Supervised Consumption Facilities: Legal and Policy Considerations

Harm Reduction Commission
January 9, 2019

Leo Beletsky, JD, MPH
Northeastern University
School of Law and
Bouvé College of Health Sciences

UC San Diego School of Medicine
Overview

1. Public health, innovation, and the law
2. Legal and policy considerations in SCFs
3. SCF part of a harm reduction approach
Public Health Innovation in Massachusetts

- Bottom-up change: local solutions lead, the law follows (e.g. seat belts, needle exchange, naloxone)
- Federalist structure designed to encourage local and state experimentation ("laboratories")
- Public health emergency declaration adds urgency, flexibility, and legal weight to efforts to innovate (Mass. G. L. Ch. 17, § 2A)
  - Commissioner can take action and incur liability necessary to maintain public health
Conceptual Precedent: Syringe Exchange

- Grass-roots innovation in response to a public health crisis
- Civil disobedience (1988-2006)
- Litigation (most recently in 2017)
- Building the research base
- Reform proceeded through legislation (M.G.L. c.111 s.215)
- In many cases, non-action by prosecutors and law enforcement (including federal)
Conceptual Precedent: Cannabis

- Grass-roots innovation starting at local level
- Civil disobedience (1980s)
- Litigation
- Reform proceeded through ballot measure
- In many cases, non-action by prosecutors and law enforcement (including federal)
Federalism: Laboratories of Innovation
SCFs Reform on State Level

1. Creation of safe harbor provisions/carveouts from state criminal law, in line with Good Samaritan law
2. Creation of indemnification for professionals, property operators, and volunteers, possibly by expanding naloxone or Good Samaritan provisions
3. Creation of technical elements, standards, licensing requirements, funding, etc.
SCFs: Expanding Existing Public Health Laws

- Building on/expanding existing laws to advance public health and save lives
- Less dramatic than actions already taken, e.g. legalizing cannabis
- Solid scientific evidence (contrast with syringe exchange and cannabis)
- Feasibility: Not pre-empted on federal level: law would be on sound legal footing
SCFs and Federal Law: Feasibility?

- Criminal
  - Controlled Substances Act
    - Individual possession, conspiracy, and intent provisions
    - “Crackhouse” statute (§856) applies to operators

- Civil
  - Property forfeiture

- Professional
  - Loss of DEA license
Criminal

- Controlled Substances Act
  - Individual possession, *distribution*, conspiracy and intent provisions
  - “Crackhouse” statute (§856) applies to operators

Civil

- Property forfeiture

Professional

- Loss of DEA license
Crack House Statute Considerations

- Legal arguments include
  - Crack House Statute was never intended to apply to a *bona fide* public health/medical facility
  - Regulation of public health is a core state power which is granted great deference
  - Locally authorized SCF is not pre-empted by the Crack House Statute (no “positive conflict”)
  - “Purpose” requirement is not met
  - Necessity defence bolstered by public health emergency
  - May depends on who is running the facility
  - Never been tested
1. Historically, possession, distribution charges rarely pursued by federal law enforcement
2. State and local law enforcement do not enforce federal law
3. Litigation (injunctive relief) could allow innovation to proceed
   - This is exactly how Insite was allowed to remain open
1. Research mechanisms:
   ▪ exemptions
   ▪ funding
2. Funding rider (e.g. Rohrabacher–Farr)
3. Court injunction pending litigation
4. Longer term: Controlled Substances Act reform
Feasibility: Politics

1. Threatening statements made by federal law enforcement w/r/t SCFs
   - Almost identical to threatening statements made by federal law enforcement w/r/t cannabis

2. Regulatory process for establishing regulations, licensing, etc. takes substantial time, whereas politics of enforcement discretion can shift quickly
   - Cannabis and syringe exchange: 1-2 years

3. Formal federal drug law reform for “hard drugs” is unlikely in the near future, but OD crisis continues
What is Harm Reduction?

Harm reduction incorporates a spectrum of strategies from safer use, to managed use, to abstinence - to meet drug users “where they’re at,” addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.

The defining features (of harm reduction) are the focus on the prevention of harm, rather than on singular focus on stopping drug use per se, and the focus on people who continue to use drugs.
## Beyond SCFs: Comprehensive Approach to Prevent Drug-Related Harms

<table>
<thead>
<tr>
<th>Intervention</th>
<th>State of Evidence</th>
<th>Existing MA Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low threshold OAT</td>
<td>Strong</td>
<td>Moderate (but uneven)</td>
</tr>
<tr>
<td>Naloxone distribution</td>
<td>Strong</td>
<td>Moderate (but uneven)</td>
</tr>
<tr>
<td>Syringe exchange</td>
<td>Strong</td>
<td>Low → Moderate</td>
</tr>
<tr>
<td>Supervised Consumption</td>
<td>Strong</td>
<td>None</td>
</tr>
<tr>
<td>Injectable OAT</td>
<td>Strong</td>
<td>None</td>
</tr>
<tr>
<td>Harm reduction in CJ settings</td>
<td>Strong</td>
<td>None</td>
</tr>
<tr>
<td>Safe disposal (syringes)</td>
<td>Moderate</td>
<td>Low</td>
</tr>
<tr>
<td>Good Samaritan Policies</td>
<td>Moderate</td>
<td>Moderate (limited scope)</td>
</tr>
<tr>
<td>Drug checking</td>
<td>Emerging</td>
<td>Low</td>
</tr>
<tr>
<td>Cannabis replacement</td>
<td>Emerging</td>
<td>None</td>
</tr>
<tr>
<td>CJ Deflection</td>
<td>Emerging</td>
<td>Low</td>
</tr>
</tbody>
</table>
Conclusion

- Change is already happening
- States or localities with the will to advance evidence-based public health have reasonable claim to legality
- State legislation puts SCFs on strongest footing
- Federal level is unpredictable, and politics (if not policies) can change quickly
- Imperative: to prevent harm with best evidence
This presentation is based, in part, on:


Thanks to MMS, Corey Davis, Evan Anderson, Scott Burris

L.beletsky@neu.edu
@leobeletsky
www.HealthInJustice.org