THE LOCALITY’S CASE FOR SAFE INJECTION FACILITIES: LEGAL OBSTACLES AND WAYS TO OVERCOME THEM

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Abstract. The legality of safe injection facilities as a harm reduction method in response to the national opioid crisis continues to be a challenging and evolving issue involving federal, state, and local jurisprudence. As one indication of the predominance of local government in dealing with these issues, in February 2020 Philadelphia’s proposed safe injection facility (SIF) successfully fended off a challenge from the U.S. Department of Justice in federal district court,1 a decision now stayed pending appeal.2 While United States v. Safehouse is an important legal step for harm reduction advocates, it is not a guarantee of legality for SIFs. Commentators have paid close attention to the federal prosecution of SIFs, but federal law is just one impediment. Just as a federal prosecutor may seek to block a SIF, so may the state, the city council, or the police. A municipality seeking to open such a facility must coordinate among many stakeholders and then clear legal hurdles at each level of government before facing the U.S. Attorney. The legal pathway for SIFs was forged by other harm reduction policies that incubated at the local level. This Article addresses the legal status of safe injection facilities (SIFs) in the context of local harm reduction policies. Part I will provide a brief summary of the modern opioid crisis and government response. Part II will explore how harm reduction policy, especially for addressing drug use, is effectuated at the level of local government. Part III will discuss how SIFs fit into the same framework of harm reduction policies incubated locally. Finally, Part IV will review the state and federal legal challenges for SIFs and examine how those challenges fared in United States v. Safehouse.

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I. BACKGROUND ON THE OPIOID CRISIS

A. A brief history of the modern opioid crisis

A problem as large as the opioid crisis can be described in many ways. Drug overdose is the leading cause of injury-related death in the United States. It is so prevalent that “[e]very day in America is like a 747 plane crash[. . .].” In 2017 alone, more than 70,000 people in the United States died from overdose, a number exceeding all U.S. military casualties during the Vietnam War.[5] Philadelphia’s overdose death rate is four times its murder rate. Suffice it to say, the misuse of opioids—heroin, prescription pain medication, and synthetic opioids—is one of the deadliest public health crises in recent memory and likely the deadliest drug-related disaster in U.S. history.[6]

An opioid drug, or “opioid,” is a drug that binds to opioid receptors in the brain with the effect of dulling the perception of pain.[7] Pharmaceutical opioids are prescribed for pain management, but their use can also produce euphoric effects, which can lead to drug abuse.[8] Scholars point to over-prescription of opioid pain medication as the root of the opioid crisis in the United States.[9] When


9 Id.

10 E.g., Corey S. Davis & Derek H. Carr, The Law and Policy of Opioids for Pain Management, Addiction Treatment, and Overdose Reversal, 14 IND. HEALTH L. REV. 1, 9 (2017) (“Opioid prescriptions nearly quadrupled from 1999 to 2010, accompanied by a nearly identical rise in the rate of prescription opioid-related deaths. . . . [I]t is clear that this increase in opioid prescriptions and related addiction has also helped fuel the recent increase in heroin overdose in the United States, which more than tripled between 2010 and 2013.”). For brief histories of the emergence of the opioid epidemic, see Nabaran Dasgupta et al., Opioid Crisis: No Easy Fix to Its Social and Economic Determinants, 108 AM. J. PUB. HEALTH 182, 182-83 (2018); Ameet Sarpatwari et al., The Opioid Epidemic: Facing a Broken Pharmaceutical Market, 11 HARV. L. & POL’Y REV. 463, 464–77 (2017).
prescription drugs run out or become prohibitively expensive, users turn instead to heroin or fentanyl, a highly potent synthetic opioid. Pharmaceutical companies have received criticism for zealous marketing of opioid pain medication and are increasingly facing liability for their role in the opioid crisis. Beyond corporate irresponsibility, scholars also blame the government’s punitive “War on Drugs” approach to opioid use, as opposed to an addiction treatment-based approach, for exacerbating the problem.

The trend of opioid consumption is generally on the rise. Opioid prescriptions nearly quadrupled from 1999 to 2010, accompanied by a nearly identical rise in the rate of prescription opioid-related deaths; a more recent study identifies synthetic opioids and spikes in eastern states and the District of Columbia as increasingly deadly. Nationwide, overdose deaths decreased four percent between 2017 and 2018 but increased again in 2019, with even more deaths anticipated in 2020 due to the COVID-19 pandemic.

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13 See Scott Burris et al., Stopping an Invisible Epidemic: Legal Issues in the Provision of Naloxone to Prevent Opioid Overdose, 1 DREXEL L. REV. 273, 277–78 (2009) [hereinafter Burris et al., Stopping an Invisible Epidemic] (describing how the War on Drugs has made it more difficult to prevent overdoses as “[i]licit drugs fluctuate in potency; illicit drug users are often afraid to call 911 when they observe overdoses; and drug users who have been incarcerated face an elevated risk of overdose at release. . . .”).


15 Matthew V. Kiang et al., Assessment of Changes in the Geographical Distribution of Opioid-Related Mortality Across the United States by Opioid Type, JAMA NETWORK OPEN, Feb. 2019, at 1, 4–6.


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Public health experts have stated for years that death from opioid overdose is easily and affordably prevented. When a person overdoses using opioids, their breathing slows gradually, which creates a window of time to administer overdose reversal medication. This medication, naloxone, is an opioid antagonist, meaning that it binds to opioid receptors without activating them, thereby displacing the opioids bound there. Naloxone is administered as a nasal spray (Narcan) or as an injection. Someone given naloxone should be monitored for several hours, but in many cases aftercare does not require a hospital visit. The relatively low cost and the minimal complexity of naloxone as a medical intervention is in stark comparison to alcohol overdose response, which can require induced vomiting, oxygen therapy, and intravenous fluids.

B. Recent government responses to the opioid crisis

In 2016, President Obama signed into law the Comprehensive Addiction and Recovery Act of 2016 (CARA), the largest piece of drug legislation since the Controlled Substances Act. CARA expanded naloxone access, supplied addiction treatment for prisoners and pregnant women, and created task forces on drug trafficking and prescribing practices. A few months later, the federal government created task forces on drug trafficking and prescribing practices.


See Burris et al., Stopping an Invisible Epidemic, supra note 13, at 276–77 (“The heart of the challenge is the possibility that things could be different: overdose is a public health problem that can be solved. Unlike many of the other leading causes of death, death from opioid overdose is almost entirely preventable, and preventable at a low cost. Opioids kill by depressing respiration, a slow mode of death that leaves plenty of time for effective medical intervention. Overdose is rapidly reversed by the administration of a safe and inexpensive drug called naloxone. Naloxone strips clean the brain’s opioid receptors and reverses the respiratory depression causing almost immediate withdrawal.”); Karl A. Sporer, Strategies for Preventing Heroin Overdose, 326 BMJ 442, 443 (2003) (describing naloxone as an “inexpensive” intervention).


Id.

See Michael W. Willman et al., Do Heroin Overdose Patients Require Observation After Receiving Naloxone?, 55 CLINICAL TOXICOLOGY 81, 82–84 (2017) (reviewing literature to conclude some patients treated with naloxone can be released safely without transport to hospitals if vitals and other factors are normal).


Comprehensive Addiction and Recovery Act § 101 (requiring HHS to convene a Pain Management Best Practices Inter-Agency Task Force); § 103 (creating grants to expand access to FDA-approved drugs for emergency overdose treatment); § 201 (creating grants for alternative to incarceration programs and prison-based family treatment programs for pregnant
government provided $1 billion in grants to states over two years for opioid prevention in the 21st Century Cures Act.26 Most federal drug spending, however, continues to go toward drug control and law enforcement.27 For its part, the Trump administration has emphasized law enforcement and funding the development of non-narcotic pain management in its response to the opioid crisis.28 Federal prosecution of opioid-related crimes focuses on distributors of heroin and fentanyl, including traffickers and “pill-mill” operations;29 prosecution for simple possession is generally not a priority.30 The Drug Enforcement Administration (DEA), as the primary administrator of the Controlled Substances Act (CSA),31 adopts and enforces regulations for prescription opioid manufacturers and distributors.32

On the state level, governments have responded in myriad ways.33 To address pill-mills and the over-prescription of opioids, states have implemented prescription drug monitoring programs at their health administrative agencies.34 Some states have opted to cover medication-assisted treatment programs.35

women); § 501 (allocating funding for outpatient treatment of pregnant and postpartum women in residential treatment programs).


30 United States v. Safehouse, No. 19-519, 2020 U.S. Dist. LEXIS 110549, at *19–20 (E.D. Pa. June 24, 2020) (“Widespread prosecution of simple possession has only occurred in tandem with other law enforcement initiatives, such as border control strategies. In 2019, nationwide, there were only 560 federal cases brought for simple possession, and 243 of those emanated from just two districts, one in a border state … When the federal government does choose to prosecute it, simple possession is a misdemeanor for a first-time offender, and, except for offenses involving unlawful entry, it results in probation or a fine more than seventy percent of the time.”) (citation omitted); Rachel L. Rothberg & Kate Stith, The Opioid Crisis and Federal Criminal Prosecution, 46 J. L., Med. & Ethics 292, 296–97 (2018) (“Traditionally, the U.S. Attorney’s Offices – along with the federal government itself – have not dedicated their limited resources to prosecuting simple possession of heroin … [and] have not sought to prosecute drug-dependent users who simply sell some of the substance to support their habit. Rather, U.S. Attorney’s Offices have typically focused on the seizure of drug transshipments and prosecution of major distributors … .”).


33 See generally Andrew M. Parker et al., State Responses to the Opioid Crisis, 46 J. L., Med. & Ethics 367 (2018).


https://scholarship.law.upenn.edu/jlasc/vol24/iss1/3
for opioid addiction under their state Medicaid plans. States have also increased access to naloxone and implemented clean needle and syringe exchange programs. To encourage use of emergency services during an overdose, state-level “Good Samaritan” laws immunize people from prosecution for drug possession when they call for help.

Scholars and public health professionals have called for these and other harm reduction approaches to the opioid epidemic. Harm reduction is a catch-all term for interventions that aim to improve health outcomes by minimizing risks and lessening adverse effects of drug use. Harm reduction began in the 1980s as a grassroots effort to limit the spread of HIV and hepatitis B. Implicit in a harm reduction approach to drug use is not criminalizing “low-level” drug users who are dealing with substance use disorder. Instead, addiction is treated as a disease and a public health concern, such that health and safety outcomes are prioritized over criminal prosecution.

The call for harm reduction approaches to the opioid epidemic is undoubtedly entangled with the framing of opioid use as a “white” problem. Whites are more likely to be prescribed opioids than non-white racial groups. Once opioid addiction and opioid-related overdose began to ravage white communities and effect a measurable decrease on white life expectancy, policymakers
responded with nonpunitive measures. The War on Drugs, by contrast, criminalized drug addiction and penalized Black drug users much more than white drug users, while drug policy proposals for disproportionately white opioid users typically take a more humane, public health based approach.

II. HARM REDUCTION BEGINS AT THE LOCAL LEVEL

Local governments are especially and uniquely equipped to accomplish harm reduction. Local governments are on the frontlines of the opioid crisis and its effects. Municipal police and emergency services respond to overdoses. In cities, behavioral health departments provide addiction recovery services and helplines. Local parks—even Little League baseball parks—have become sites for intravenous drug users to inject, and for municipal recreation departments to clean up.

The opioid crisis, while often associated with rural communities, has had a major impact on urban centers, where residents are concentrated and where opioids are trafficked along major highway routes to buyers in cities. Trafficking patterns channel opioids to cities in the Northeast, creating a distribution highway. Cities, as concentrated governing bodies dealing with residents in crisis, are quicker on the uptake with harm reduction initiatives than states. At the local level, city governments can collect input from harm reduction advocates and test out nonpunitive harm reduction strategies. Harm reduction, especially when taken up in lieu of criminalization, requires coordination among police, emergency responders, prosecutors, and public health departments. Such multifaceted coordination is piloted most seamlessly within a locality. Cities also have the legal might

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42 Hansen & Netherland, supra note 41.
43 See generally James & Jordan, supra note 41 (explaining how the framing of the opioid epidemic as an issue mainly facing white communities ignores the impact of the epidemic on Black communities and perpetuates the disparate treatment they receive). For an overview of the anti-Black motivation for, and racially disparate impact of, the War on Drugs, see Michelle Alexander, The New Jim Crow 97–101 (2010).
46 See, e.g., Katherine M. Keyes et al., Understanding the Rural–Urban Differences in Nonmedical Prescription Opioid Use and Abuse in the United States, 104 AM. J. PUB. HEALTH e52, e52 (2014) (“[D]eath and injury from nonmedical prescription opioid misuse are concentrated in states with large rural populations, such as Kentucky, West Virginia, Alaska, and Oklahoma. . . . [I]ndividuals in counties outside metropolitan areas have higher rates of drug poisoning deaths, including deaths from opioids, and opioid poisonings in nonmetropolitan counties have increased at a rate greater than threefold the increase in metropolitan countries.”). While “rural” describes geographic concentration, it is also racially tinged, drawing a distinction between rural/white and urban/Black. Christine Minhee & Steve Calandrillo, The Cure for America’s Opioid Crisis? End the War on Drugs, 42 HARV. J. L. & PUB. POL’Y 542, 568–70, 575, 577 (2019).
to face off challenges from state and federal governments.

Once a harm reduction policy is workshopped in localities, it can be adopted as statewide policy. As the controversy surrounding a policy diminishes over time, its effectiveness can be measured. For instance, localities led the charge on such initiatives as public smoking bans, environmental protection, and civil rights. Such initiatives were not without controversy and legal opposition. This *cities-as-laboratories* policy device is particularly important for developing harm reduction solutions to the opioid crisis that present viable alternatives to the federal government’s more punitive approach to drug use. Syringe exchanges and naloxone availability provide two such illustrations.

### A. Syringe exchange programs

Syringe exchange programs (SEPs), also known as needle exchanges, are emblematic of a harm reduction strategy effectuated at the local level to the chagrin of state and federal officials. SEPs provide clean needles and syringes for intravenous drug users to reduce the risk of infection and disease transmission. Private charitable organizations opened the first U.S. SEP in 1988 in Tacoma, Washington as a harm reduction response to the HIV epidemic. SEPs were legally risky because they involved the distribution of drug paraphernalia. Throughout the mid-twentieth century, states enacted “head shop” laws based on the DEA’s Model Drug Paraphernalia Act. Under these laws, which were designed to prosecute sellers of rolling papers and freebasing kits, anyone supplying or owning injection equipment could be criminally prosecuted. Gradually, more and more cities opened SEPs. By 1995, there were at least 60 SEPs across 21 states, many of them in violation of their states’ head shop laws and lacking other legal authorization.

The experience of SEPs in New Jersey illustrates the evolution of harm reduction from private, criminalized activity to local policy, and then to eventual state authorization. New Jersey had a head shop law closely matching the DEA model law but with an additional section to prohibit non-physician, illegitimate distribution of syringes and needles. In the 1990s, the State of New Jersey

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48 Burris et al., *Federaion*, supra note 44, at 1108–09.
49 See, e.g., M.L. Nixon et al., *Tobacco Industry Litigation to Deter Local Public Health Ordinances: The Industry Usually Loses in Court*, 13 *Tobacco Control* 65, 66–68 (2004) (discussing industry challenges to local smoking bans where challenges were based on state preemption grounds).
50 *Syringe Services Programs (SSPs) Fact Sheet*, CTRS. FOR DISEASE CONTROL & PREVENTION 1 (July 19, 2019), https://www.cdc.gov/ssp/docs/SSP-FactSheet.pdf [https://perma.cc/GDW9-E64W]. SEPs are demonstrably effective at reducing disease spread and connecting drug users into addiction treatment. *Id.*
52 *Id.* at 816–17; see generally 21 U.S.C. § 863.
53 *Id.*
pursued successful criminal convictions under the head shop law against community organizers distributing syringes and needles in several cities in the state. In 2004, the local government of Atlantic City established a SEP by city ordinance to reduce the spread of HIV and Hepatitis C. Atlantic City’s SEP ordinance was defeated in state court, but the New Jersey legislature gave SEPs the green light just two years later.

Likewise, in New York, a privately-run SEP faced criminal charges but evaded them, having successfully argued a necessity defense. One year later, the state’s health department adopted regulations authorizing a needle exchange program. In Illinois, SEPs operated under a creative “research” exemption to the state head shop law until they became specifically authorized under state statute in 2019. Prevention Point, an SEP in Philadelphia, began as an underground effort in 1991 before operating in the open under a 1992 mayoral executive order. Efforts to legalize SEPs in Pennsylvania are ongoing.

Where state governments are willing to authorize SEPs, local government cooperation is still paramount and functionally dispositive of whether the SEP will be successfully implemented. In Scott County, Indiana, a large outbreak of HIV among intravenous drug users in 2015 prompted the state to authorize SEPs under limited circumstances. Localities, however, were not always on cooperative. County councils defunded and shut down state-authored SEPs, citing concerns about abetting drug use. Police officers voiced their opposition to syringe distribution efforts because they undermined charges for private needle exchange under state law that prohibited the distribution of hypodermic needles without a prescription.

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the policing responsibility to enforce laws prohibiting possession and intent to inject controlled substances. West Virginia has had similar decreases in SEP availability due to local backlash. Local police can also undermine SEP efforts by targeting people who lawfully use SEP services. In Bridgeport, Connecticut, the local police repeatedly harassed and arrested drug users for lawfully possessing injection equipment they had received from their SEP and stopped only when a class of users secured a permanent injunction in federal court.

Privately funded SEPs are unlikely to last without tacit cooperation from their respective local government, which can otherwise mount a legal challenge. Some states that authorize SEPs condition that authorization on local approval. But even when such approval is not statutorily required, a local government can still bar implementation of a private SEP by withholding approval on various pretexts. For example, in Belleville, Illinois, the city government successfully challenged a proposed SEP at an HIV care facility for improper zoning. The facility was in a “light industrial” zone, but the city denied approval on the basis that the SEP failed to allege sufficiently specific facts about how it “packed the pharmaceuticals,” i.e. the syringes, “in some way” that would allow it to claim a permitted “packing” use in the district. While some localities, like the counties in Indiana, make their opposition to SEPs known by withholding public health money, the Belleville case illustrates the subtler legal lengths to which a locality can stretch to block even a private SEP.

B. Naloxone availability and overdose response training

Local governments have also led the charge in equipping residents with naloxone and training them to identify and treat overdoses. The importance of municipalities’ roles in advancing naloxone availability is less obvious than for SEPs because it is generally less controversial, facing negligible opposition from state governments. Every state has taken steps to expand naloxone access. In most states, this is accomplished by a standing order to give a prescription for naloxone

[https://perma.cc/2LV6-XXUK].


69 Bruce, supra note 67.


73 Bethany Place, 2014 WL 4415237, at *2–3.

74 For an overview of naloxone distribution to laypersons, see Eliza Wheeler et al., Crs. for Disease Control & Prevention, Opioid Overdose Prevention Programs Providing Naloxone to Laypersons—United States, 2014, 64 MORBIDITY & MORTALITY Wkly. Rep., June 19, 2015, at 631.

to everyone in the jurisdiction.\textsuperscript{76} States can also authorize pharmacists to prescribe naloxone directly, such that a naloxone purchase resembles an over-the-counter purchase.\textsuperscript{77} Even the federal government, which is typically bellicose on issues of harm reduction, has been unopposed to the states’ sanction of naloxone.\textsuperscript{78}

When it comes to actualizing naloxone availability, however, standing orders fall short. In practice, access to naloxone varies. Individual purchasers are a small proportion of naloxone sales,\textsuperscript{79} which suggests that standing orders and pharmacist authorizations account little for increasing naloxone access. Moreover, audit studies reveal that a minority of pharmacies actually stock naloxone and provide accurate information about its availability.\textsuperscript{80}

As a result, the work of getting naloxone in the hands of people who need it falls on harm reduction advocates and local governments. There is strong evidence that local opioid education and naloxone distribution programs are working to reduce overdose deaths.\textsuperscript{81} Equipping police officers

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\textsuperscript{76} See NAT’L INST. ON DRUG ABUSE, MEDICATIONS TO TREAT OPIOID USE DISORDER RESEARCH REPORT 24 (2018), https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/naloxone-accessible [https://perma.cc/6SGN-ARZB]; Janet Weiner et al., Expanding Access to Naloxone: A Review of Distribution Strategies, PENN LEONARD DAVIS INST. OF HEALTH ECON. 3 (May 29, 2019), https://ldi.upenn.edu/brief/expanding-access-naloxone-review-distribution-strategies [https://perma.cc/MYS5-TM9V] (“Most states have passed laws that allow pharmacists to dispense naloxone under a standing order, which does not require a physician’s prescription.”). A city health commissioner or other licensed public health official may also give such a standing order, but that power comes from the state’s authorization of licensed providers to prescribe naloxone by standing order. See Weiner et al., supra note 76 (“At least 23 states have issued statewide standing orders by a physician-official, while 24 others allow jurisdictions to pass standing order laws.”); see, e.g., Md. CODE ANN., HEALTH-GEN § 13-3103(c) (West 2017) (allowing individuals without training and education in opioid overdose response to obtain naloxone); Md. CODE ANN., HEALTH-GEN § 13-3106(b)(1) (West 2017) (allowing a licensed health care provider employed by the state or local health departments to prescribe and dispense naloxone by issuing a standing order); Press Release, Baltimore City Health Dep’t, Baltimore City Health Commissioner Signs New Standing Order for Opioid Overdose Reversal Medication (June 1, 2017), https://health.baltimorecity.gov/news/press-releases/2017-06-01-baltimore-city-health-commissioner-signs-new-standing-order-opiod [https://perma.cc/7SCG-8ZGJ].

\textsuperscript{77} See Weiner et al., supra note 76 (“Nine states give pharmacists direct authority to prescribe and sell naloxone to the public.”).

\textsuperscript{78} See, e.g., 21st Century Cures Act, supra note 26. The Trump administration has shown support for naloxone availability. In April 2018, the Surgeon General issued an “advisory” encouraging individuals to obtain and carry naloxone. EXEC. OFF. OF THE PRESIDENT, supra note 28, at 17.

\textsuperscript{79} See Weiner et al., supra note 76, at 1 (“About 83% of naloxone units were sold to non-retail settings of care, such as hospitals and clinics, health departments, and institutions that supply first responders, emergency medical services, and community groups. Seventeen percent of sales were to retail and mail-order/specialty pharmacies. . . . The retail setting accounted for a small but growing proportion of total naloxone dispensing.”).

\textsuperscript{80} Id.

\textsuperscript{81} See, e.g., Alexander Y. Walley et al., Opioid Overdose Rates and Implementation of Overdose Education and Nasal Naloxone Distribution in Massachusetts: Interrupted Time Series Analysis, BMJ, Feb. 9, 2013, at 1 (presenting a comparative study of nineteen Massachusetts localities with overdose education and naloxone distribution programs which showed a reduction in opioid overdose death); Eliza Wheeler et al., Ctrs. for Disease Control & Prevention, Community-Based Opioid Overdose Prevention Programs Providing Naloxone—United States 2010, 61 MORTALITY & MORTALITY Wkly. REP., Feb. 17, 2012, at 101, 103 (finding that community-based programs have resulted in over ten thousand overdose reversals); ida Margaret Lowenstein et al., Overdose Awareness and Reversal Trainings at Philadelphia Public Libraries, AM. J. HEALTH PROMOTION, July 14, 2020, at 1 (finding improved

https://scholarship.law.upenn.edu/jlasc/vol24/iss1/3
with naloxone, another local government policy decision, is a potentially important means of naloxone dispersal.\footnote{See Corey S. Davis et al., \textit{Expanded Access to Naloxone Among Firefighters, Police Officers, and Emergency Medical Technicians in Massachusetts}, 104 Am. J. Pub. Health e7 (2014) (describing how police officers are often the first ones to reach the scene of an overdose, and often more prevalent throughout cities, enabling them to administer naloxone more quickly than other first responders).} Most police officers do not carry naloxone—it is up to localities and police departments to budget for it.\footnote{Id.} Even in major cities like Chicago and Seattle, whether or not officers carry naloxone is based on where they patrol, leaving many without it.\footnote{Mattie Quinn, \textit{Most Police Still Don’t Carry the Drug That Reverses an Opioid Overdose}, GOVERNING (May 2019), https://www.governing.com/topics/public-safety/gov-naloxone-police-officers-cities.html [https://perma.cc/M2TN-FASG].} Like for SEPs, the role of localities is essential to the effectiveness of naloxone distribution as a harm reduction policy.

III. SAFE INJECTION FACILITIES AS LOCAL HARM REDUCTION

Like other harm reduction policy proposals to address the opioid crisis, SIFs are incubating at the local level of government. An SIF or, more euphemistically, an overdose prevention site or community health engagement location (CHEL), is a place where intravenous drug users can consume drugs under medical supervision.\footnote{European Monitoring Centre for Drugs and Drug Addiction, \textit{Drug Consumption Rooms: An Overview of Provision and Evidence} 5–6 (2018), https://www.emcdda.europa.eu/system/files/publications/2734/POD_Drug%20consumption%20rooms.pdf [https://perma.cc/KX27-LA4P]; S.F. DEPT OF PUB. HEALTH, \textit{Harm Reduction Services in San Francisco} Issue Brief 15–20 (June 2017), https://www.sfdph.org/dph/files/SIFtaskforce/IssueBrief-06202017.pdf [https://perma.cc/RYE7-54DF].} Medical personnel can intervene with overdose-reversal medication like naloxone and provide information about treatment for opioid addiction and general social services. Sites in Canada, Australia, and Europe have reported notable successes with reducing opioid overdose deaths and connecting users with treatment.\footnote{Press Release, Am. Med. Ass’n, \textit{AMA Wants New Approaches to Combat Synthetic and Injectable Drugs} (June 12, 2017), https://www.ama-assn.org/press-center/press-releases/ama-wants-new-approaches-combat-synthetic-and-injectable-drugs [https://perma.cc/G6XW-XP9J].} SIFs have even received the attention and endorsement of the American Medical Association.\footnote{There are reports of one secret, unsanctioned site operating in an undisclosed location in the United States. Alex H. Kral & Peter J. Davidson, \textit{Addressing the Nation’s Opioid Epidemic: Lessons from an Unsanctioned Supervised Injection Site in the U.S.}, 53 Am. J. Preventive Med. 919 (2017). Some existing SEPs are starting to resemble SIFs in that they provide safety measures in their bathrooms for drug users, such as an intercom system to check for users’ consciousness every three minutes. See Vallejo, supra note 71, at 1202–04.} Although no SIF operates in any official capacity in the United States,\footnote{N.Y.C. DEPT OF HEALTH & MENTAL HYGIENE, \textit{Overdose Prevention in New York City: Supervised Injection as a Strategy to Reduce Opioid Overdose and Public Injection} 41–42 (2018), https://www.mass.gov/doc/nye-sif-report-2018/download [https://perma.cc/5APE-XP9J].} plans are underway. Seattle has allocated funding and established a working group to locate a site.\footnote{Jess Aloe, \textit{As Heroin Overdoses Rise, Safe Injection Site Considered in Burlington}, BURLINGTON FREE PRESS (July 17, 2018, 104 Am. J. Pub. Health e7 (2014) (describing how police officers are often the first ones to reach the scene of an overdose, and often more prevalent throughout cities, enabling them to administer naloxone more quickly than other first responders).}
Denver, all passed local ordinances authorizing SIFs, should their state legislatures approve. The mayors of New York City, Ithaca, and Somerville, Massachusetts, have voiced their interest in opening SIFs. Harm reduction advocates are also organizing in cities like Baltimore and Portland, where state legislative approval failed even as municipal governments may permit privately-run SIFs in the future.

In virtually every case, the SIF legality origin story is about municipal governments—city councils open to making a SIF or at least willing to look the other way. Seattle’s plans for an SIF were set in motion by the King County Heroin and Prescription Opiate Addiction Task Force, comprised of city officials, police, emergency services, Native tribe representatives, and behavioral health experts. In September 2016, the Task Force issued policy recommendations that included piloting


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https://scholarship.law.upenn.edu/jlasc/vol24/iss1/3
two community health engagement location (CHEL) sites, one within Seattle and one outside city limits.99 Seattle City Council approved implementation and funding,100 but local opposition delayed CHEL plans.101 A community group opposing the CHEL pursued a ballot initiative to prohibit the use of public funds for a SIF that received over 69,000 voter signatures.102 The City Council reaffirmed its support for CHELs in November 2017, allocating $1.3 million of funding in its fiscal year 2018 budget.103 At the end of 2018, the ballot initiative was tossed in state court for improper interference with the City Council’s budget authority.104 No site yet exists, but plans are still underway to establish one, possibly as a mobile unit stationed near other behavioral health services.105

In 2018, San Francisco opened a nonoperative, “pop-up” SIF to showcase the concept to community members and government officials.106 The showcase coincided with plans underway to open a SIF—the California State Legislature had passed a bill permitting a three-year pilot SIF in San Francisco upon local approval.107 Then-Governor Jerry Brown vetoed the bill,108 stalling plans until the next governorship.109 The San Francisco Board of Supervisors unanimously approved an SIF ordinance in June 2020,110 and a bill has been refiled in the State Assembly.111

[https://perma.cc/4RKM-JKDV].

99 Id. at 2.


103 Associated Press, supra note 100.

104 Protect Pub. Health, 430 P.3d at 645.


106 Holder, supra note 101.


110 San Francisco Officials Approve Controversial Safe Injection Sites; Await State Approval, supra note 92.
Denver’s plan to open an SIF encountered difficulties similar to those that occurred in San Francisco. In 2017, Denver public health officials traveled to Seattle and Vancouver to study their opioid crisis responses. In 2018, Denver City Council approved an SIF with a 12–1 vote, authorizing a pilot program but without public funding and contingent on state statutory authority. A state-level task force on substance abuse proposed SIF authorization, but, according to one state senator, as of 2019 there was not yet enough support in the state legislature.

The most developed SIF plan in the United States is Philadelphia’s Safehouse, a privately funded, nonprofit corporation operating without explicit authorization from Philadelphia City Council. Instead, Safehouse directors consulted on the project with stakeholders in city government, including the mayor’s office, public and behavioral health officials, and the police department. While some councilmembers expressed reservations, the council did not preemptively block the Safehouse rollout in 2018. The early formation of Safehouse thus resembles a “discretion-based” approach wherein SEPs operate without formal legal authorization.

Safehouse’s SIF has faced planning challenges similar to the King County, Washington, SIF and the Belleville SEP: where to put it? Philadelphia Mayor Jim Kenney initially voiced his support for Safehouse as a private entity, but he subsequently raised concerns about its location. In

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113 Denver City Council Passes Ordinance to Create Safe Injection Sites, supra note 91; see generally Denver, Colo., City Council Bill No. 18-1292 (Nov. 7, 2018).
115 See Jennifer Brown, Supervised Injection Site Supporters Aren’t Ready to Give Up on the Conversation in Colorado, The Colo. Sun (Oct. 4, 2019, 7:05 AM), https://coloradosun.com/2019/10/04/supervised-injection-site/ [https://perma.cc/WSB3-9RLU] ("Sen. Brittany Pettersen, who planned to run the legislation last session but then didn’t introduce it because it didn’t have enough support, said [...] she had no plans to run it next year. ‘It’s a good first step, but we have a lot of work to do to build enough support in Colorado and the Capitol to pass a bill’.").
118 Whelan, supra note 6.
119 See generally Vallejo, supra note 71, at 1196–97 (“Some SEPs are not authorized by statute or declaratory judgment. Discretion-based SEPs manage to exist either as underground SEPs or at the discretion of police enforcement and city officials.”).
120 See supra notes 98–105 and accompanying text.
121 See supra notes 72–73 and accompanying text.
2019, Safehouse was offered a lease in Kensington, one of Philadelphia’s neighborhoods most gravely affected by the opioid epidemic.\(^\text{123}\) Kenney met with Safehouse directors and urged them to look elsewhere, citing public safety concerns.\(^\text{124}\) One city councilmember proposed legislation to prohibit Safehouse from opening in Kensington,\(^\text{125}\) and most candidates for City Council when polled stated they were opposed to Safehouse or did not respond.\(^\text{126}\)

After a federal district court ruled that Safehouse did not violate federal drug laws,\(^\text{127}\) City Council took a more overtly disapproving stance. At Safehouse’s subsequent press conference, community members and councilmembers complained that South Philadelphia, the next proposed location, had been blindsided and excluded from decision-making.\(^\text{128}\) One week after Safehouse won the federal challenge, City Council adopted a resolution by 15-2 vote condemning the lack of transparency on Safehouse’s location and asking to halt its plans.\(^\text{129}\) To assess the legal viability of SIFs, then, is to understand their genesis and hang-ups at the municipal level. As for other forms of harm reduction, local approval is necessary for the successful realization of SIFs.


\(^\text{124}\) Id.


\(^\text{127}\) See infra Part IV.B.2.


IV. THE STATE AND FEDERAL LEGAL HURDLES FOR SIFS

As SEPs and nascent SIFs demonstrate, harm reduction cannot happen without advocates, inside or outside of government, coordinating among municipal leaders, police, and communities to obtain collective buy-in. Once this coordination is achieved at the local level, harm reduction policy can still clash with punitive approaches from state and federal governments. This was evident for SEPs whose sites faced legal challenges under state head shop laws. SIFs have the additional legal quandary of on-site drug use, triggering the attention of federal prosecutors. The federal crack house statute, the Controlled Substances Act of 1970 (CSA), prohibits the use of a facility for the consumption of controlled substances.130 Much media attention and scholarly commentary has been devoted to what the CSA means for SIFs. The first federal legal battleground over SIFs is United States v. Safehouse, in which Philadelphia’s Safehouse secured a favorable declaratory judgment that is now on appeal. The following Sections reviews the legal hurdles SIFs face and legal arguments to overcome those hurdles.

A. The state hurdle: disapproving governors and legislatures

Even with local entities on board, a locality must then consider potential state challenges to its proposed SIF. Most cities with SIF interest have stalled plans until they receive explicit sanction from the state legislature and governor. In New York, Governor Andrew Cuomo quite transparently held off on considering approval of New York City’s proposed SIFs until after his 2018 re-election,131 and he is still concerned about the continued threat of federal lawsuits.132 New York City Mayor Bill de Blasio, whose office “punt[ed] on the issue” for several months, maintains that the city needs authorization from the state Health Department before setting up sites.133 Ithaca’s mayor also awaits Governor Cuomo’s green light.134 San Francisco is in a similar position with respect to approval from the State of California.135

The easiest path forward for a locality is state-level exemption from criminal liability.136 But

130 21 U.S.C §§ 801-971; see also infra Part IV.B.1.
133 Eisenberg, supra note 131.
134 See Juneja, supra note 94.
135 See San Francisco Officials Approve Controversial Safe Injection Sites; Await State Approval, supra note 92.
could New York City or San Francisco pursue a SIF without explicit state-level\textsuperscript{137} permission? A brazen-enough locality could attempt the position that “it is better to ask forgiveness than permission” from its state government.\textsuperscript{138} Declaring a public health emergency within the locality could help legitimize the effort.\textsuperscript{139} In Philadelphia’s case, Safehouse directors opted for private funding and declined to seek an explicit authorizing statute, given that Pennsylvania Governor Tom Wolf vocally opposes the use of public funds for a SIF.\textsuperscript{140} To date, no state has passed a law affirmatively allowing a SIF.

If a locality prefers to rely on affirmative legal authority over prosecutorial discretion by the state, it has several legal defenses available in the realm of state delegation of power to localities. Localities can look to state constitutional arguments for the legal authority to conduct their own public health initiatives in the face of crisis. About one-third of state constitutions reference public health.\textsuperscript{141} In California, municipalities have broad discretionary power to “make and enforce within its limits all local, police, sanitary, and other ordinances and regulations not in conflict with general laws.”\textsuperscript{142} In fact, California localities need not limit their ordinances to local affairs. A locality’s ordinance is restricted only by the laws and constitutions of the state and federal governments. While California has a state crack house statute imposing criminal liability for a property owner where the place is maintained “for the purpose of” drug use,\textsuperscript{143} San Francisco could, if faced with prosecution by the state, argue that state law does not preempt its ordinance and that the statute does not apply.

To establish its local authority to pass an ordinance authorizing an SIF, San Francisco would argue that the ordinance occupies a different field and has a different purpose from the state crack house statute.\textsuperscript{144}

In states with home rule statutes, localities enjoy a favorable bent when municipal ordinances face possible preemption by state law. In Pennsylvania, the First Class City Home Rule

\footnotesize{\textsuperscript{137} A state government may authorize a SIF by statute, executive order, or administrative rulemaking, depending on allocation of powers. Leo Beletsky et al., \textit{The Law (and Politics) of Safe Injection Facilities in the United States}, 98 AM. J. PUB. HEALTH 231, 233 (2009).


\textsuperscript{139} See Marrell-Crawford, supra note 136, at 129 (“Health emergencies have been declared to justify the use of needle exchange programs for many of the same reasons used to justify SIFs, such as the prevention of HIV/AIDS and to work to curb the . . . heroin epidemic.”). In 2017, President Trump declared the opioid crisis a public health emergency, \textit{The White House, Ending America’s Opioid Crisis}, https://www.whitehouse.gov/opioids/ [https://perma.cc/JM4B-Z48Y] (last visited Oct. 14, 2020), but this was likely without any intention to change the legal authority of municipalities.


\textsuperscript{142} CAL. CONST. art. XI, § 7.

\textsuperscript{143} CAL. HEALTH & SAFETY CODE § 11366 (West 1991).

\textsuperscript{144} \textit{Cf.} Santa Monica Pines, Ltd. v. Rent Control Board, 35 Cal.3d 858, 868–69 (Cal. 1984) (holding that a Santa Monica rent control law is within its police power because it is distinct from and would not “materially interfere” with the purposes of a state legislation).}
Act grants cities authority of local self-government, including “complete powers of legislation and administration in relation to [their] municipal functions.” The Act’s enabling legislation provides that “[a]ll grants of municipal power to municipalities governed by a home rule charter under this subchapter, whether in the form of specific enumeration or general terms, shall be liberally construed in favor of the municipality.”

A Pennsylvania city seeking to host a safe injection site, opposite a disapproving state legislature and governor, can argue that authorization for the site is within the municipality’s local power. Preventing opioid overdose death within a locality, the argument goes, is a municipal function. After all, it is the city’s own police forces, public health department, parks department, libraries, street cleaners, and residents who must deal with overdoses and overdose deaths. In Philadelphia, the city has already authorized a clean needle exchange and equipped first responders with naloxone. If the city can provide clean needles and administer naloxone under a home rule structure of legal authority, surely it can use that authority to sanction a space to administer naloxone when it is most critically needed.

States enjoy broad authority to criminalize drug-related activity and preempt local law. The timidity of cities like New York City and San Francisco is understandable. Their legal counsel likely warned of state preemption and costly litigation defending a proposed safe injection site absent the governor’s blessing. But local authority to self-govern and to enact public health initiatives permits cities to proceed without necessarily getting overt state-level authorization. Where a locality disagrees with the state on the legality of an SIF, it should look to state constitutions and home rule statutes as sources of local legal authority.

B. The federal hurdle: The Controlled Substances Act (CSA)

1. Perspectives on CSA § 856(a) liability

Under what is colloquially known as the crack house statute, the Controlled Substances Act of 1970 (CSA) imposes liability for property owners and lessees of facilities whose purpose is to allow consumption of controlled substances. Heroin is a Schedule I substance, and fentanyl is a Schedule II substance. Federal interference with cities’ plans to open injection sites began in August 2018, with Deputy Attorney General Rod Rosenstein’s New York Times op-ed stating that such sites are illegal under federal law. U.S. Attorneys across the country have echoed a commitment to

THE LOCALITY’S CASE FOR SAFE INJECTION FACILITIES

prosecute sites, reiterating this position whenever a locality has brought a site proposal. While sites maintain a bring-your-own-drugs policy and would not violate laws relating to drug possession, distribution, or trafficking, they do appear to, at least according to federal prosecutors, violate the crack house provision:

[I]t shall be unlawful 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 substance. Others identified legal arguments an SIF could make to protect it from liability. Scott Burris and his colleagues have reviewed local and state authority to open an SIF as well as statutory interpretation and constitutional arguments to fend off federal charges. Alex Kreit has also analyzed at length the legality of SIFs in the face of the CSA. They both argue that, beyond hoping for the federal government to exercise restraint, SIFs have salient legal defenses.

Scholars and commentators have examined what the CSA may mean for SIFs. Some see federal criminality as a given, with the only paths forward being prosecutorial discretion or a change in the law. Others identified legal arguments an SIF could make to protect it from liability. Scott Burris and his colleagues have reviewed local and state authority to open an SIF as well as statutory interpretation and constitutional arguments to fend off federal charges. Alex Kreit has also analyzed at length the legality of SIFs in the face of the CSA. They both argue that, beyond hoping for the federal government to exercise restraint, SIFs have salient legal defenses.


155 Burris et al., Federalism, supra note 44, at 1089.

156 Kreit, supra note 85, at 413.
First, SIFs could advocate for a narrow reading of the CSA that requires the property owner to have specific intent to store, distribute, manufacture, or use drugs. The Eighth Circuit considered and rejected such an argument in United States v. Tebeau. There, the defendant, who owned land used for music festivals, was charged under 21 U.S.C. § 856(a)(2) after an investigation uncovered drug use and drug sales at the festivals. He argued that his mere knowledge of drug use and drug sales was not sufficient to violate § 856(a)(2) absent the specific intent to engage in the forbidden drug-related conduct. But the Eighth Circuit held that specific intent was not required and the statute required only the purpose of maintaining property, not the purpose of drug activity. Several circuit courts had previously arrived at a similar interpretation by construing the statute narrowly. They reasoned that to read § 856(a)(2) to require specific intent of drug activity would make redundant § 856(a)(1), violating a "cardinal principle of statutory construction . . ." The Supreme Court has not taken up this statutory interpretation issue.

The second proposed legal defense is that bona fide, locally authorized health facilities are excluded from the scope of the CSA. This is functionally a federalism defense following precedent relating to physician-assisted suicide. Scholars have suggested that the 2006 Supreme Court case Gonzales v. Oregon could provide SIFs with legal protection. In Gonzales, the Court stated that the CSA "manifests no intent to regulate the practice of medicine generally." On one hand, some scholars maintain that Gonzales favors the legality of SIFs because they are public health initiatives managed and staffed by medical professionals. Kreit, however, has warned that the precedential power of Gonzales is limited in a SIF case because Gonzales involved a rule authorizing the Attorney General to determine what uses of a medicine are legitimate, whereas a SIF case does not require an executive to assess the medical value of a site.

157 See id. at 431–34.
158 713 F.3d 955 (8th Cir. 2013).
159 Tebeau, 713 F.3d at 958.
160 Id. at 958–59.
161 Id. at 960.
162 United States v. Chen, 913 F.3d 183, 190 (5th Cir. 1990); United States v. Tamez, 941 F.2d 770, 774 (9th Cir. 1991); United States v. Wilson, 503 F.3d 195, 197–98 (2d Cir. 2007); United States v. Bilis, 170 F.3d 88, 92–93 (1st Cir. 1999); United States v. Banks, 987 F.2d 463, 466 (7th Cir. 1993).
163 Tebeau, 713 F.3d at 960 (citing Williams v. Taylor, 529 U.S. 362, 404 (2000)).
164 Certiorari was denied in Tebeau v. United States, 571 U.S. 888 (2013).
165 Burris et al., Federalism, supra note 44, at 1121–34.
167 E.g., Burris et al., Federalism, supra note 44, at 1134–39.
168 Gonzales, 546 U.S. at 270.
169 See, e.g., Burris et al., Federalism, supra note 44, at 1138–39; see also Beletsky et al., supra note 137, at 234 (arguing that CSA’s legislative history shows that Congress’s intent was not to regulate a “legally authorized public health intervention” – traditionally within the realm of state police powers – but rather crack houses “during the height of the crack epidemic” and “‘rave’ parties”).
170 Kreit, supra note 85, at 436–37.
Kreit also brought attention to a third idea: the CSA’s own immunity provision. The provision states that:

no 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.

According to Kreit, the immunity provision was designed to protect police officers from prosecution related to the drug crimes they would necessarily commit during undercover operations, but he posited that the provision could also be invoked for a state- or municipality-sanctioned SIF. The provision allows immunity for: (1) an officer of any state, territory, political subdivision thereof, (2) with due authority, (3) lawfully engaging in the enforcement of any law or municipal ordinance relating to the controlled substance. Should a city council pass an ordinance authorizing an SIF, Kreit proposed that the municipality and staff running the site be officers with due authority, pointing to state medical marijuana laws as precedent. Courts repeatedly have held that police officers are immune from federal drug laws when ordered under state law to return marijuana to a patient.

Burris and his colleagues have raised an additional Commerce Clause argument, stating that “[o]ccasionally, and unpredictably, the Supreme Court decides that Congress has gone too far by seeking to regulate a matter with too tenuous a connection to commerce.” They conceded that this argument was “speculation on stilts” given unfavorable precedent in Gonzales v. Raich, where the Supreme Court held that CSA application to individuals who cultivated or obtained free medical marijuana was within the scope of the Commerce Clause. Likewise, Kreit has called Raich “the death-knell for ‘as-applied’ challenges to a congressional exercise of Commerce Clause authority.”

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171 Id. at 442–62.
173 Kreit, supra note 85, at 443.
175 Kreit, supra note 85, at 445–46.
176 See id. at 446–49 (discussing state court decisions immunizing police officers in medical marijuana-related cases).
177 Beletsky et al., supra note 137, at 234.
178 Burris et al., Federalism, supra note 44, at 1144.
179 Gonzales v. Raich, 545 U.S. 1 (2005).
180 Burris et al., Federalism, supra note 44, at 1144 n.240 (citing Alex Kreit, Rights, Rules, and Raich, 108 W. Va. L. Rev. 705, 706 (2006)).
2. *United States v. Safehouse*: the § 856(a) battleground for SIFs

On February 5, 2019, the Department of Justice made good on its warning to block SIFs\(^1\) when William McSwain, the U.S. Attorney for the Eastern District of Pennsylvania, filed a civil complaint against Safehouse.\(^2\) Forgoing criminal charges with possible prison time, a fine of up to $250,000, and forfeiture of property, the federal government chose to act preemptively with an austere request for declaratory judgment.\(^3\) The complaint alleges that Safehouse “will knowingly and intentionally provide a place for drug users to use controlled substances unlawfully”\(^4\).

Safehouse filed an answer, counterclaim, and third-party complaint on April 3, 2019.\(^5\) The answer contains many of the statutory interpretation arguments posited by legal scholars who considered this issue. First, Safehouse cited *Gonzales* as a limitation of CSA on “regulating the practice of medicine.”\(^6\) Second, Safehouse argued for a narrow reading of § 856(a) to apply to drug dealers and “crack houses,” not public health measures: “the purpose of” language in the statute makes it inapplicable to their site, stating that its only purpose is to save lives by “enabling access to a critical medical intervention.”\(^7\) Third, Safehouse also invoked a Commerce Clause argument.\(^8\)

Safehouse did not argue that it was immune from the CSA because, as Kreit observed, the immunity provision applies only to “duly authorized officer[s]” of a state or locality, so a privately-run SIF would not invoke the defense.\(^9\) Safehouse could have tried to argue that it was duly authorized by the City of Philadelphia. However, while Philadelphia Mayor Jim Kenney has acknowledged the public benefits of a SIF, and Philadelphia District Attorney Larry Krasner has announced he does not intend to press charges in relation to the facility, Philadelphia City Council has not officially prohibited Safehouse from operating, and there is opposition to the use of public funds for this purpose.\(^10\) To invoke the immunity defense, Safehouse would also need a law or municipal ordinance

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\(^{1}\) See supra notes 150-51.


\(^{3}\) The CSA imposes severe criminal penalties. 21 U.S.C. § 856(d); see also Rosenstein, supra note 151 (“It is a federal felony to maintain any location for the purpose of facilitating illicit drug use. Violations are punishable by up to 20 years in prison, hefty fines and forfeiture of the property used in the criminal activity.”).


\(^{6}\) Id. at 20.

\(^{7}\) Id. at 29, 32–33.

\(^{8}\) Id. at 35–38.

\(^{9}\) See Kreit, supra note 85, at 462 (suggesting Philadelphia may trigger CSA immunity by “passing an ordinance to closely regulate safe injection sites and designating all Safehouse employees as ‘duly authorized officer[s]’ of the city.”).

to enforce. A Philadelphia city ordinance authorizing Safehouse would have been the most straightforward vehicle, but without it, Safehouse could still look to the myriad laws and ordinances regarding clean needle exchanges, naloxone distribution, counseling and social services, and other legislation related to its mission.

Safehouse’s answer was a vivid appeal to logic. Safehouse pointed to state and federal laws endorsing and funding syringe exchange programs and naloxone.\textsuperscript{191} The government supports the furnishing of clean needles for drug consumption, and of overdose medication such as naloxone, but “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... under the supervision of its medical practitioners at the critical moment of consumption when death is most likely to occur.”\textsuperscript{192} Implicit in this line of argument is the suggestion that policy should make sense—that steadfast enforcement of criminal law against an SIF is not compatible with the commonsense policy that when drug users have access to clean needles, and to people who can administer naloxone, they should not be forced to leave the building and go to an unsupervised park to use their drugs.

Safehouse’s most innovative argument, the only one not foreseen in the scholarly literature, invoked protection under the Religious Freedom Restoration Act (RFRA). Safehouse brought a counterclaim that RFRA bars the application of § 856(a) to their organization, where the founders and directors are exercising their religious beliefs to save lives.\textsuperscript{193} Under RFRA,

\begin{quote}
[government shall not substantially burden a person’s exercise of religion even if the burden results from a rule of general applicability [unless the government can] demonstrate] that application of the burden to the person (1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest.\textsuperscript{194}
\end{quote}

In the Safehouse case, the defendants stated they were exercising their Judeo-Christian religious beliefs by protecting life, providing shelter, and caring for the ill.\textsuperscript{195} The government then faced the burden of proving that the enforcement of § 856(a) to close Safehouse is the least restrictive means of fostering its compelling interest.\textsuperscript{196}

Safehouse is not a religiously affiliated organization, and its proposed site will not hold religious services. But RFRA applies to any federal action that substantially burdens a person’s exercise of religion, and, under \textit{Burwell v. Hobby Lobby}, running a corporation “in a manner consistent with” religious beliefs is an exercise of religion.\textsuperscript{197}

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{191} Answer, supra note 185, at 24–28.
\item \textsuperscript{192} Id. at 24.
\item \textsuperscript{193} Id. at 38–41.
\item \textsuperscript{194} 42 U.S.C. §§ 2000bb-1(a), (b).
\item \textsuperscript{195} Answer, supra note 185, at 41.
\item \textsuperscript{196} Id.
\item \textsuperscript{197} 572 U.S. 682, 703, 708–19 (2014).
\end{itemize}
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RFRA analysis compels a discussion of the policy issues at stake. Rather than arguing about whether § 856(a) can be enforced against Safehouse, under RFRA the government had to explain why § 856(a) must be enforced against them. Is the government’s compelling interest to prevent drug consumption? To save lives? Safehouse can then provide evidence on how its site would advance, not hinder, those interests. Defendants pitched United States v. Safehouse as an ideological re-match of RFRA protections after Hobby Lobby, whose holding has been admonished as discriminatory.\footnote{See, e.g., Richard J. D’Amato, Note, A “Very Specific” Holding: Analyzing the Effect of Hobby Lobby on Religious Liberty Challenges to Housing Discrimination Laws, 16 Colum. L. Rev. 1063, 1063, 1085–88 (2016) (theorizing that landlords seeking to discriminate against LGBT individuals may be able to seek exemption from antidiscrimination laws under RFRA as a result of Hobby Lobby).}

The government did not take the RFRA bait to discuss its compelling interest in shutting down SIFs. Instead, in its motion for judgment on the pleadings, the government contended that Safehouse was not protected by RFRA.\footnote{Plaintiff’s Motion for Judgment on the Pleadings at 23–24, 408 F. Supp. 3d 583 (E.D. Pa. June 11, 2019) (No. 19-0519), 2019 WL 8723739.} They argued that defendants’ beliefs were not substantially burdened because the defendants were not being coerced to do anything—the government merely asked that they keep to the status quo.\footnote{Plaintiff’s Motion for Judgment on the Pleadings at 25.} Moreover, the government argued, Safehouse had alternative means available, and their proposed conduct was not so much religious as socio-political or philosophical.\footnote{Id. at 28–29.} On the RFRA issue, the court also expressed its disfavor for “transform[ing] an issue of statutory construction into a public policy debate.”\footnote{United States v. Safehouse, No. 19-0519, 2020 U.S. Dist. LEXIS 31620, at *8 (E.D. Pa. Feb. 25, 2020).}

In February 2020, the district court granted Safehouse’s motion for declaratory judgment.\footnote{United States v. Safehouse, No. 19-0519, 2020 U.S. Dist. LEXIS 31620, at *1 (E.D. Pa. Feb. 25, 2020).} The court found for Safehouse on § 856(a)(2) interpretation,\footnote{United States v. Safehouse, No. 19-0519, 2020 U.S. Dist. LEXIS 31620, at *1.} in part because Congress did not intend or mean for § 856(a)(2) to apply to SIFs as they had not yet entered public discourse.\footnote{United States v. Safehouse, 408 F. Supp. 3d 583, 618 (E.D. Pa. Oct. 2, 2019).} For now, the application of RFRA and the Commerce Clause to SIFs has been tabled,\footnote{Safehouse, 2020 U.S. Dist. LEXIS 31620, at *9 (referencing prior opinion); Safehouse, 408 F. Supp. 3d at 585 (“[N]o credible argument can be made that facilities such as safe injection sites were within the contemplation of Congress either when it adopted § 856(a) in 1986, or when it amended the statute in 2003.”).} but as of this Article’s publication, the final outcome remains to be seen. In June 2020, the court granted the government’s request for a stay pending their appeal to the Third Circuit.\footnote{Safehouse, 2020 U.S. Dist. LEXIS 110549, at *1.}
V. CONCLUSION

February 2020 headlines read: “Judge clears path for Philadelphia nonprofit to open safe-injection site to combat overdoses;”208 “Philly’s Safehouse to open nation’s first supervised injection site after judge clearance;”209 “Federal Judge Clears Way For Nation’s First Supervised Injection Site To Open In Philadelphia.”210 But experience demonstrates that an SIF’s legal viability cannot be guaranteed by a federal judge. Decisionmakers and stakeholders at each level of government must also clear the way. A locality seeking to open an SIF will undoubtedly face a complex series of hurdles, from local ordinances and zoning to state preemption. Even with Safehouse’s latest victory in federal court, its legal status remains precarious as Philadelphia City Council voices its disapproval. When the U.S. gets its first SIF, it will not be because of a federal case, or because of a change in presidential administration. It will be because of the careful alignment of harm reduction advocacy, local law, police noninterference, state sanction or discretion, and federal sanction or discretion.

