-but-mj-sales-not-permitted/ [https://perma.cc/XF7L-HM7B] (describing Vermont's law).

[145] As of September 2016, in Colorado alone there were six-hundred licensed marijuana vendors generating nearly $1 billion in annual sales. ROBERT A. MIKOS, MARIJUANA LAW, POLICY, AND AUTHORITY 4 (2017).

[146] For example, after Philadelphia announced its intent to help facilitate the establishment of a safe injection facility in the city, city official Brian Abernathy told reporters, "[w]e're confident and hopeful that the federal government has more important things to do than to not save people's lives." Jeremy Roebuck & Chris Palmer, *Will Trump Administration, Law Enforcement Challenge Safe Injection Site Plans?*, INQUIRER (Jan. 23, 2018), http://www.philly.com/philly/news/pennsylvania/philadelphia/philly-safe-injection-opioids-law-enforcement-trump-sessions-police-20180123.html [https://perma.cc/S5DY-NKYJ]; *see also* The Editorial Board, *supra* note 24 (arguing that the DOJ should "turn a blind eye" to states and cities who wish to establish safe injection sites "as it's largely done with marijuana" legalization laws).

[147] In the context of marijuana enforcement, the DOJ's non-enforcement policy identified eight "enforcement priorities that are particularly important to the federal government." Cole Memo, *supra* note 142. Although federal enforcement priorities may differ for a substance like heroin, it is nevertheless notable that none of the priorities outlined in the Cole Memo—such as preventing against the enrichment of criminal enterprises, the diversion of drugs to other states, or the use of firearms in connection with drug trafficking—would be implicated by safe injection facilities. *See id.*

[148] *Statement of U.S. Attorney's Office Concerning Proposed Injection Sites*, *supra* note 21.

Despite a seemingly strong public policy case in favor a non-enforcement policy for safe injection sites,[149] it would be a surprise to see the DOJ take this approach. First, putting political considerations to the side for the moment, the marijuana non-enforcement policy was mostly a product of resource constraints that left the federal government effectively unable to block state marijuana reforms. Before adopting the non-enforcement policy, the DOJ spent more than a decade trying to shut down state medical marijuana laws with little success.[150] The federal government won a number of legal victories in the process—including two United States Supreme Court cases[151] —but by 2009, it was clear that federal enforcement was not going to stop a significant number of medical marijuana businesses from operating in states that permitted them. As Professor Robert Mikos explained at the time, because "[o]nly 1 percent of the roughly 800,000 marijuana cases generated every year are handled by federal authorities . . . [m]ost medical marijuana users and suppliers can feel confident they will never be caught by the federal government."[152] Short of *dramatically* increasing federal marijuana enforcement in legalization states, the federal government was powerless to end state marijuana legalization.[153] Rather than continuing to indiscriminately prosecute a handful of state-legal marijuana businesses with little to show for it, the DOJ issued its non-enforcement policy.

The dynamic would be much different for safe injection sites.[154] The cities that have discussed establishing safe injection facilities appear to con-

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[149] This Article makes no claim about the advisability of prosecutorial non-enforcement policies in general, only that the arguments in favor of a non-enforcement policy for safe injection sites are strong in comparison to the arguments for such a non-enforcement policy for activity that complies with state marijuana legalization laws. For a critique of the use of non-enforcement policies in general, see Zachary S. Price, *Enforcement Discretion and Executive Duty*, 67 VAND. L. REV. 671, 757–59 (2014) (discussing the DOJ's non-enforcement policy for individuals in compliance with state marijuana laws).

[150] *See* Alex Kreit, *Reflections on Medical Marijuana Prosecutions and the Duty to Seek Justice*, 89 U. DENV. L. REV. 1027, 1033–41 (2012) (discussing federal efforts to block state medical marijuana laws between 1996 and 2012).

[151] Gonzales v. Raich, 545 U.S. 1 (2005); Oakland Cannabis Buyers' Coop., 532 U.S. 483.

[152] Robert A. Mikos, *On the Limits of Supremacy: Medical Marijuana and the States' Overlooked Power to Legalize Federal Crime*, 62 VAND. L. REV. 1421, 1424 (2009).

[153] The DOJ acknowledged this dynamic in its non-enforcement memo by referring to the need for it to "us[e] its limited investigative and prosecutorial resources to address the most significant threats in the most effective, consistent, and rational way." Cole Memo, *supra* note 142.

[154] Indeed, when explaining in an interview why his office would not take the same approach to safe injections sites as it has to marijuana businesses, the United States Attorney for the District of Massachusetts Andrew Lelling pointed to resources: "What I have tried to say is what I can, which is I have limited resources and they're not focused on marijuana. Right now they're focused on opioids." Deborah Becker & Chris Citorik, *'Supervised Injection Sites Are a Terrible Idea,' U.S. Attorney Lelling Says*, RADIO BOS. (July 20, 2018), http://www.wbur.org/radioboston/2018/07/20/lelling-supervised-injection-marijuana-enforcement [https://perma.cc/7RMB-J7D5].

template a handful of sites at most.[155] Shutting them down would be a relatively easy and inexpensive proposition in comparison to contending with the hundreds of marijuana businesses that were operating openly in California by the late-2000s.[156] Indeed, federal prosecutors would not even have to bring criminal prosecutions against safe injection sites to stop them if they thought doing so would be a questionable use of prosecutorial discretion (or, at least, a bad move politically). Under the crack house statute, prosecutors could simply sue safe injection facilities to enjoin their operation.[157] Because resource constraints would not present an obstacle to blocking safe injection sites, the DOJ might not follow the same deferential approach that it has taken with respect to state marijuana legalization laws in recent years, even under a progressive administration.

Second, and more important for the near future, the Trump administration's retrograde approach to drug policy suggests it would be exceedingly unlikely to defer to states and cities when it comes to safe injection sites. During a time when politicians from across the political spectrum have denounced the drug war,[158] the Trump administration has largely moved to double down on it.[159] Jeff Sessions, who served as Attorney General from the start of Trump's term until late 2018, has a long history as a staunch supporter of the drug war. As a Senator, "Sessions spent years as one of the most vocal obstacles to criminal justice reform in Congress," according to his former Senate colleague Sheldon Whitehouse.[160] During his time as Attorney General, Sessions rescinded an Obama-era policy that limited the use

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[155] For example, New York's proposal contemplates four safe injection sites. Neuman, *supra* note 79.

[156] Roger Parloff, *How Marijuana Became Legal*, FORTUNE MAG. (Sept. 18, 2009), http://archive.fortune.com/2009/09/11/magazines/fortune/medical_marijuana_legalizing.fortune/index.htm [https://perma.cc/K3YK-TAB2] (reporting that there were an estimated 700 medical marijuana dispensaries openly operating in California).

[157] 21 U.S.C. § 856(e) (2012) ("Any person who violates subjection (a) of this section shall be subject to declaratory and injunctive remedies as set forth in section 843(f) of this title."). Notably, federal officials used the strategy of seeking injunctions against early medical marijuana dispensaries in California with some success. *See* United States v. Cannabis Cultivators Club, 5 F. Supp. 2d 1086 (N.D. Cal. 1998) (granting a preliminary injunction against a medical marijuana establishment), *rev'd sub nom.* United States v. Oakland Cannabis Buyers' Coop., 190 F.3d 1109 (9th Cir. 1999) (per curiam), *rev'd,* 532 U.S. 483 (2001).

[158] *See* Kreit, *supra* note 10, at 1324–26 (discussing this trend).

[159] *See* Matt Ford, *Jeff Sessions Reinvigorates the Drug War*, THE ATLANTIC (May 12, 2017), https://www.theatlantic.com/politics/archive/2017/05/sessions-sentencing-memo/526029/ [https://perma.cc/X2CQ-V353] (discussing Sessions's decision to rescind an Obama-era policy that limited the use of mandatory minimum sentences in certain lower-level drug cases).

[160] Sheldon Whitehouse, *Foreword: Beyond the War on Drugs*, 11 HARV. L. & POL'Y REV. 359, 373 (2017).

of mandatory minimum penalties in lower-level drug cases.[161] He did the same with the DOJ's marijuana non-enforcement policy.[162] With respect to the opioid crisis specifically, Sessions said that he thinks the only solution is to increase the number of prosecutions.[163] Although, the DOJ has not announced a formal policy regarding safe injection sites, Deputy Attorney General Rod Rosenstein wrote an editorial denouncing them, and threatened "swift and aggressive action"[164] against any city or state that opens a safe injection site. Even if Rosenstein's editorial does not definitively rule out the possibility of the DOJ allowing individual United States Attorneys to decide what approach to take, as it has done with marijuana legalization after rescinding the non-enforcement policy, there is little reason to think Trump-appointed United States Attorneys would be likely to take a hands-off approach. Indeed, the four United States Attorneys who have made public statements about safe injection facilities have threatened to bring prosecutions against anyone who tries to open one,[165] and, shortly before this article went to press, the United States Attorney for the Eastern District of Pennsylvania filed a lawsuit to block a safe injection site from opening in Philadelphia.[166] The Drug Enforcement Administration (DEA), for its part, has also announced opposition to safe injection facilities, with a DEA spokesperson saying that facility operators would likely be prosecuted.[167]

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In sum, safe injection facilities seem to be on very shaky ground under federal law. Because safe injection site operators would know that clients are coming to their building in order to use illegal drugs, they would almost certainly be guilty of maintaining a drug-involved premises under the federal crack house statute. Indeed, even lower level employees could be at risk

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[161] Alan Vinegrad, *DOJ Charging and Sentencing Policies: From Civiletti to Sessions*, 30 FED. SENT'G REP. 3, 4 (2017) (discussing this development).

[162] Sessions Memo, *supra* note 141.

[163] Whitehouse, *supra* note 160 ("[D]uring Senate debate of the Comprehensive Addiction and Recovery Act, Sessions summed up his approach to the opioid crisis by saying, 'we're going to have to enhance prosecutions. There just is no other solution.'") (citation omitted).

[164] Rosenstein, *supra* note 22.

[165] *See supra* note 21 and accompanying text.

[166] *See supra* note 23 and accompanying text.

[167] Paige Winfield Cunningham, *The Health 202: Supervised Injection Facilities Are Illegal in the United States. These Cities Want to Open Them Anyway*, WASH. POST (Apr. 30, 2018), https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2018/04/30/the-health-202-supervised-injection-facilities-are-illegal-in-the-united-states-these-cities-want-to-open-them-anyway/5ae5dbc630fb043711926901/?noredirect=on&utm_term=.6b54fd0ab3bc [https://perma.cc/M6C4-T946].

of federal prosecution.[168] Absent a change in federal law, then, the viability of safe injection sites would seem to depend on one of a few long-shot possibilities. Courts could reject the prevailing interpretation of the crack house statute, under which a facility operator does not need to act with the purpose of permitting drug use. States and cities could pursue novel constitutional claims in defense of safe injection sites[169] or invite the Supreme Court to reconsider the extent to which the commerce power permits the federal government to regulate intrastate drug activity.[170] Federal prosecutors could allow safe injection sites to move forward as a matter of prosecutorial discretion. All of these are unlikely outcomes, however.

In the next section, I argue that there may yet be hope for safe injection sites in the form of a "relatively obscure provision"[171] of the CSA that grants immunity to state and local officials who violate the CSA while enforcing state and local drug laws. This provision, which has been entirely absent from the discussion of safe injection sites and has received little attention from legal academia in general,[172] may very well immunize safe injection sites and the individuals who run them from federal prosecution.

III. THE CONTROLLED SUBSTANCES ACT'S IMMUNITY PROVISION AND SAFE INJECTION SITES

A. Overview

Buried within the Controlled Substances Act is a provision that confers immunity on federal, state, and local officials who commit federal crimes while enforcing drug laws. The statute provides, in relevant part, that "no

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[168] *See* 21 U.S.C. § 856(a)(2) (liability extends to those who "manage or control any place, whether permanently or temporarily, either as an owner, lessee, agent, *employee*, occupant, or mortgagee") (emphasis added); U.S. ATTORNEY'S OFFICE DIST. OF VT., *supra* note 21 (announcing that "exposure to criminal charges would arise for . . . workers").

[169] In addition to a federalism-based constitutional claim, one commentator recently proposed defending safe injection sites on equal protection grounds, on the theory that federal opposition to the facilities might be "a violation of the equal protection rights of those drug addicts attempting to get treatment." Martell-Crawford, *supra* note 27, at 141. Courts have consistently and swiftly rejected equal protection-based challenges to other controlled substances classifications, including in the medical marijuana context, however, and there is little reason to think there would be a different result with respect to safe injection sites. *See, e.g.*, Untied States v. Green, 222 F. Supp. 3d 267, 279–80 (W.D.N.Y. 2016) (rejecting an equal protection challenge to the classification of marijuana); United States v. Pickard, 100 F. Supp. 3d 981, 1009 (E.D. Cal. 2015) (same).

[170] *See Raich*, 545 U.S. at 1 (holding that the Commerce Clause grants the federal government the power to criminalize the noncommercial, intrastate possession of marijuana for medical purposes).

[171] Mikos, *supra* note 152, at 1457.

[172] *Id*. (observing that the immunity provision has mostly "escaped the attention of the legal academy").

civil or criminal liability shall be imposed by virtue of this subchapter upon . . . any duly authorized officer of any State, territory, political subdivision thereof, the District of Columbia, or any possession of the United States, who shall be lawfully engaged in the enforcement of any law or municipal ordinance relating to controlled substances."[173] There does not appear to be any legislative history explaining the origins of this provision[174], but it is reasonable to assume it was meant to protect police officers that commit drug crimes in the course of undercover operations.[175]

Although the CSA is nearly fifty years old, there is very little case law interpreting its immunity provision.[176] This is perhaps to be expected, since prosecutions of undercover police officers are exceedingly rare,[177] regardless of the existence of a statutory grant of immunity. After all, "outside of extraordinary situations (such as that of the rogue official),"[178] prosecutors do not typically bring criminal charges against police officers for overstepping their authority. Even without the CSA's immunity provision, prosecutorial

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[173] 21 U.S.C. § 885(d) (2012). The Controlled Substances Act consists of two subchapters. The immunity provision and the criminal provisions that apply to domestic activity, including the crack house statute, are housed in the first subchapter. The second subchapter addresses the import and export of controlled substances. The immunity provision expressly limits this grant of immunity based on two federal statutes: 18 U.S.C. § 2234 (2012) and 18 U.S.C. § 2235 (2012). These two statutes, respectively, make it a crime for an officer to willfully exceed her authority in executing a search warrant and to maliciously procure a search warrant.

[174] The House Report summarizing the CSA stated only that the immunity provision "exempts federal officers from liability when lawfully engaged in enforcing Title II and further exempts state and local officers when lawfully engaged in enforcing any law relating to controlled substances." H.R. REP. NO. 91-1444 (1970), *reprinted in* 1970 U.S.C.C.A.N. 4566, 4625.

[175] Mikos, *supra* note 152, at 1458 (arguing that "the purpose of section 885(d) immunity is readily apparent" in that "[w]ithout it undercover agents and informants could not feel secure handling narcotics in the course of a drug sting; in theory, by handling the drugs, they could face the same charges as the drug pushers they investigate"). The statute also extends immunity to officials in other settings—for example, laboratory personnel who "obtain and transfer controlled substances for use as standards in chemical analysis." Exemption of Law Enforcement Officials, 21 C.F.R. § 1301.24 (2018) ("Laboratory personnel, when acting in the scope of their official duties, are deemed to be officials exempted by this section and within the activity described in section 515(d) of the Act (21 U.S.C. § 885(d)).").

[176] A Westlaw search conducted in September 2018 revealed just twenty-six published decisions that have cited 21 U.S.C. § 885(d).

[177] Elizabeth E. Joh, *Breaking the Law to Enforce It: Undercover Police Participation in Crime*, 62 STAN. L. REV. 155, 170 (2009) (observing that the public authority defense has not been "rigorously tested" because police "are seldom, if ever, prosecuted" in cases where the defense might be raised); Mikos, *supra* note 152, at 1459 (discussing the CSA's immunity provision and noting that "Congress could have relied on the good sense of U.S. Attorneys not to prosecute such violations, but one can hardly fault Congress for wanting to codify immunity and remove any doubts").

[178] Jacqueline E. Ross, *Impediments to Transnational Cooperation in Undercover Policing: A Comparative Study of the United States and Italy*, 52 AM. J. COMP. L. 569, 576 (2004).

discretion would almost certainly protect police officers from being prosecuted for crimes they commit in the course of uncover drug operations.

Until the early 2000s, the few cases to address the CSA's immunity provision almost exclusively involved rogue officials who attempted to rely on it as a defense.[179] In one such case that stands out for its colorful set of facts, *United States v. Fuller*, the mayor of the small town Vance, South Carolina, was prosecuted after being videotaped selling crack cocaine outside of a convenience store on four separate occasions.[180] At his trial, Mayor Fuller admitted to selling crack cocaine at the convenience store, but he testified that he had done it as part of "a police-style undercover investigation into employee misconduct at Angler's Mini-Mart."[181] Fuller claimed that he had not enlisted the police department in his supposed sting operation because he was unhappy with the performance of the chief of police.[182] On appeal, the Fourth Circuit found the CSA's immunity provision inapplicable on the grounds that South Carolina law did not give mayors the power to engage in law enforcement activity. Because "Fuller was not authorized under South Carolina law to engage in illegal drug transactions as part of his investigation," the court reasoned, "the immunity conferred by 21 U.S.C. § 885(d) does not apply."[183]

Cases like *Fuller* make clear that the CSA's immunity provision does not extend to officials who act outside the bounds of state and local law. But they do not shed much light on how the immunity provision might apply to a state- or city-run safe injection site. Is the grant of immunity limited to officials who are engaged in the enforcement of drug prohibition laws

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[179] *See* United States v. Reeves, 730 F.2d 1189, 1195 (8th Cir. 1984) (upholding the marijuana distribution convictions of a sheriff and deputy sheriff on the grounds that the evidence was sufficient to disprove their claim that their acts were "related to their law enforcement duties" and consequently "sanctioned by 21 U.S.C. § 885(d)"); Matje v. Leis, 571 F. Supp. 918, 929 n.3 (S.D. Ohio 1983) (rejecting the defendant's effort to rely on the CSA's immunity provision because it "pertains to *lawful* enforcement of narcotics laws" and the "evidence raises questions as to the lawfulness of his activities").

[180] United States v. Fuller, 162 F.3d 256, 257–58 (4th Cir. 1998) (noting that the case began when the FBI received a complaint "from the owner of Angler's Mini-Mart in Vance, South Carolina, that Vance's mayor, Frank Fuller, was attempting to sell drugs in and around the store and was attempting to enlist the store's employees to sell drugs on his behalf").

[181] *Id.* at 258.

[182] *Id.*

[183] *Id.* at 262; *see also* United States v. Cortes-Caban, 691 F.3d 1, 21 (1st Cir. 2012) ("Police officers who plant drugs on persons in order to create a false basis for arrest are not 'lawfully engaged' in law enforcement activities, and thus under the plain language of the [immunity] statute they may be prosecuted for distribution."); United States v. Wright, 634 F.3d 770, 777 (5th Cir. 2011) (approving the trial court's instruction based on the CSA's immunity provision and upholding the defendant's conviction where his "statutory or formal duties as a deputy sheriff and parish jailer did not include engaging in covert undercover narcotics investigations").

through undercover work? Or, can it apply state and local drug laws that are in tension with the CSA?

B. The Case for Applying the Immunity Statute to Safe Injection Sites

On the surface, the idea of applying an immunity statute meant to facilitate undercover police stings to a safe injection site might seem farfetched. But a closer look reveals that government-run safe injection sites would have both a strong and surprisingly straightforward argument for receiving protection under the CSA's immunity provision. The discussion that follows considers how the CSA's immunity provision would apply to a government-run safe injection site established by a state or locality pursuant to a state law or municipal ordinance. The facility would be operated entirely by government employees whose duties and authority would be spelled out in the applicable state law or municipal ordinance.

By its terms, the CSA's immunity provision shields from prosecution "any duly authorized officer of any State, territory, political subdivision thereof, the District of Columbia, or any possession of the United States, who shall be lawfully engaged in the enforcement of any law or municipal ordinance relating to controlled substances."[184] A government-run safe injection site would appear to satisfy each of these requirements. The issue that has caused trouble for defendants in cases like *Fuller*—namely, that they were not "duly authorized" to engage in undercover policing—would not present a problem for a safe injection site run by government officials. So long as the applicable state or local law made clear that the managers and employees of the safe injection site were authorized to run the facility, they would surely qualify as "duly authorized officer[s]"[185] for purposes of the immunity provision.[186] Likewise, a state law or city ordinance establishing a government-run safe injection site would constitute a law "relating to controlled substances."[187] This is because the core function of a supervised injection facility is to provide a space for people to use controlled substances. To be sure, supervised injection facility personnel do not distribute or handle controlled substances. The facilities are not intended to encourage the use of controlled substances but rather to provide overdose prevention

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[184] 21 U.S.C. § 885(d).

[185] *Id.*

[186] In contrast, the defendant in *Fuller* was not entitled to rely on the immunity provision because, as the Mayor, he was not "authorized under South Carolina law to conduct under-cover drug operations." 162 F.3d at 261. Likewise, in *Wright*, the Fifth Circuit held that a jailer could not rely on the immunity provision because his duties "did not include engaging in covert undercover narcotics investigations." 634 F.3d at 777.

[187] 21 U.S.C. § 885(d).

and other services to drug users. But this would not leave them outside of the scope of the immunity provision. Because a safe injection site is a place for people to use controlled substances, a law or municipal ordinance governing the operation of such a site would be a law "relating to controlled substances."[188] Finally, the government employees working at a safe injection site would be implementing the city or state's safe injection law and thus would be "lawfully engaged in the enforcement"[189] of that law. As a result, based on the plain language of the CSA's immunity provision, a government run safe injection site would have a very strong case for immunity from "civil or criminal liability"[190] for any potentially applicable federal drug crime, including the crime of maintaining a drug-involved premises under the crack house statute.[191]

The case for applying the CSA's immunity statute to government run safe injection sites is also supported by a handful of court decisions that have applied it in the context of state medical marijuana laws. These cases, which like the immunity provision itself have received very little attention from scholars and practitioners, have mostly involved motions for the return of marijuana that had been seized by the police. In each of these return of property cases, the police seized marijuana in a state with a medical marijuana law from a person who turned out to be a patient entitled to possess the marijuana. When the patient sought the return of their property, the police refused on the grounds that federal law makes it a crime to distribute marijuana. To resolve the dispute, courts in these cases have looked to the CSA's immunity provision. To date, four published appellate decisions have involved this general fact pattern.[192] In all but one of these cases, the court held that the CSA grants immunity to a police officer who is ordered to return marijuana to a patient in compliance with state law. (The fourth case is discussed in the next section, along with a Ninth Circuit case that consid-

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[188] *Id.*

[189] *Id.*

[190] *Id.*

[191] The immunity provision only applies to the first subchapter of the CSA. *Id.* The second subchapter of the CSA addresses the import and export of controlled substances, and it includes some criminal offenses. Because safe injection sites would not be engaged in the import or export of controlled substances, however, they would not run afoul of the CSA's import and export offenses.

[192] *See generally* State v. Okun, 296 P.3d 998 (Ariz. Ct. App. 2013); City of Garden Grove v. Superior Court, 68 Cal. Rptr. 3d 656 (Ct. App. 2007); People v. Crouse, 388 P.3d 39 (Colo. 2017); State v. Kama, 39 P.3d 866 (Or. App. 2002). The appellate division of a California trial court has also addressed this issue in a published case, holding that the CSA's immunity provision applies to "the return of marijuana 'lawfully possessed' under California law." San Francisco Cty. v. Smith, 28 Cal. App. 5th Supp. 1, 6 (Super. Ct. App. Div. 2018).

ered application of the immunity provision to a private individual who had been "deputized" to grow marijuana for the City of Oakland.)

In the 2013 Arizona Court of Appeals case *Arizona v. Okun*, for example, Valerie Okun was arrested at a Border Patrol checkpoint after an agent found marijuana in her car.[193] Okun, a Californian, had a medical marijuana recommendation pursuant to California law. Although Okun was arrested at a border checkpoint, her case was apparently referred to local prosecutors, who filed drug charges against her in state court. After Okun provided evidence that she was allowed to possess the marijuana under California law, the state dismissed its case against Okun.[194] Okun filed a request for the seized marijuana to be returned, which the trial court granted.[195] On appeal, the Sheriff argued that whoever returned the marijuana to Okun would be committing a federal crime, namely distribution of a controlled substance.[196] It is worth noting here that the crime of distribution is not limited to the sale of a controlled substance; the act of physically handing a controlled substance to someone else is considered to be distribution under the CSA.[197] As a result, the Sheriff's concern that it would be a federal crime to return Okun's marijuana to her was well founded. Nevertheless, relying on the CSA's immunity provision, the Arizona Court of Appeals upheld the trial court's order. The court reasoned that even if returning the marijuana would constitute a federal drug crime, 21 U.S.C. § 885(d) "immunizes law enforcement officers such as the Sheriff from any would-be federal prosecution for complying with a court order to return Okun's marijuana to her."[198] The court did not elaborate on this conclusion, perhaps viewing application of the CSA's immunity provision to the case to be clear-cut.

Appellate courts in California and Oregon have reached the same conclusion in similar fashion. In 2002, in *Oregon v. Kama*, the Oregon Court of Appeals was the first court to address the immunity provision issue.[199] In a four page decision spent mostly relaying the factual and procedural background of the case, the court concluded that "[e]ven assuming that returning

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[193] *Okun*, 296 P.3d at 999.

[194] *Id*. Arizona's medical marijuana law includes a reciprocity provision for "visiting qualifying patient[s]" like Okun. ARIZ. REV. STAT. ANN. § 36-2801(17) (2017).

[195] *Okun*, 296 P.3d at 1000.

[196] *Id*. at 1001; *see* 21 U.S.C. § 841(a)(1) (2012) (making it a crime "for any person knowingly or intentionally to manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense, a controlled substance").

[197] *See* United States v. Wallace, 532 F.3d 126, 129 (2d Cir. 2008) (collecting cases and holding that "the sharing of drugs, without a sale, constitutes distribution for purposes of 21 U.S.C. § 841(a)").

[198] *Okun*, 296 P.3d at 1002.

[199] *Kama*, 39 P.3d at 866.

the marijuana otherwise might constitute delivery of a controlled substance, the city does not explain—and we do not understand—why police officers would not be immune from any federal criminal liability that otherwise might arise from doing so."[200] In 2007, in *City of Garden Grove v. Superior Court*, a California appeals court similarly found that because the CSA "makes law enforcement personnel immune from any civil or criminal liability arising out of their handling of controlled substances as part of their official duties,"[201] an order requiring the police to return seized marijuana would not put them at risk of federal criminal prosecution.

In addition to these three return of property cases, appeals courts in Arizona and California have suggested that the CSA's immunity provision would shield officials from federal prosecution for issuing business licenses to marijuana stores (assuming that such conduct would otherwise constitute a federal crime).[202] Both of these cases involved preemption challenges to state and local medical marijuana laws. In the course of finding that the CSA did not preempt the laws, the courts cited the CSA's immunity provision. In the 2016 California Court of Appeals case, *City of Palm Springs v. Luna Crest Inc.*, the court mentioned the immunity provision only in passing, as additional support for the proposition that the issuance of a license to a marijuana business would not violate federal law.[203] In the Arizona case, an Arizona County argued that its employees would be aiding and abetting a federal crime if they implemented the state's medical marijuana law and so the law should be struck down as preempted by the CSA. The court disagreed and held that, in part because of the immunity provision, Arizona's medical marijuana law did not pose a positive conflict with the federal ban on marijuana. The County argued that the CSA's immunity provision was not sufficient to protect its employees because it was "limited to law enforcement personnel."[204] The court disagreed, holding that "County officials are 'engaged in the enforcement' of state statutes by processing applications

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[200] *Id.* at 868 (citing the CSA's immunity provision).

[201] *City of Garden Grove*, 68 Cal. Rptr. 3d at 664. In contrast to its relatively brief analysis of the CSA's immunity provision, the *City of Garden Grove* decision included lengthy discussions of standing, California's medical marijuana laws, and preemption.

[202] White Mountain Health Ctr., Inc. v. Maricopa Cty., 386 P.3d 416, 432 (Ariz. Ct. App. 2016) ("County officials are 'engaged in enforcement' of state statutes by processing applications for the zoning permits and promulgating regulations to permit [Medical Marijuana Dispensaries] pursuant to state law.") (citing 21 U.S.C. § 885(d)); City of Palm Springs v. Luna Crest Inc., 200 Cal. Rptr. 3d 128, 132 (Ct. App. 2016) (concluding that because of the CSA's immunity provision "Luna's premise that the City's implementation of its permitting and testing requirements for medical marijuana dispensaries is in violation of federal law is . . . false").

[203] *Luna Crest Inc.*, 200 Cal. Rptr. 3d at 132.

[204] *White Mountain Health Ctr., Inc.*, 386 P.3d at 431.

for the zoning permits and promulgating reasonable regulations to permit [medical marijuana dispensaries] pursuant to state law."[205]

To be sure, a handful of state court decisions can only be so helpful in analyzing a federal statute. But, if federal courts were to agree with the interpretation of the immunity provision adopted by their state counterparts in these cases, government-run safe injection sites would be on very firm ground. With respect to application of the immunity provision, it is hard to imagine a basis for distinguishing a state or local official operating a safe injection site from a police officer tasked with returning illegally seized marijuana or a land use department employee issuing a marijuana business license.

C. Considering Possible Counter Arguments

Of course, not everyone agrees that the CSA's immunity provision applies to conduct like returning illegally seized marijuana or issuing a marijuana business license. Three possible objections to the prevailing interpretation of the immunity statute present themselves, two based on the text of the statute and one based on its purpose and structure.

1. Does Implementing a Safe Injection Site Constitute "Enforcement?"

First, one might question whether safe injection site operators (or police who return illegally seized marijuana or land use employees who issue marijuana business licenses) are "engaged in the enforcement" of a state or local law, as the CSA's immunity statute requires.[206] In the law enforcement setting, "enforcement" typically means "to compel compliance with the law."[207] If the word "enforcement" in the immunity statute were limited to this definition, safe injection sites might be excluded from its protection. This is because although the employees of government-run safe injection facilities would be "implementing or facilitating" the local policy,[208] they would not be compelling anyone to comply with a law.

A 2006 Ninth Circuit case, *United States v. Rosenthal*,[209] provides some support for reading the CSA's immunity provision this way. *Rosenthal* involved somewhat unusual facts. Not long after Californians passed the first modern medical marijuana law in 1996, a handful of medical marijuana dispensaries opened, most of them in the San Francisco bay area. When the

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[205] *Id.* at 432.

[206] 21 U.S.C. § 885(d).

[207] United States v. Rosenthal, 454 F.3d 943, 948 (9th Cir. 2006) (*disapproved of on other grounds by* Godoy v. Spearman, 861 F.3d 956, 968 n.6 (9th Cir. 2017)).

[208] *Id.*

[209] *See generally Rosenthal*, 454 F.3d 943.

federal government moved to shut the dispensaries down, some local elected officials began searching for ways to fight back. It was in this context that, in 1998, the Oakland City Council passed an ordinance to try to protect local medical marijuana providers from federal prosecution. Although Oakland's ordinance was designed with the CSA's immunity provision in mind, the city did not establish a city-run medical marijuana program. Instead, under the ordinance, Oakland would officially designate private marijuana growers and sellers as "individuals to help distribute medical cannabis to seriously ill persons."[210] Pursuant to the ordinance, the city deputized the Oakland Cannabis Buyers' Cooperative (OCBC) as "an official medical-cannabis-provider-association."[211] OCBC's executive director then designated a man named Ed Rosenthal "to be an agent of OCBC and to cultivate marijuana plants for distribution to authorized medical-cannabis users."[212] Ed Rosenthal was eventually arrested and convicted of three federal drug crimes for growing marijuana.[213]

On appeal, Rosenthal argued that his status under Oakland's marijuana ordinance entitled him to immunity under the CSA. The Ninth Circuit disagreed, homing in on the word "enforcement" in the immunity provision. Enforcement, the court wrote, "means 'to compel compliance with the law'" and Rosenthal was "not compelling anyone to do or not to do anything."[214] As a result, the court concluded that Rosenthal's cultivation of "marijuana for medical use does not constitute 'enforcement' within the meaning of [the CSA's immunity statute]."[215] Notably, despite this holding, the *Rosenthal* court approvingly cited and distinguished the only medical marijuana return-of-property decision that had been issued at the time, *Kama*.[216] In its discussion of *Kama*, the Ninth Circuit explained that Oregon law "*mandated* the return of marijuana to the individual from whom the marijuana had been seized, and therefore the officers in question were 'enforcing' the state law that *required* them to deliver the marijuana to that individual."[217] Oakland's ordinance, by contrast, did not require that Rosenthal sell medical marijuana.[218] For this reason, according to the Ninth Circuit, *Kama* was "not inconsistent with" its interpretation of the immunity provision.[219]

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[210] *Id.* at 945.
[211] *Id.*
[212] *Id.*
[213] *Id.* at 946–47.
[214] *Id.* at 948.
[215] *Id.*
[216] *Id.* (citing *Kama,* 39 P.3d at 868).
[217] *Id.* (quoting *Kama,* 39 P.3d at 868).
[218] *Id.*
[219] *Id.*

Although *Rosenthal* would certainly provide some support for interpreting the word "enforcement" in the CSA's immunity statute narrowly, the case is at-odds with how courts have defined "enforce" in other settings. Courts—including the United States Supreme Court—have consistently recognized that "[t]he word 'enforce' is defined as 'to give force to' or to 'put in force: cause to take effect: give effect to."[220] Strangely, the *Rosenthal* court did not acknowledge the fact that leading dictionaries define the word enforce this way, nor did it attempt to distinguish or even cite any of the court decisions that have adopted this interpretation of the word enforce. Instead, the court stated without any elaboration that "enforce" means only "to compel compliance with the law" and that "implementing" a statute—in other words, giving effect to a statute—does not constitute enforcement for purposes of the immunity provision.[221] The oversight is conspicuous enough that one cannot help but wonder whether the argument that enforce can mean to "give effect to" was simply not presented to the court.

Indeed, limiting the definition of "enforcement" to official actions that "compel compliance with the law" would seem to exclude at least some traditional police work from the immunity provision. Consider police laboratories that need "to obtain and transfer controlled substances for use as standards in chemical analysis," for example.[222] On the basis of the CSA's immunity provision, the DEA has expressly exempted this type of activity from the registration requirements that would normally apply to analysts who handle controlled substances.[223] But, in contrast to testing a controlled substance seized from a suspect for purposes of prosecution, setting a lab's chemical analysis standards does not compel anyone to comply with a drug law. Similarly, the police regularly display seized controlled substances at media press conferences. While displaying drugs to the media might promote the department's work and send a message to other potential suspects, it certainly does not compel anyone to comply with the law in the sense that police investigations and prosecutions do.

Adding to the mystery of *Rosenthal*'s narrow interpretation of the word "enforce" is its discussion of *Kama*. The police did not compel Samuel Kama to comply with the law by returning marijuana to him. Rather,

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[220] Lacey v. Palatine, 904 N.E.2d 18, 26 (Ill. 2009) (quoting *Webster's Third New International Dictionary*); *see* Merrill Lynch v. Manning, 136 S. Ct. 1562, 1569 (2016) (finding that "'enforce' means 'give force [or] effect to'"); *see also* Bellagio v. Nat'l Labor Relations Bd., 863 F.3d 839, 848 (D.C. Cir. 2017) ("The leading law dictionary gives it a broad definition: to 'enforce' rules is '[t]o give force or effect to' them.").

[221] *Rosenthal*, 454 F.3d at 948.

[222] *See* 21 C.F.R. § 1301.24(c).

[223] *Id.*

Kama presented a case of enforcing a law by putting it into effect. But the Ninth Circuit approvingly cited *Kama* anyway, distinguishing it on the ground that Oregon "law *mandated* the return of marijuana" while Oakland's ordinance did "not mandate that Rosenthal manufacture marijuana."[224] This reasoning suggests that the court's real objection to Ed Rosenthal's argument was not that he was not compelling people to comply with Oakland's law by growing marijuana, but that Oakland's law did not compel Rosenthal to grow marijuana in the first place. In any case, based on its treatment of *Kama*, it seems that despite the *Rosenthal* court's stated definition of the word "enforcement", it understood the term to include at least some acts that give effect to a law without compelling compliance.[225]

In sum, although *Rosenthal* could be cited for the proposition that implementing a safe injection site statute does not constitute enforcement, there is little else to support such a constrained definition of the term. No other court decision appears to have limited the term "enforcement" to acts that compel compliance with the law. Instead, other court cases have consistently recognized that "enforce" means to give effect to a law.[226] Because operators of a government-run safe injection facility would cause the state or local law that establishes and regulates the facility to take effect, they would be engaged in enforcement under this definition. Similarly, because employees of a government-run safe injection site would be operating pursuant to a statutory mandate, they would be in the same position as the police officer from *Kama*, who the *Rosenthal* court seemed to agree was entitled to immunity under the CSA.

2. Safe Injection Sites and "Lawful" Enforcement

A second possible objection to the application of the CSA's immunity statute to safe injection sites would focus on the word "lawful." Recall that the immunity provision only protects state and local officials who are "*lawfully* engaged in the enforcement of any law or municipal ordinance relating to controlled substances."[227] There is precedent suggesting that conduct is

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[224] *Rosenthal*, 454 F.3d at 948.

[225] Indeed, *Rosenthal*'s discussion of *Kama* led a Colorado Supreme Court Justice to include a "see also" citation to *Rosenthal* for the proposition that enforce "means 'giving force to.'" *Crouse*, 388 P.3d at 45 (Gabriel, J., dissenting) (citation omitted). In a parenthetical, Justice Gabriel described *Rosenthal* as "noting that in returning seized marijuana to an individual pursuant to a state law mandating the return of such marijuana, the officers were 'enforcing' that state law." *Id.*

[226] *See* Merrill Lynch v. Manning, 136 S. Ct. 1562, 1569 (2016) (finding that "'enforce' means 'give force [or] effect to'"); *Lacey*, 904 N.E.2d at 26 (quoting *Webster's Third New International Dictionary*); *see also Bellagio* 863 F.3d at 848 (D.C. Cir. 2017) ("The leading law dictionary gives it a broad definition: to 'enforce' rules is '[t]o give force or effect to' them.").

[227] 21 U.S.C. § 885(d) (2012) (emphasis added).

"lawful" only if it is permitted under *both* federal and state law.[228] This could present a problem for immunizing safe injection site operators. Arguably, because a safe injection site violates the federal crack house statute, the officials running the site would not be engaged in "lawful" enforcement and so not entitled to immunity. This interpretation of the word "lawful" finds support in a 2017 Colorado Supreme Court decision, *People v. Crouse*, which is the only case to hold that the CSA does not grant immunity to a police officer who is ordered to return marijuana to someone in compliance with state law.[229]

Crouse involved a constitutional challenge to a provision of Colorado's medical marijuana law that required officers to return seized medical marijuana to individuals if they were eventually acquitted of the charges.[230] The dispute began when a trial court ordered the Colorado Springs Police Department to return marijuana to a man who had been acquitted of growing a significant amount of marijuana for medical purposes.[231] The police appealed the order, arguing that because Colorado's return of marijuana law required them to commit a federal crime—namely, distribution of marijuana—it was preempted by the federal CSA. By a 4–3 vote, the Colorado Supreme Court agreed. The court reasoned that compliance with Colorado's return-of-marijuana law would "necessarily require[] noncompliance" with the CSA, thereby creating "a 'positive conflict' between [Colorado law] and the CSA such that the two cannot consistently stand together."[232]

Relevant here, in the process of striking down Colorado's return of marijuana statute on preemption grounds, the *Crouse* court rejected an argument that 21 U.S.C. § 885(d) resolved the apparent conflict between state and federal law by immunizing officers who return seized marijuana. The court's analysis of the issue turned on what it means to be "lawfully engaged in the enforcement"[233] of the law. The *Crouse* majority found that to be lawfully engaged in the enforcement of a state or local drug law, an official's actions must "compl[y] with both federal and state law."[234] Because

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[228] *Crouse*, 388 P.3d at 43.

[229] *Id.*

[230] *Id.* at 40; *see* 21 U.S.C. § 903 (2012) ("No provision of this subchapter shall be construed as indicating an intent on the part of the Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a positive conflict between that provision of this subchapter and that State law so that the two cannot consistently stand together.").

[231] *Crouse*, 388 P.3d at 40–41 (reporting that the police had seized 55 marijuana plants and 2.9 kilograms of marijuana product from Crouse's home).

[232] *Id.* at 41.

[233] 21 U.S.C. § 885(d).

[234] *Crouse,* 388 P.3d at 43.

returning marijuana "necessarily requires law enforcement officials to violate federal law," the court concluded, "officers complying with that provision cannot be said to be acting 'lawfully' and thus are not protected by § 885(d)'s exemption."[235]

The *Crouse* court's analysis has some intuitive appeal and might well be the most natural understanding of the word "lawful" in some contexts. Consider, for example, a labor law that protects employees from being fired for their "'lawful' outside-of-work activities."[236] Because "the commonly accepted meaning of the term 'lawful' is 'that which is 'permitted by law,'"[237] it might be reasonable to conclude that an activity that violates federal criminal law is necessarily "unlawful" within the meaning of such a statute. The same does not hold true for the CSA's immunity provision, however, because it only applies to conduct that would otherwise be unlawful. A grant of immunity presupposes that a government officer has done something that would normally be a crime under the CSA. The only thing that makes that government official's otherwise illegal conduct legal is 21 U.S.C. § 885(d). As a result, the fact that a police officer's conduct violates one of the CSA's criminal provisions cannot possibly tell us whether her conduct is "permitted by law"[238] within the meaning of the immunity statute. After all, *every* state or local official who might seek protection under the immunity statute—whether an undercover officer or a safe injection site employee—will have necessarily done something that would normally be a federal crime.

The *Crouse* dissenters recognized this flaw in the majority's reasoning. They argued that the majority's definition of the term "lawful" was unsound because it did not provide a basis for distinguishing an officer who distributes marijuana as part of an undercover sting operation from one that returns marijuana in accordance with the CSA's immunity provision. In both situations, officers "are distributing marijuana in violation of the CSA" and so "defin[ing] 'lawful' with reference to the CSA's prohibition on distribution of controlled substances" is unhelpful.[239] Implicit in the majority's ruling, the dissent submitted, was the premise that to be "lawful," state and local officials must be "carry[ing] out the purpose of the CSA."[240] But limiting immunity in this way cannot be squared with the immunity provision's

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[235] *Id.*
[236] Coats v. Dish Network, LLC, 350 P.3d 849, 850 (Colo. 2015).
[237] *Id.* at 852.
[238] *Crouse*, 388 P.3d at 43 (quoting *Coats*, 350 P.3d at 852).
[239] *Id.* at 45 (Gabriel, J., dissenting).
[240] *Id.*

text, "which makes no reference to any purpose of the CSA."[241] The majority's only response on this point was to write in a footnote, without any elaboration, that undercover "sting operations are 'lawful' enforcement and consistent with federal law."[242]

If the *Crouse* majority got it wrong, what does it mean to be "lawfully" engaged in the enforcement of a law related to controlled substances? The text and structure of the statute, which applies to state and local officers who are "lawfully engaged in the enforcement of any law or municipal ordinance relating to controlled substances,"[243] provides a clear answer. The term "lawful" must mean that the official has been given the authority to enforce a law or municipal ordinance in a way that, but for the grant of authority (and the existence of the immunity provision), would violate the CSA. The only possible source for this grant of enforcement authority is state or local law. This is because a state or local officer's duties and authority are determined by state and local law. With respect to grants of immunity to state and local officials, then, the term "lawfully" is given meaning by state and local law.[244] Courts that have denied immunity under the CSA to rogue state and local officials have adopted exactly this interpretation.[245] As the Fifth Circuit held in a decision denying immunity to a parish prison guard, the immunity statute "require[s] the application of a state's laws to determine the status of the state official and the legality of the state official's actions."[246] Officials charged with running government safe injection sites would be engaged in lawful enforcement under this definition, which is on much more solid footing with respect to the immunity provision's text and precedent than the *Crouse* majority's narrow interpretation.

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[241] *Id.* at 46.

[242] *Id.* at 43 n.2.

[243] 21 U.S.C. § 885(d).

[244] *Wright*, 634 F.3d at 776 (holding that the terms "duly authorized" and "lawfully engaged" in the CSA's immunity provision "are given meaning through a state's statutes regarding state officials and through other rules and policies that govern the actions and duties of law enforcement officers").

[245] *Id*; *see Fuller,* 162 F.3d at 261 (holding that the defendant was not lawfully engaged in the enforcement of the law where "nothing in the South Carolina statutes or case law supports Fuller's belief that, as mayor, he possessed this enforcement power").

[246] *Wright*, 634 F.3d at 776 (noting that the immunity provision "is silent as to what it means to be a 'duly authorized' state officer 'lawfully engaged in the enforcement of' the controlled substances laws" and concluding that "[w]e will therefore look to Louisiana law to determine whether Wright is covered by" the immunity provision).

3. Legislative Intent

Finally, one might argue against applying the CSA's immunity provision to safe injection facilities on the grounds that doing so would be inconsistent with the purpose of the immunity statute and the broader goals of the CSA. This argument immediately runs into a seemingly insurmountable problem. Courts have no reason to consider congressional intent when the text of a statute is dispositive.[247] For the reasons already discussed, the text of the immunity provision would plainly apply to state and local officials operating a government-run safe injection facility. In order to conclude otherwise, a court would need to find either that the term "enforce" does not mean what the dictionary says it does, or that the term "lawful" is impliedly limited to actions that "carry[] out the purposes of the CSA."[248] Although there is precedent for both of these propositions, as discussed above, they are not possible to square with the statute's text.

In addition to the points already discussed, the structure of the immunity provision underscores the breadth of its grant of immunity to state and local officials. The immunity provision's treatment of state and local officials is especially striking in comparison to its treatment of federal officials. With respect to federal officials, the immunity provision applies only to "any duly authorized Federal officer lawfully engaged in the enforcement *of this subchapter*."[249] Congress could have tied immunity for state and local officials to federal priorities by using identical or similar language for the state and local immunity clause. Specifically, the immunity statute could have been drafted to apply only to state and local officers engaged in the enforcement of any law or municipal ordinance *prohibiting* controlled substances, any law or municipal ordinance *consistent with the purposes of the federal Controlled Substances Act*, or even any law or municipal ordinance *not in conflict with the purposes of the Controlled Substances Act*. Instead, the CSA's state and local immunity clause protects officers who are "lawfully engaged in the enforcement of *any* law or municipal ordinance *relating to* controlled substances."[250]

Similarly, if Congress had wanted to reserve immunity for state and local officials whose enforcement furthers the purposes of the CSA, it could have given federal agencies oversight or control over state and local gov-

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[247] Conn. Nat'l Bank v. Germain, 503 U.S. 249, 254 (1992) ("When the words of a statute are unambiguous, then, this first canon is also the last: 'judicial inquiry is complete.'") (citation omitted).

[248] *Crouse*, 388 P.3d at 45 (Gabriel, J., dissenting).

[249] 21 U.S.C. § 885(d) (emphasis added).

[250] *Id.* (emphasis added).

ernment use of the immunity provision. Congress could have required the DEA or the DOJ to pre-clear state and local enforcement operations in order for the immunity provision to apply. Or it could have required state or local agencies to register and report their actions to the DEA, similar to the CSA's registration and reporting requirements for physicians and researchers.[251] The fact that Congress did not include an oversight mechanism in the CSA's immunity statute is especially telling when one considers the dynamics of undercover policing. Undercover police operations can risk causing harm to innocent third parties.[252] In so-called reverse stings, illegal drugs provided by undercover officers sometimes reach consumers.[253] For this reason, the Drug Enforcement Administration has adopted guidelines for undercover operations that involve furnishing a controlled substance.[254] Nevertheless, many state and local agencies grant their undercover officers nearly unfettered discretion with few guidelines.[255] As a result, in the absence of coordination with federal officials, there is always a risk that state and local undercover police operations may inadvertently undermine federal drug enforcement efforts. Indeed, it is not entirely unheard of for undercover officers from different agencies to unexpectedly encounter and then try to arrest one another.[256] Congress could have limited the CSA's grant of immunity to make sure that state and local drug enforcement did not (wittingly or unwittingly) work at cross-purposes with federal goals. Instead, Congress enacted an immunity statute whose text gives broad deference to state and local governments to decide which officials and what conduct to immunize. In

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[251] *Id.* §§ 821–31.

[252] Elizabeth E. Joh & Thomas W. Joo, *Sting Victims: Third-Party Harms in Undercover Police Operations*, 88 S. CAL. L. REV. 1309, 1323 (2015).

[253] For example, in one of the leading Supreme Court decisions on the entrapment defense, an undercover police officer supplied the defendant with a difficult-to-get chemical for use in manufacturing methamphetamine. The defendant manufactured methamphetamine using the chemical that the undercover agent had supplied and kept a portion of it. The defendant was not arrested until a little over one month later. United States v. Russell, 411 U.S. 423, 425–26 (1973).

[254] United States v. Mustakeem, 759 F. Supp. 1172, 1176 (W.D. Pa. 1991) (discussing DEA guidelines regarding reverse sting operations that involve the furnishing of a controlled substance).

[255] Joh, *supra* note 177, at 183.

[256] *See, e.g.*, Harriet Sinclair, *Detroit Cops Fight Each Other in 'Very Embarrassing' Undercover Mix-up*, NEWSWEEK (Nov. 13, 2017), https://www.newsweek.com/detroit-cops-fight-each-other-very-embarrassing-undercover-mix-710270 [https://perma.cc/8RC3-NLP7] ("Officers from the 12th precinct, who were pretending to sell drugs in an attempt to arrest drug users, were approached by two officers from the 11th precinct, who treated them as they would any other 'drug dealers' and attempted to arrest them."); Scott Morgan, *Undercover Cop Arrested for Selling Drugs to an Undercover Cop*, STOPTHEDRUGWAR.ORG (July 21, 2009), https://stopthedrugwar.org/speakeasy/2009/jul/21/undercover_cop_arrested_selling [https://perma.cc/Q92M-RCKA] (describing how officers from one county arrested an officer from another county when he tried to buy a small amount of marijuana).

sum, only by engaging in a strained reading of terms like "enforcement" and "lawfully" and ignoring the breadth of the phrase "any law or municipal ordinance relating to controlled substances," would it be possible to conclude there is any ambiguity about how the immunity statute should apply to a government-run safe injection site.[257]

It bears noting here that interpreting a statute to apply more broadly than its drafters likely envisioned would not be at all unusual. We need look no further than the court decisions interpreting the crack house statute for an example. The legislative history of that law leaves little doubt that Congress enacted it with crack houses in mind. Both "the short title and the Congressional record synopsis refer to crack houses."[258] The Senate summarized the new law as one "that 'outlaws operation of houses or buildings, so-called 'crack houses' where 'crack,' cocaine and other drugs are manufactured and used."[259] Nevertheless, courts have not limited application of the law to so-called crack houses or even to defendants who personally act with the purpose of promoting drug activity. Instead, they have adopted a much broader interpretation than the legislative history would suggest because "the words of the statute clearly imply more expansive coverage."[260] Courts should not hesitate to apply these same principles to the CSA's immunity provision. Because the words of the immunity statute unambiguously include state or local officials charged with operating a government supervised injection facility, congressional intent is irrelevant.

Even if a court were to find ambiguity in the immunity provision's text, however, the argument that applying it to safe injection sites is inconsistent with congressional intent is not nearly as strong as one might assume. As noted before, in contrast to the crack house statute, there does not appear to be any legislative history on the CSA's immunity provision.[261] It may be reasonable to assume lawmakers did not contemplate in 1970 that the statute might one day immunize a manager of a government safe injection site or a police officer returning marijuana to an acquitted defendant.[262]

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[257] *See* 21 U.S.C. § 885(d).

[258] *Tamez*, 941 F.2d at 773.

[259] United States v. Sturmoski, 971 F.2d 452, 462 (10th Cir. 1992) (quoting 132 CONG. REC. S13, 780 (daily ed. Sept. 26, 1986)).

[260] *Tamez*, 941 F.2d at 773.

[261] *See supra* note 174 and accompanying text.

[262] The CSA was enacted in 1970. The first modern state medical marijuana law was not passed until 1996, and cities and states only recently began to seriously consider establishing safe injection sites. Proposals for states and cities to pass drug laws at-odds with prohibition were not entirely unheard of in the late 1960s and early 1970s, however. Perhaps the most notable examples of this were proposals for so-called heroin maintenance programs (also known as heroin-assisted treatment programs), which had been endorsed "by the New York County Medical Society, the New York Academy of Medicine, the New York State Bar Association, the *New York Times*, New

But there is no legislative history that demonstrates or even suggests any congressional intent to limit application of the immunity provision only to state and local officers who are "carry[ing] out the purposes of the CSA."[263] In fact, there is at least as much reason to think that Congress meant to give states and localities the broad deference that the immunity provision's text suggests as there is to think that Congress intended for the provision to apply only to state and local enforcement that furthers federal goals. As the Supreme Court has recognized, "[t]he CSA explicitly contemplates a role for the States in regulating controlled substances."[264] The immunity provision itself is evidence of this fact.[265] So too is the CSA's preemption provision, which "indicates that, absent a positive conflict, none of the Act's provisions should be 'construed as indicating an intent on the part of Congress to occupy the field in which the provision operates . . . to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State."[266]

Finally, even if it were possible to divine a congressional intent to exclude the enforcement of state and local laws that are at-odds with the CSA's goals from its immunity provision, it is far from clear that this would doom safe injection sites. In passing the CSA, Congress's primary purposes were to combat drug abuse and trafficking.[267] Safe injection sites do not appear to be in tension with either of these goals. With respect to the goal of

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York City Comptroller Abraham Beam," and others in the late 1960s and early 1970s. Cyril D. Robinson, *A Proposal for a Heroin Maintenance Experiment in New York City: The Limits of Reform Strategy*, 2 CONTEMP. CRISES 1, 7 (1978). In 1971, officials in New York City began to seriously consider a concrete proposal to establish a heroin-assisted treatment program, under which the city or a non-profit partner would distribute heroin to a small segment of people with substance use disorders as part of a more comprehensive treatment program. *Id*. at 7–9. Although the proposal never came close to becoming reality, it did reach the point of an application to the Food and Drug Administration (FDA) for approval. *Id*. at 10. Notably, in response to the proposal, a few members of the House introduced bills intending to stop heroin usage in drug maintenance programs, like the one proposed in the application to the FDA. *Id*. To be sure, this does not bear directly on legislative intent regarding the immunity provision. The move suggests, however, that at least some members of Congress were unsure that the CSA, which at the time had only recently been enacted, would prevent New York City from enacting such a policy. And importantly, the pre-1970 calls for heroin maintenance programs reveal that Congress was aware of the possibility that a state or locality might enact a policy in conflict with the CSA's criminal provision when it was writing the CSA's immunity provision.

[263] *Crouse*, 388 P.3d at 45 (Gabriel, J., dissenting).

[264] *Gonzales*, 546 U.S. at 251.

[265] *Crouse*, 388 P.3d at 46 (Gabriel, J., dissenting) (arguing that the immunity provision "is also part of the CSA and thus must be considered in determining the CSA's purposes").

[266] *Gonzales*, 546 U.S. at 270–71 (quoting 21 U.S.C. § 903).

[267] Gonzales v. Raich, 545 U.S. 1, 12–13 (2005) (finding that in passing the CSA Congress's "main objectives . . . were to conquer drug abuse and to control the legitimate and illegitimate traffic in controlled substances").

controlling traffic in illegal drugs, unlike the typical drug offender—or the typical undercover officer for that matter—safe injection facilities do not manufacture, distribute, or possess drugs. Here, a comparison to the relationship between the immunity provision and the medical marijuana laws at issue in *Crouse* and *Rosenthal* is helpful. It is clear enough that allowing the City of Oakland to deputize people as "officers" empowered to grow and sell marijuana would undermine the goal of controlling the traffic in controlled substances. The same is true of requiring the police to return seized marijuana to an arrestee. In both cases, government officials would be placing marijuana into an "illicit channel[]"[268] in the market. In contrast, safe injection sites are not involved in the illegal drug market in any way. They allow injection drug users to possess and use illegal drugs on their premises, but this does nothing to undermine federal efforts to control the traffic in illegal drugs.

Nor are safe injection sites in conflict with the CSA's purpose of combatting drug abuse. Their aim is to provide medical services to drug users and reduce the harms associated with drug use, not to encourage drug use. Indeed, the cities and states that are considering safe injection sites see them as part of a strategy for treating people with a substance use disorder by "transition[ing] . . . [them] into detox services."[269] Far from undermining the CSA's goals, supervised injection sites seek to *further* them. To be sure, some safe injection site opponents argue that they will "normalize drug use and facilitate addiction by sending a powerful message to teenagers that the government thinks illegal drugs can be used safely."[270] But disagreement over whether safe injection sites will succeed at achieving their stated goals does not mean they are at-odds with the purposes of the CSA. On this point, it is especially important to remember that supervised injection facilities do not violate any of the original criminal provisions of the CSA. Injection site operators do not manufacture, distribute, or possess illegal drugs.[271] If a city or state had established a supervised injection facility in 1971, the year after passage of the CSA, there would have been little reason to question their legal status under federal law. It is only because of the 1986 crack house statute that they violate the CSA. And, although safe injection sites may violate the letter of the crack house statute, they clearly fall outside of the

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[268] *Id.* at 13.

[269] S.F. DEP'T OF PUB. HEALTH, *supra* note 62, at 4.

[270] Rosenstein, *supra* note 22.

[271] Safe injection site *clients* who use drugs onsite are guilty of possession of a controlled substance, of course. But as noted previously, because safe injection site operators do not intend to encourage the possession of illegal drugs, it is very unlikely that they would be accomplices to the crime of possession. *See supra* note 17 and accompanying text.

congressional purpose behind that law, which was to criminalize "so called 'crack houses.'"[272] For these reasons, the argument that safe injection sites are in conflict with the CSA's goals of combating drug abuse and traffic in controlled substances is not a particularly compelling one. As a result, even if courts were to reserve immunity under the CSA for state and local enforcement that does not violate the purposes of the CSA, safe injection sites might very well still qualify for protection.

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The case for applying the CSA's immunity provision to government-run safe injection sites may not quite be open-and-shut. There is a very strong argument that the immunity provision's text is unambiguous. Even if legislative intent is considered, the claim that immunizing safe injection sites undermines the purposes of the CSA is not nearly as strong as one might assume. On the other hand, there is some precedent in support of applying the statute more narrowly than its text would suggest—specifically, the Ninth Circuit's decision in *Rosenthal* and the Colorado Supreme Court's decision in *Crouse*.

Even though the CSA's immunity provision may not give supervised injection sites a certain path to federal legitimacy, it appears to be their best hope, at least for now. Unless and until federal officials can be convinced to adopt a non-enforcement policy with respect to safe injection sites, cities and states that hope to establish them have only a few options available. The proposals that have received the most attention to date—convincing courts to narrowly interpret the crack house statute or to defer to states on federalism grounds—appear to be long-shots. But there is a solid argument that the CSA's immunity provision, which has so far gone entirely unnoticed in the public debate over safe injection sites, could allow them to go forward without federal interference.

Two final caveats merit comment. First, because the immunity provision applies only to "duly authorized officer[s]" of a state or locality,[273] it would not shield a purely privately-run safe injection site. This is especially notable because Philadelphia, which has gone the furthest towards establishing a safe injection facility, plans for its site(s) to be privately run.[274] Indeed, the DOJ filed suit against Safehouse, a Philadelphia nonprofit that has been working with the City, to stop them from opening a safe injection

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[272] *Tamez*, 941 F.2d at 773 (internal citation omitted); *cf.* Burris et al., *supra* note 17, at 1117–28 (arguing that courts should adopt a narrower interpretation of the crack house statute that would exclude safe injection sites from its reach based on congressional intent).

[273] 21 U.S.C. § 885(d).

[274] Gordon, *supra* note 14.

site.[275] Based on the above analysis, Philadelphia might be well-advised to reconsider its strategy in favor of opening a government-run facility or, at least, passing an ordinance to closely regulate safe injection sites and designating all Safehouse employees as "duly authorized officer[s]" of the city.[276] Second, in order to test whether the CSA immunizes government-run safe injection sites, a city or state will need to get the issue into federal court. Whether this can be done without putting city or state employees at risk of federal criminal prosecution is not entirely clear. As the DOJ's lawsuit against Safehouse shows, United States Attorneys have more tools at their disposal than criminal enforcement; they can seek declaratory relief in advance of a site opening. But the decision to file suit against Safehouse may have been driven by the nonprofit's apparent commitment to opening a safe injection site in the face of threats of criminal prosecution. Understandably, government attorneys are unlikely to sign-off on a plan that would have city or state employees break federal law in order to get a test case into court. As a result, federal prosecutors may decide it is not necessary to preemptively sue a city that expresses interest in opening a safe injection site, on the belief that local officials will not actually go through with it. Thus, unless a city or state is willing to openly defy federal law, risking their employees in the process, they may need to sue the federal government in order to press the issue. To do this, they will need standing, which may be difficult to achieve.[277]

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[275] *See supra* note 23 and accompanying text.

[276] 21 U.S.C. § 885(d). This approach would be similar to what Oakland tried to do with certain medical marijuana providers in the late 1990s and early 2000s. Whether such an arrangement would be enough to make private employees "duly authorized officer[s]" within the meaning of the immunity provision is far from clear. *Id.* While a government-run site would give cities the best chance of winning an immunity argument, countervailing considerations may weigh in favor of a privately run facility. Private parties may be more willing to risk violating federal law than city officials. As a result, even if a privately run facility might have a weaker legal argument against federal prosecution than a government-run site, city lawmakers might believe that it will be easier for them to get a privately run site to open than it would be to open a site that is run by the city.

[277] While an analysis of the issue of standing is beyond the scope of this Article, it is not impossible to imagine a set of facts in which a city or state might have standing to sue the government to enjoin them from prosecuting a planned safe injection site. After all, the Supreme Court's decision upholding the federal government's power to reach intrastate medical marijuana activity under the Commerce Clause involved a lawsuit *against* the government by medical marijuana patients, and not a criminal prosecution. *See generally Raich*, 545 U.S. 1. Although the Supreme Court did not consider whether the plaintiffs in *Raich* had standing, the Ninth Circuit panel that heard the case split on the question. Raich v. Ashcroft, 352 F.3d 1222, 1226 n.1 (9th Cir. 2003). Of course, *Raich* involved a constitutional challenge to the CSA, whereas a claim based on the CSA's immunity provision would be statutory.

IV. SAFE INJECTION SITES AND THE FUTURE OF THE WAR ON DRUGS

Only time will tell how the looming conflict between cities and the federal government over safe injection sites will be resolved. Regardless of the outcome, the relationship between the crack house statute and the effort to establish safe injection sites reveals a great deal about the status of the drug war in the United States. The beginning of this decade saw a consensus begin to emerge that the war on drugs has failed.[278] Prominent politicians from across the political spectrum have called for an end to the war on drugs.[279] But it is far from clear what "ending the drug war" would mean. This is in part because drug war critics do not appear to agree about what should come next. As just one example, those who have labeled the drug war a "failure" include politicians who vehemently oppose marijuana legalization (like former New Jersey Governor Chris Christie) and those who strongly support it (like California Lieutenant Governor Gavin Newsom).[280] It is possible, of course, that the political winds will shift again, especially since the Trump administration has taken steps to revive the drug war. But, if support for replacing the war on drugs with a new strategy does continue to grow, questions regarding what the new strategy should look like will linger. Safe injection sites may provide a perfect test case.

As I have argued elsewhere,[281] one of things that has separated the U.S. war on drugs from drug prohibition in other countries is the view that any policy that is inconsistent with a drug-free society, even if only in appearance, is a "form[] of surrender"[282] and accordingly unacceptable. The drug war frames prohibition as a life and death struggle in which, as Reagan's Attorney General Edwin Meese put it, "there are no neutrals."[283] Under the ideology of the drug war, ideas like safe injection sites or needle exchange programs are rejected out of hand.[284] There is no need to debate the costs and benefits. In fact, the debate might itself be a concession to the enemy. Former drug czar William J. Bennett characterized "[b]uzzwords like 'harm reduction'" as a type of surrender because they "crowd[] out

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[278] Kreit, *supra* note 10, at 1324–26.

[279] *Id.*

[280] *Id.* at 1325–26.

[281] *Id.*

[282] Bennett, *supra* note 11; *see* Caulkins & Reuter, *supra* note 32, at 117 ("In the United States 'harm reduction' became a toxic term, seen within law enforcement circles as a Trojan horse for legalization.").

[283] DAN BAUM, SMOKE AND MIRRORS: THE WAR ON DRUGS AND THE POLITICS OF FAILURE 214 (1996) (quoting Edwin Meese).

[284] *See* Vallejo, *supra* note 32, at 1192–93 (discussing opposition to syringe exchange programs in the drug war era).

clear no-use messages."[285] In the drug war, there can be no allowance for states and cities to tryout harm reduction policies to gather evidence about what works and what does not. The only acceptable measures are those that take a zero-tolerance approach to drug use.

This outlook led Congress to pass increasingly punitive and far-reaching anti-drug legislation in the 1980s, the crack house statute being a prime example. The law had no connection to any significant federal enforcement interest and was largely unnecessary in any event. Crack houses are essentially a land use concern; they are blighted properties that happen to involve drug activity rather than some other type of nuisance. To the extent that crack houses contribute to the drug trade, Congress did not need to pass a new law to address the problem. The great majority of people who maintain a place for the purpose of manufacturing, selling, or using drugs are guilty of other federal drug crimes—namely manufacturing, distributing, or possessing drugs—either as a principal or an accomplice.[286] A law like the crack house statute is not necessary to prosecute drug manufacturers or sellers, or even landlords who rent their property to drug dealers at a premium. Nevertheless, Congress created a new crime to address the problem of crack houses and wrote the statute so broadly that it applies to a person who knows someone is using her property for a prohibited purpose, even if she does not share that purpose.[287] As a result, the statute sweeps in people with a tenuous connection to the drug trade who would be guilty of no crime under traditional accomplice liability principles[288] including, very likely, government-run safe injection sites.

If calls to end the drug war are ever going to move beyond rhetoric, federal lawmakers must reconsider laws like the crack house statute and give cities and states room to experiment with policies like safe injection facilities. The war on drugs may require a uniformity of purpose among federal, state, and local laws. But a drug policy that is focused on public health can allow—and, indeed, should encourage—innovation and a diversity of approaches.[289] If we are no longer fixated on achieving a drug-free society, there is no reason to insist that all state and local drug laws be di-

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[285] Bennett, *supra* note 11.

[286] Indeed, published decisions involving crack house prosecutions often involve defendants who have also been convicted of other drug offenses. *See* Sachdev, *supra* note 96, at 596 (discussing crack house statute prosecutions).

[287] *See generally* United States v. Tebeau, 713 F.3d 955 (8th Cir. 2013).

[288] *See* United States v. Wilson, 503 F.3d 195, 195 (2d Cir. 2007) (upholding the conviction for maintaining a drug-involved premise of a woman who shared an apartment with a drug dealer).

[289] *See* Kreit, *supra* note 10, at 1375–78 (arguing that giving states room to adopt policies that may be inconsistent with a zero-tolerance strategy should be viewed as one of three guiding principles for a post-war drug policy).

rected exclusively, or even primarily, toward use reduction. Instead, cities and states should have the space to try out new policies that prioritize goals like harm reduction over concerns about sending a message of permissiveness. The federal government has already recognized as much when it comes to state marijuana legalization laws, albeit somewhat reluctantly. Through its (formal and now informal) non-enforcement policy and a congressional budget rider that shields state medical marijuana businesses from prosecution,[290] the federal government has let states try new approaches to marijuana policy.

The argument for deferring to states and cities is even stronger when it comes to policies like supervised injection sites that do not implicate federal or cross-state concerns. In contrast to the legal manufacture and sale of marijuana, which has the potential to impact neighboring states,[291] the effects of safe injection sites are almost entirely limited to the city (even more likely, just the neighborhood) where they are located.[292] They neither distribute nor purchase drugs, nor do they promote drug use. Any conceivable influence they might have on the demand for illegal drugs would be negligible. Not surprisingly, then, federal opposition to letting states and cities test safe injection sites appears to be premised on a belief that they are incompatible with the war on drugs strategy. As Deputy Attorney General Rod Rosenstein recently put it, instead of opening supervised injection sites, cities and states "should join [the federal government] and fight drug abuse."[293] In Rosenstein's view, the "fight" is waged by "aggressively prosecut[ing] criminals who supply the deadly poison,"[294] and the only acceptable goal is reducing drug use. Safe injection sites, which are designed to reduce harm among users (rather than use itself), are seen as little more than a way to "help people abuse drugs by providing needles [with staff] stand[ing] ready to resuscitate addicts who overdose."[295] There is no serious claim that safe injection sites would contribute to the market for illegal drugs or have any real effect outside of the cities in which they would operate. But, among drug warriors,

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[290] *See* Scott W. Howe, *Constitutional Clause Aggregation and the Marijuana Crimes*, 75 WASH. & LEE L. REV. 779, 802–03 (2018) (discussing the appropriations rider that precludes the DOJ from using funds to prevent states from implementing medical marijuana laws).

[291] Chad DeVeaux & Anne Mostad-Jensen, *Fear and Loathing in Colorado: Invoking the Supreme Court's State-Controversy Jurisdiction to Challenge the Marijuana-Legalization Experiment*, 56 B.C. L. REV. 1829, 1837–43 (2015) (arguing that Colorado's marijuana law has a negative impact on neighboring states).

[292] *Cf.* Marshall et al., *supra* note 48 (finding that overdose deaths in the immediate vicinity of Vancouver's safe injection site fell by 35% after its opening, but the rate for the city as a whole decreased by only 9.3% during the same period).

[293] Rosenstein, *supra* note 22.

[294] *Id.*

[295] *Id.*

they are a federal concern because they would "normalize drug use" and send the wrong "message to teenagers."[296]

For this reason, the movement to establish safe injection sites raises fundamental questions about our national approach to drug policy. Should we return to the strategy of the drug war, with every level of government marching in lockstep toward the elusive goal of a drug free society? Or should we continue moving toward a public health strategy, with a focus on trying out new policies and gathering evidence to determine what works? As cities and states continue their effort to establish safe injection sites, federal officials will be forced to wrestle with these questions. This includes courts that, in the words of Justice John Paul Stevens, acted mostly as "loyal foot soldier[s]"[297] in the war on drugs. If judges view the CSA's immunity provision through the lens of the drug war, they will be much more willing to read it narrowly and exclude harm reduction measures that conflict with a zero-tolerance approach from its reach.

More important than the courts when it comes to the future of federal drug policy, however, is Congress. So far, Congress has been absent from the debate over supervised injection sites. People on both sides of the issue have been operating on the assumption that federal law will remain as it is. From the perspective of safe injection site advocates and opponents, this makes some sense. In light of Congress's failure to resolve the much more pressing conflict between federal and state marijuana laws, it seems unlikely that federal lawmakers would take up the issue of safe injection sites now. But if interest in safe injection sites continues to grow at the state and local level, it will only be a matter of time before the issue reaches Congress.

CONCLUSION

Safe injection sites are currently operating in ten countries, including Canada. There is a good deal of evidence that they can reduce overdose deaths and the spread of blood-borne diseases among injection drug users. Only recently have they begun to receive serious attention from policymakers in the United States, however. For years, harm reduction measures like safe injection sites were rejected out-of-hand on the grounds that they were incompatible with the war on drugs. Somewhat suddenly, the landscape has changed. Waning enthusiasm for the drug war, coupled with the opioid cri-

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[296] *Id*. To be sure, safe injection site opponents believe that they would "create serious public health risks." *Id*. But these alleged risks involve mostly uniquely local concerns such as the possibility that they might "destroy the surrounding community." *Id*.

[297] California v. Acevedo, 500 U.S. 565, 601 (1991) (Stevens, J., dissenting).

sis, have led a number of cities and states to take concrete steps toward establishing safe injection sites. A few cities have even held press conferences to announce their plans to open the first safe injection site in the United States. But, so far, none of these efforts has moved beyond the planning stage because federal law stands in the way. The federal crack house statute makes it a crime to maintain a building for the purpose of using a controlled substance. Safe injection sites almost surely violate that law.

This Article proposes a novel solution to the conflict between cities and the federal government over safe injection sites in the form of an obscure provision of the Controlled Substances Act that immunizes officials who are engaged in the enforcement of state and local laws relating to controlled substances. Although the CSA's immunity provision was likely written with undercover police officers in mind, the plain language of the law seems to apply to a government-run safe injection site. A handful of courts have already relied on the statute to immunize government officials who were engaged in the enforcement of state medical marijuana laws. The logic of those decisions supports immunizing the operators of government-run safe injection sites. To be sure, there is other precedent that points toward a narrower reading of the immunity provision, so the case for applying it to safe injection sites is not open-and-shut. But if courts were to agree with the interpretation of the immunity provision outlined in this Article, cities would be free to open safe injection sites without putting their employees at risk of federal prosecution.

Even if the threat of federal prosecution were removed for safe injection site operators, other challenges would remain. Most notably, the federal government could try to interfere with the operation of safe injection sites by targeting users for arrest and prosecution. Although simple drug possession is rarely prosecuted in federal court, it is a federal crime.[298] A grant of immunity to safe injection site employees would not prevent Drug Enforcement Administration agents from "camp[ing] out in front of the site and arrest[ing] anyone in possession" of drugs.[299] Whether a strategy like

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[298] 21 U.S.C. § 844 (2012).

[299] Katie Zezima, *Awash in Overdoses, Seattle Creates Safe Sites for Addicts to Inject Illegal Drugs*, WASH. POST (Jan. 27, 2017), https://www.washingtonpost.com/politics/awash-in-overdoses-seattle-creates-safe-sites-for-addicts-to-inject-illegal-drugs/2017/01/27/ddc58842-e415-11e6-ba11-63c4b4fb5a63_story.html?noredirect=on&utm_term=.d88bfd200ee7 [https://perma.cc/D4WK-D4U2] (quoting King County Sheriff John Urquhart). This risk is not limited to the DEA. Unless a state was to decriminalize drug possession, local police and prosecutors would have the authority to arrest and prosecute safe injection site clients. Police and prosecutors in some of the cities that are considering safe injection sites have pledged not to do this, however. *See, e.g.*, Roebuck & Palmer, *supra* note 146 (reporting that Philadelphia District Attorney Larry Krasner has "pledged that his office would not target the operators or users at a safe injection site"); Zezima, *supra* (reporting that

this would succeed in effectively blocking the implementation of safe injection sites is far from clear, however.[300] Still, the prospect of the federal government arresting and prosecuting safe injection site clients would at the very least present another problem for cities and states to consider.

Whether cities and states will succeed in their efforts to establish safe injection sites in the face of federal opposition remains to be seen. Safe injection site advocates are understandably focused on how this conflict will impact the opioid crisis. But the outcome will also say a lot about the state of drug policy in the United States more broadly. United States drug policy appears to stand at a crossroads. Throughout the Obama administration, the country seemed to be moving slowly but steadily toward an end to the war on drugs. Well-known politicians from both parties denounced the drug war as a failure. The Trump administration has worked to "reverse"[301] this trend, however. Under Attorney General Sessions, the DOJ withdrew the modest limits that the Obama administration had placed on applying mandatory minimum penalties to low-level drug offenders. Sessions also rescinded the DOJ's policy of non-enforcement against people who comply with state marijuana laws, although that move has not had much practical effect. In a sign that the federal government has given up the fight over marijuana legalization, it has continued to take a hands-off approach when it comes to state marijuana legalization laws. By all appearances, the next battle between state and federal drug laws will concern safe injection sites. The result may tell us whether the United States is willing to put an end to the war on drugs or merely to the war on marijuana.

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the King County Sheriff, where Seattle is located, would instruct his deputies not to target individuals who are coming or going from a safe injection facility).

[300] It seems unlikely that merely entering or exiting a safe injection site would give agents probable cause to search or arrest, especially if the site were housed in a building with other government services or agencies. State v. Weyand, 399 P.3d 530, 536 (Wash. 2017) (holding that "walking quickly and looking around, even after leaving a house with extensive drug history at 2:40 in the morning, is not enough to create a reasonable, articulable suspicion of criminal activity"). In addition, targeting users would be incredibly resource intensive in comparison to targeting site operators. As the example of state marijuana reform demonstrates, the legal authority to prosecute people for violating federal law means very little if federal officials do not have the money and manpower to act as a credible deterrent.

[301] Rosenstein, *supra* note 22.

CITY OF PORTLAND
Health and Human Services
Kristen Dow, Interim Director

MEMORANDUM

TO: **Health and Human Services – Public Safety Committee**

FROM: **Bridget Rauscher, Public Health Division**

DATE: **May 23, 2019**

SUBJECT: **Responses to questions raised at 5/14 meeting re: Safe Injection Sites**

CC: **Kristen Dow, Interim Health and Human Services Director**
Kolawole Bankole, Director of Public Health

Introduction

The information contained in this memo is in response to questions posed by HHS-PS committee members during meeting on 5/14 regarding the Public Health Division's presentation on safe injection sites.

State Level Action

Gordon Smith, Director of Opioid Response, was invited to attend the meeting scheduled for 5/28 and discuss overdose prevention and response related action at the state level. Unfortunately, he is unable to attend this meeting but stated that he would like to attend the meeting on 6/11 and will confirm his availability as soon as possible.
An emergency ruling allowing for community distribution of naloxone has been published and statewide naloxone distribution will begin shortly.

Cost of Overdose

Regarding the cost of emergency department transport, information gathered in the last year from staff of the Portland Fire Department shows that each basic ambulance transport is approximately $1000 - $1200, depending on level of intervention. Lack of insurance and other information obtained at the time of these encounters reduce the chances that bills will be able to be sent and paid.

The Portland Fire Department administered naloxone 45 times between 8/1/18 and 12/31/18 (utilization of new software prevents accounting for entire year). As stated during the meeting, in depth analysis would be necessary to determine a more complete picture of calls responded to where naloxone was administered prior to the arrival of emergency medical services.

Efficacy-related Sources

Sources of studies providing both cost benefit and efficacy results from the presentation:

1. Anderson, M. & Boyd, N. (June, 2009) *A cost-benefit and cost-effectiveness analysis of Vancouver's supervised injection facility.* The International Journal on Drug Policy.

https://www.researchgate.net/publication/24409321_A_cost-benefit_and_cost-effectiveness_analysis_of_Vancouver's_supervised_injection_facility
2. Abernathy, B., Farley, T., Gladstein, E., Jones, D. (January, 2018) *Report on Exploratory Site Visits for Comprehensive User Engagement Site (CUES).* City of Philadelphia, Pennsylvania. https://dbhids.org/wp-content/uploads/2018/01/OTF_Comprehensive-User-Engagement-Site-Report-clean_jg.pdf
3. Gordon, Elana (September, 2018). *What's the Evidence That Supervised Drug Injection Sites Save Lives?* NPR. https://www.npr.org/sections/health-shots/2018/09/07/645609248/whats-the-evidence-that-supervised-drug-injection-sites-save-lives

Supportive Place for Observation and Treatment (SPOT)

According to staff of Boston Health Care for the Homeless, their Supportive Place for Observation and Treatment (SPOT) Program is funded collaboratively by Boston Health Care for the Homeless, grant opportunities, and third party reimbursement.

Safehouse

Safehouse is a privately funded Pennsylvania nonprofit corporation whose mission is to save lives by providing a range of overdose prevention services and is motivated by Judeo-Christian beliefs. Safehouse is working with community partners to find a suitable location(s) to deliver those services.

On February 5, 2019, the U.S. Attorney for the Eastern District of Pennsylvania filed a civil lawsuit against Safehouse. This lawsuit is not seeking money, it is not seizing property, and no one is being prosecuted criminally. The lawsuit asks a federal court to declare that supervised consumption sites are illegal.

On April 3, 2019, Safehouse filed their response to the civil lawsuit, stating Safehouse believes that supervised consumption sites are legal and save lives.

Cost of Portland Needle Exchange Program (NEP)

The Portland NEP, housed at 103 India Street is staffed by two full time employees and several volunteers. Approximate annual costs to operate the NEP are as follows:

General Funds:
Salary (not including fringe benefits) - $109,290
Supplies - $19,000
Rent & Utilities – approx. $38,500 (total is ~ $77,000 shared among PHD programs)

Other FY19 Funds:
Maine CDC - $17,142
AIDS United Grant - $15,000
Average annual donations - $12,000

TOTAL: $197,435