

**FEDERALISM, POLICY LEARNING, AND LOCAL INNOVATION IN  
PUBLIC HEALTH: THE CASE OF THE SUPERVISED INJECTION  
FACILITY**

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## INTRODUCTION

In her Childress Lecture,<sup>1</sup> Sandra Johnson performs a skillful dissection of medicos' claims that the legal regime they suffer under is "bad" in a variety of respects. Her aim is not just conceptual clarity, but a clearer vision of how reasonable legal ideas can, in implementation, decay into ineffective or even counterproductive exercises of regulatory power over a resistant, and in some instances rightfully incensed, population of well-meaning health professionals.<sup>2</sup> The problems she describes arise in public health as well as in health care. People toiling in the fields of public health complain, for example, about the ways in which broad regulatory structures, like HIPAA or the Common Rule, interfere with their work in pointless ways.<sup>3</sup> Public health scholars have devoted much ink to the problems of clarity, specificity, and

1. Sandra H. Johnson, Professor Emerita of Law & Health Care Ethics at Saint Louis University School of Law, Keynote Address at the Saint Louis University School of Law Richard J. Childress Memorial Lecture: Still Crazy After All These Years: Is Regulating Physician Practice an Exercise in Futility? (Oct. 17, 2008), in Sandra H. Johnson, *Regulating Physician Behavior: Taking Doctors' "Bad Law" Claims Seriously*, 53 ST. LOUIS U. L.J. 973 (2009).

2. Anyone who, like Professor Johnson, has invested enough years in trying to improve the regulation of health and health care, must be forgiven for phrases like "still crazy after all these years," because a certain level of madness is evident in systems that seem to resist rational change—and reformers who keep trying. If it is insane to believe that data and rigorous analysis can guide health policy toward a more optimal state, then Professor Sandra Johnson is surely among the most hardened cases in the asylum, and for that this Lecture offers us a wonderful occasion to praise and thank her. After all, as the March Hare in the movie *Alice in Wonderland* so succinctly put it, "If you don't care for tea, you could at least make polite conversation!" ALICE IN WONDERLAND (Walt Disney Productions 1951). In fact, Professor Johnson has done far more than talk. She has a distinguished record of policy change, not least in the area of access to pain medication during her service as head of the Mayday Project. We dedicate this Article to her on the occasion of her retirement.

3. See, e.g., Scott Burris et al., *Applying the Common Rule to Public Health Agencies: Questions and Tentative Answers About a Separate Regulatory Regime*, 31 J.L. MED. & ETHICS 638 (2003); Julie R. Ingelfinger & Jeffrey M. Drazen, *Registry Research and Medical Privacy*, 350 NEW ENG. J. MED. 1452 (2004); Douglas B. McCarthy et al., *Medical Records and Privacy: Empirical Effects of Legislation*, 34 HEALTH SERVICES RES. 417 (1999); L. Turnberg, *Common Sense and Common Consent in Communicable Disease Surveillance*, 29 J. MED. ETHICS 27 (2003).

usability of basic public health powers, and debated whether statutory reform in public health helps or interferes with good practice.<sup>4</sup>

At the heart of Professor Johnson's treatment plan for "bad law" is a sound appreciation for empirical facts. She elevates empiricism to the level of a "cultural norm" in health law, affirming the value of data, the need to collect it, and the obligation to consider it as an important part of what health lawyers do.<sup>5</sup> She implies that examining how laws are actually implemented, and their outcomes in real life, disciplines policy: it requires us to hypothesize our outcomes, measure them, and respond to inevitable shortcomings and unintended consequences. Empiricism certainly does so in theory, and may often do so helpfully in vivo, even if real life lags behind theory. In public health, if not in medicine, lawyers who do not value data have little in common with the professionals they collaborate with or represent.

Yet valuing data in public health policy is not the same as making public health policy with data in mind. Indeed, there are swaths of important public health laws that operate for the most part as "data-free zones," realms where data not only fails to guide policy but does not even get a respectful hearing. What is worse, some of these laws include self-preservation mechanisms that block the generation of empirical knowledge that may prompt calls for their revision. No policy area exemplifies this more regrettably than the one we will probe in this Article: drug control policy.<sup>6</sup> Under the banner of protecting the populace, the United States continues to expend vast resources to prevent and eliminate the use of illicit drugs.<sup>7</sup> Drug use nevertheless remains a significant public health problem in this country.<sup>8</sup> The injection of illicit drugs, especially

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4. Compare Lawrence O. Gostin et al., *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 59 (1999), with Edward P. Richards & Katharine C. Rathbun, *Legislative Alternatives to the Model State Emergency Health Powers Act (MSEHPA)* (LSU Program in Law, Sci., & Pub. Health, White Paper No. 2, 2003), available at [http://biotech.law.lsu.edu/blaw/bt/MSEHPA\\_review.htm](http://biotech.law.lsu.edu/blaw/bt/MSEHPA_review.htm).

5. Professor Johnson's prescription resonates with Wendy Parmet's argument in her new book. Professor Parmet offers a thorough and compelling account of public health as a fundamental legal norm in our constitutional order. Her argument provides a rationale for courts to integrate an epidemiological, evidence-based population perspective into their legal analysis, and to do so with the explicit recognition that advancing public health is one of the central purposes of our system. See WENDY E. PARMET, *POPULATIONS, PUBLIC HEALTH, AND THE LAW* (2009).

6. See generally ROBERT J. MACCOUN & PETER REUTER, *DRUG WAR HERESIES: LEARNING FROM OTHER VICES, TIMES, & PLACES* (2001) (framing the drug control problem as an empirical question and assessing the state of evidence).

7. WHITE HOUSE, NATIONAL DRUG CONTROL STRATEGY: FY 2009 BUDGET SUMMARY 13 tbl. 3 (2008) (according to the U.S. Office of National Drug Control Policy, federal spending on the drug war in 2002 totaled \$10.781 billion, rising to \$12.005 billion in 2004, and \$13.844 billion in 2007).

8. See *infra* Part II.

among the most underprivileged, underserved social groups—the homeless, those with severe mental health problems, commercial sex workers, and others—continues to be particularly harmful, both to those injection drug users (IDUs) and to their families and the community at large.<sup>9</sup> Few, if any, scholars would argue that national drug policy has benefited these IDUs and the communities in which they cluster. In fact, many scholars suggest that national drug policy over the last half century has actually exacerbated the harms associated with injection drug use.<sup>10</sup> This is as ironic as it is unfortunate, inasmuch as the injection practices of the chronically homeless<sup>11</sup> and other high-risk populations may be responsible for the lion's share of the individual and social costs of illicit drug use.<sup>12</sup>

There are inherent difficulties in crafting interventions that benefit homeless and extremely vulnerable populations and their communities, including the high prevalence of mental and behavioral problems, local variation in homelessness as a social phenomenon, and the stigmatized stereotypes of drug users and homeless or marginally housed people. Crafting interventions that effectively address the epidemic of addiction in this country is a difficult challenge, but the inherent challenges are greatly magnified by the functionally centralized and politically charged nature of drug policy in the United States. Although there have been some welcome changes in recent years, including the (painfully) gradual acceptance of sterile syringe access programs, drug policy in the United States continues to be dominated by the ideology and practice of strict federal prohibition. While there are no perfect solutions to problems of severe drug dependence, unenlightened and inflexible

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9. See *infra* notes 35–39 and accompanying text (noting the harms to injection drug users and the negative externalities of public injection drug use, including discarded needles, the spread of disease, public intoxication, and depleted emergency services).

10. See *infra* notes 39–42 and accompanying text (noting how current policies have created an environment that encourages harmful injection behavior).

11. Our use of the term “homeless” in the remainder of the piece includes populations living proverbially near or on the streets. Many IDUs who inject publicly might have access to housing, but not sufficient privacy to inject there.

12. As colorfully described by the economist Malcolm Gladwell, and in contrast with the popular perception that the cost of providing services to homeless, substance-abusing populations follows a normal distribution, it may well be the case that a small group of the chronic substance-abusers are disproportionately costly for municipalities. See Malcolm Gladwell, *Million-Dollar Murray: Why Problems like Homelessness May Be Easier to Solve than to Manage*, NEW YORKER, Feb. 13, 2006, at 96, 98–99. In fact, caring for some homeless persons who abuse alcohol and drugs costs local municipalities as much as one million dollars a year, each in unreimbursed ambulance and emergency room care, whereas the cost of providing housing, support, and prevention services to most homeless persons is much lower. See *id.* at 97. Ambulance utilization is a particularly costly expense related to injection drug overdose. See *infra* notes 33–38, 83 and accompanying text.

national drug policy has stifled opportunities to explore more locally responsive and scientifically derived public health interventions.

In the face of federal claims to sole practical jurisdiction over drug policy, and the failure of our policies to measurably improve the health of the most vulnerable IDUs and their communities, some scholars have argued that policy makers at the state and local level are better-positioned than the federal government to craft innovative, targeted interventions—and should be allowed to do so.<sup>13</sup> One particularly promising intervention, the supervised injection facility (SIF), may represent a medically effective and economically efficient strategy for reducing the incidence and harms of injection drug use among the chronically homeless and otherwise marginalized people.<sup>14</sup>

SIFs are facilities where drug users can self-administer pre-obtained drugs under the supervision of healthcare providers.<sup>15</sup> International evidence shows the SIF to be a plausible intervention for promoting public health and order, and there is marked interest among some states and localities in piloting an SIF in their jurisdictions.<sup>16</sup> In a rational policy-making climate, the intervention would be tested, evaluated, and then scaled up, modified, or abandoned as the evidence directed. In the United States, the testing and deployment of SIFs will be what one might call a mixed question of evidence and ideology: merely testing the intervention will entail sustained political and legal struggle. The authority to operate an SIF often can be found in the broad police power that states and localities have to act for the protection and furtherance of the public health.<sup>17</sup> However, the authorization of an SIF by a state or locality is open to challenge by federal law enforcement agencies as a violation of federal law.<sup>18</sup> In crafting strategies, negotiating with opponents, or disputing in court, the

13. See, e.g., Scott Burris & Steffanie A. Strathdee, *To Serve and Protect? Toward a Better Relationship Between Drug Control Policy and Public Health*, 20 AIDS 117 (2006).

14. See *infra* Part II.B.

15. Ian Malkin, *Establishing Supervised Injecting Facilities: A Responsible Way to Help Minimise Harm*, 25 MELB. U. L. REV. 680 (2001).

16. We are aware of discussions about SIFs among health advocates in a number of U.S. cities. Consideration has gone furthest in San Francisco. See Lisa Leff, *San Francisco Considers Injection Room*, WASH. POST, Oct. 19, 2007, <http://www.washingtonpost.com/wp-dyn/content/article/2007/10/18/AR2007101801701.html>. In a public meeting in May, even a police captain in the Tenderloin section of San Francisco publicly advocated setting up an SIF. C.W. Nevius, *Tenderloin Cop Gets Neighborhood's Attention*, SFGATE, May 29, 2008, <http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2008/05/28/BA5V10VC02.DTL>. A forum “Safe Injection Facilities of New York” took place on May 22, 2009. *Feature: Effort to Bring Safe Injection Facility to New York City Getting Underway*, DRUG WAR CHRON., May 29, 2009, available at <http://stopthedrugwar.org/chronicle/587/fulltext#1>.

17. See *infra* notes 84–89 and accompanying text.

18. We assume that state authorization is more likely than federal authorization due to political realities, but note that federal authority could support the creation of an SIF as well. See *infra* note 90.

stakeholders will be wading into the unpredictable waters of federalism jurisprudence and statutory interpretation that have been further muddled by recent decisions regarding medical marijuana, assisted suicide, gun-free school zones, and other medical and health issues. The practicalities of enforcement in a federal system also have to be considered; as the medical marijuana experience indicates, an enterprise legal under state law may be able to operate at a fairly substantial scale over a sustained period of time, in spite of being considered illegal under federal law.<sup>19</sup>

The primary aim of this Article is to demonstrate that a state (or even some city governments) could authorize and, in legal terms, successfully operate an SIF. States have the authority to enact “health laws of every description.”<sup>20</sup> If federal law enforcers assert that a state-sponsored SIF is illegal, there are reasonable legal arguments that states may raise to the contrary. Though the legal deck may appear to be stacked in favor of the federal government, states or localities with the political will to advance evidence-based public health have ample legal room to maneuver.<sup>21</sup>

We begin, in Part I, by describing the persistent harms of injection drug use and the public health evidence behind SIFs—the kind of evidence that should guide policy. Part II explains the various mechanisms for authorizing an SIF under state law. Part III begins by briefly explaining the dual (state and federal) regulation of controlled substances in the United States, and then considers how a state would counter a federal challenge to a state-authorized SIF. This analysis considers relevant provisions of existing federal statutes—principally, but not exclusively, the “Crack House Statute”<sup>22</sup>—and demonstrates how principles of statutory interpretation support a plausible construction of these provisions in favor of the legality of an SIF. We also discuss the arguments that could be raised as to the scope of federal power to limit state public health measures having no impact on interstate commerce. The interests in preserving state police power are most acute when the state has taken the initiative in providing crucially needed medical care and protecting the public health.

The secondary aim of this Article, in the spirit of Professor Johnson’s Childress address, is to highlight the importance of empirical inquiry in drug policy in particular and public health law generally. In drug policy as in many other difficult areas of regulation—from obesity, to firearms, to smoking—we

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19. See David Samuels, *Dr. Kush: How Medical Marijuana Is Transforming the Pot Industry*, NEW YORKER, July 28, 2008, at 48, 50.

20. *Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905) (internal quotation marks omitted).

21. In practical terms, “room to maneuver” encompasses authorizing an SIF, funding its operation and evaluation, protecting it politically from law enforcement interference, and defending it legally from any action meant to stop it from operating.

22. 21 U.S.C. § 856 (2006).

do not actually know what policy interventions will work best, in the plain sense of maximizing the level and distribution of public health benefits in a way that uses resources wisely and does not create new, unintended problems. This is not, strictly speaking, an evidence problem: we have enough evidence to begin testing plausible policies in all these areas, but not enough evidence to make doubt unreasonable. Even when strong evidence supports a particular approach, evidence about policy is rarely incontestable and even more rarely determinative. In our Conclusion, we distinguish evidence-based health policy from “policy learning,” and discuss how the difference matters. We end with observations about the well-tried, but nonetheless surely true, potential of states to act as the laboratories for policy-learning in difficult areas like drug policy.<sup>23</sup>

## I. IDUs AND SIFs

### A. *Injection Drug Use and Its Harms*

Injection drug use has been a public health problem in the United States for centuries,<sup>24</sup> but has for the most part been treated as a matter of criminal deviance rather than chemical dependency. “Getting tough on drugs” is a grand American tradition.<sup>25</sup> Along with the powerful abuse potential of some illicit drugs, American drug policy has been tinted by cultural factors like racism<sup>26</sup> and the temperance movement.<sup>27</sup> In spite of strict regulation,

23. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) (“Denial of the right to experiment may be fraught with serious consequences to the Nation. It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”).

24. See DAVID F. MUSTO, *THE AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL* 1–13 (expanded ed., Oxford Univ. Press, Inc. 1987) (1973) (noting that injection drug use dates back to the nineteenth century); see also LLOYD D. JOHNSTON ET AL., U.S. DEP’T OF HEALTH & HUMAN SERVS., *MONITORING THE FUTURE NATIONAL SURVEY RESULTS ON DRUG USE, 1975–2006* (2007), available at [http://www.monitoringthefuture.org/pubs/monographs/vol2\\_2006.pdf](http://www.monitoringthefuture.org/pubs/monographs/vol2_2006.pdf) (detailing the current trends in heroin abuse); Lawrence Kolb & A.G. Du Mez, *The Prevalence and Trend of Drug Addiction in the United States and Factors Influencing It*, 39 PUB. HEALTH REP. 1179 (1924); H. Pickering & Gerry V. Stimson, *Prevalence and Demographic Factors of Stimulant Use*, 89 ADDICTION 1385, 1386–67 (1994).

25. See MUSTO, *supra* note 24.

26. JAMES A. INCIARDI, *THE WAR ON DRUGS: HEROIN, COCAINE, CRIME, AND PUBLIC POLICY* 26–27 (1986); Edward Huntington Williams, *Negro Cocaine “Fiends” Are a New Southern Menace*, N.Y. TIMES, Feb. 8, 1914, at 12; see also *Report of the Committee on Acquirement of the Drug Habit*, PROC. AM. PHARMACEUTICAL ASS’N FIFTIETH ANN. MEETING 572 (1902) (“If the Chinaman cannot get along without his ‘dope,’ we can get along without him.”).

27. MUSTO, *supra* note 24, at 5–12.

unrelenting prosecution, and the enforcement of a powerful stigma of drug abuse, however, the number of IDUs in the United States has steadily increased.<sup>28</sup>

There is no question that injection drug use is dangerous. IDUs are at high risk of acquiring blood-borne diseases such as hepatitis and HIV.<sup>29</sup> Life-threatening health problems resulting from injection with unsterile equipment include abscesses and bacterial infections.<sup>30</sup> Overdose also significantly

28. Reports in the 1980s suggested that there were at least 1 to 1.5 million IDUs. NAT'L RESEARCH COUNCIL & INST. OF MED., PREVENTING HIV TRANSMISSION: THE ROLE OF STERILE NEEDLES AND BLEACH 58 (Jacques Normand et al. eds., 1995). Studies from the early 1990s suggested that the number of IDUs had grown to about 1.7 million. *Id.* at 59. The most recent survey data indicates that as many as 3.4 million Americans have injected illicit drugs at some time in their life. Gregory L. Armstrong, *Injection Drug Users in the United States, 1979–2002*, 167 ARCH. INTERN. MED. 166, 169 (2007); *see also* U.S. GEN. ACCOUNTING OFFICE, DRUG CONTROL: U.S. NONMILITARY ASSISTANCE TO COLOMBIA IS BEGINNING TO SHOW INTENDED RESULTS, BUT PROGRAMS ARE NOT READILY SUSTAINABLE 1, 5 (2004) (explaining that despite expending \$3.3 billion between 2000 and 2004 in attempting to slow the importation of Colombian cocaine, “cocaine prices nationwide have remained relatively stable—indicating that cocaine is still readily available—and Colombia dominates the market for heroin in the northeastern United States”); Samuel R. Friedman et al., *Estimating Numbers of Injecting Drug Users in Metropolitan Areas for Structural Analyses of Community Vulnerability and for Assessing Relative Degrees of Service Provision for Injecting Drug Users*, 81 J. URB. HEALTH 377, 380 (2004) (estimating that there were 1,364,874 IDUs in the United States in 1998). Estimations of the incidence and persistence of injection drug use in the last two decades, even when growth rates appear flat, are particularly disturbing when compared with the exponential growth in the incarceration of people convicted of drug-related offenses. *See* PAIGE M. HARRISON & ALLEN J. BECK, U.S. DEP'T OF JUSTICE, PRISONERS IN 2004, BUREAU OF JUSTICE STATISTICS BULLETIN 10 (2005), *available at* <http://www.ojp.usdoj.gov/bjs/pub/pdf/p04.pdf> (noting that from 1995 to 2004, the number of federal prisoners incarcerated for drug offenses grew by almost 50%); JENNIFER C. KARBERG & DORIS J. JAMES, U.S. DEP'T OF JUSTICE, SUBSTANCE DEPENDENCE, ABUSE, AND TREATMENT OF JAIL INMATES, 2002, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT 2 (2005), *available at* <http://www.ojp.usdoj.gov/bjs/pub/pdf/sdatji02.pdf> (stating that 68% of inmates entering jail in 2002 were “dependent on or abus[ing] alcohol or drugs”).

29. *See* Miriam J. Alter, *Prevention of Spread of Hepatitis C*, 36 HEPATOLOGY S93, S94–95 (2002); Richard S. Garfein et al., *Prevalence and Incidence of Hepatitis C Virus Infection Among Young Adult Injection Drug Users*, 18 J. ACQUIRED IMMUNE DEFICIENCY SYNDROME & HUM. RETROVIROL S11 (1998); Juan C. Reyes et al., *Prevalence and Correlates of Hepatitis C Virus Infection Among Street-Recruited Injection Drug Users in San Juan, Puerto Rico*, 83 J. URB. HEALTH 1105 (2006); Rebecca Wells et al., *Hepatitis A Prevalence Among Injection Drug Users*, 19 CLINICAL LABORATORY SCI. 12 (2006); Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., Factsheet, *Drug-Associated HIV Transmission Continues in the United States*, May 2002, <http://www.cdc.gov/hiv/resources/factsheets/PDF/idu.pdf>.

30. Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *Soft Tissue Infections Among Injection Drug Users—San Francisco, California, 1996–2000*, 50 MORBIDITY & MORTALITY WKLY. REP. 381 (2001), *available at* <http://www.cdc.gov/mmwr/PDF/wk/mm5019.pdf>.



threatens IDUs, a danger illustrated by hundreds of deaths in 2007 connected to the adulteration of street heroin with the synthetic pain-killer fentanyl.<sup>31</sup> The outbreak turned long-overdue attention to the high number of fatal overdose incidents involving heroin and other opioid drugs.<sup>32</sup> Injection drug use accounts for a third of this country's cumulative AIDS cases.<sup>33</sup> Injection drug use—and particularly injection in public—threatens the community well-being in the form of discarded needles<sup>34</sup> and the intoxicated behavior of those who inject publicly.

Public injection drug use indirectly harms communal health by forcing localities and municipalities to expend scarce public resources inefficiently. Significant numbers of IDUs live in economically stressed communities, and the health harms associated with IDUs place a large burden on emergency rooms, healthcare facilities, and first responders.<sup>35</sup> In many cities, law enforcement officers must frequently interact with intoxicated injection drug users, drawing them away from other objectives and placing them in situations

31. See Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *Nonpharmaceutical Fentanyl-Related Deaths—Multiple States, April 2005–March 2007*, 57 MORBIDITY & MORTALITY WKLY. REP. 793 (2008), available at <http://www.cdc.gov/mmwr/PDF/wk/mm5729.pdf>; Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *Unintentional Poisoning Deaths—United States, 1999–2004*, 56 MORBIDITY & MORTALITY WKLY. REP. 93 (2007), available at <http://www.cdc.gov/mmwr/PDF/wk/mm5605.pdf>; see also Dan Hurley, *Emergency Antidote, Direct to Addicts*, N.Y. TIMES, Dec. 11, 2007, at F5; Editorial, *Lifeline for Addicts*, BOSTON GLOBE, Nov. 19, 2007, at A12; Robert Sears & Lane Lambert, *OD Antidote Controversy: Quincy Chief Supports Plan to Supply Drugs to Addicts; Others Disagree*, PATRIOT LEDGER, Nov. 3, 2007, at 1.

32. Ingrid A. Binswanger et al., *Release from Prison—A High Risk of Death for Former Inmates*, 356 NEW ENG. J. MED. 157, 158–63 (2007) (noting that newly-released inmates are a group at extremely high risk of overdose deaths in the first several weeks of time on the “outside”); Shane Darke & Deborah Zador, *Fatal Heroin ‘Overdose’: A Review*, 91 ADDICTION 1765 (1996) (describing the epidemiology of heroin overdose); Karen H. Seal et al., *Predictors and Prevention of Nonfatal Overdose Among Street-Recruited Injection Heroin Users in the San Francisco Bay Area, 1998–1999*, 91 AM. J. PUB. HEALTH 1842 (2001); Karl A. Sporer, *Strategies for Preventing Heroin Overdose*, 326 BRIT. MED. J. 442, 442 (2003).

33. Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *supra* note 29.

34. Scott Burris et al., *State Syringe and Drug Possession Laws Potentially Influencing Safe Syringe Disposal by Injection Drug Users*, 42 J. AM. PHARMACEUTICAL ASS'N S94 (2002); P. Nyiri et al., *Sharps Discarded in Inner City Parks and Playgrounds—Risk of Bloodborne Virus Exposure*, 7 COMMUNICABLE DISEASE & PUB. HEALTH 287 (2004) (testing publicly discarded needles in London's parks for blood-borne diseases confirmed the danger of the transmission of such diseases to park goers)

35. See Scott D. Holmberg, *The Estimated Prevalence and Incidence of HIV in 96 Large US Metropolitan Areas*, 86 AM. J. PUB. HEALTH 642, 648 (1996); Karl A. Sporer, *Acute Heroin Overdose*, 130 ANNALS INTERNAL MED. 584, 584 (1999) (reporting that emergency room visits involving heroin climbed from 33,900 in 1990 to 70,500 in 1996).

for which they seldom have sufficient training.<sup>36</sup> At the same time, incarceration of non-violent drug offenders is filling prisons, creating overcrowding, and draining public resources.<sup>37</sup> American prisons and jails not only fail to meaningfully rehabilitate or treat drug abuse, but they may actually serve as epicenters of the spread of addiction and infectious disease through continued drug use and unsafe, sometimes violent, sexual practices.<sup>38</sup>

The infection risks associated with injection drug use stem from the fact that many IDUs do not have ready access to sterile injection equipment or hygienically safe places to inject—a situation created by legal frameworks and shaped by law enforcement practices.<sup>39</sup> The likelihood that IDUs will contract a blood-borne disease increases significantly when they inject in such settings, including public spaces or “shooting galleries.”<sup>40</sup> Although opiate overdose is almost always reversible, witnesses often hesitate to summon first responders

36. Leo Beletsky et al., *Attitudes of Police Officers Towards Syringe Access, Occupational Needle-Sticks, and Drug Use: A Qualitative Study of One City Police Department in the United States*, 16 INT’L J. DRUG POL’Y 267 (2005).

37. See HARRISON & BECK, *supra* note 28, at 10; KARBERG & JAMES, *supra* note 28, at 2.

38. See, e.g., Mitchell I. Wolfe et al., *An Outbreak of Syphilis in Alabama Prisons: Correctional Health Policy and Communicable Disease Control*, 91 AM. J. PUB. HEALTH 1220 (2001); Ctrs. for Disease Control & Prevention, U.S. Dep’t of Health & Human Servs., *Tuberculosis Outbreaks in Prison Housing Units for HIV-Infected Inmates—California, 1995–1996*, 48 MORBIDITY & MORTALITY WKLY. REP. 69, 79 (1999), available at <http://www.cdc.gov/mmwr/PDF/wk/mm4804.pdf>.

39. See Ricky N. Bluthenthal et al., *Collateral Damage in the War on Drugs: HIV Risk Behaviors Among Injection Drug Users*, 10 INT’L J. DRUG POL’Y 25 (1999); Ricky N. Bluthenthal et al., *Drug Paraphernalia Laws and Injection-Related Infectious Disease Risk Among Drug Injectors*, 29 J. DRUG ISSUES 1 (1999); Scott Burris et al., *Addressing the “Risk Environment” for Injection Drug Users: The Mysterious Case of the Missing Cop*, 82 MILBANK Q. 125 (2004); Kim Dovey et al., *Safety Becomes Danger: Dilemmas of Drug-Use in Public Space*, 7 HEALTH & PLACE 319 (2001); Samuel R. Friedman et al., *Laws Prohibiting Over-the-Counter Syringe Sales to Injection Drug Users: Relations to Population Density, HIV Prevalence, and HIV Incidence*, 91 AM. J. PUB. HEALTH 791 (2001); Samuel R. Friedman et al., *Relationships of Deterrence and Law Enforcement to Drug-Related Harms Among Drug Injectors in US Metropolitan Areas*, 20 AIDS 93 (2006); Stephen K. Koester, *Copping, Running, and Paraphernalia Laws: Contextual Variables and Needle Risk Behavior Among Injection Drug Users in Denver*, 53 HUM. ORG. 287 (1994); Michael Marmor et al., *Risk Factors for Infection with Human Immunodeficiency Virus Among Intravenous Drug Abusers in New York City*, 1 AIDS 39 (1987); Tim Rhodes et al., *Situational Factors Influencing Drug Injecting, Risk Reduction and Syringe Exchange in Togliatti City, Russian Federation: A Qualitative Study of Micro Risk Environment*, 57 SOC. SCI. & MED. 39 (2002).

40. See Crystal M. Fuller et al., *Social Circumstances of Initiation of Injection Drug Use and Early Shooting Gallery Attendance: Implications for HIV Intervention Among Adolescent and Young Adult Injection Drug Users*, 32 J. ACQUIRED IMMUNE DEFICIENCY SYNDROME 86 (2003); Marmor et al., *supra* note 39.

out of fear of legal consequences.<sup>41</sup> Lack of proper syringe disposal facilities and legal disincentives to safe disposal increase the risk that used syringes will be improperly discarded, creating anxiety and some risk of accidental disease transmission among members of the general public.<sup>42</sup>

Drug treatment for opioid dependence works, but getting people into drug treatment is a constant challenge. People dependent on drugs first have to make a decision to seek treatment, and then there has to be a slot available. Because drug dependence is a chronic illness, relapse rates are high—even for users determined to quit.<sup>43</sup> Given that people will continue to use drugs regardless of the law, improving syringe access and disposal, targeted outreach, overdose prevention, opiate replacement therapy, and easy access to drug treatment programs are essential to limiting the individual and social harms of illegal drug use.<sup>44</sup>

### B. Supervised Injection Facilities

Municipalities bear the brunt of the human and financial costs associated with injection drug use and its collateral consequences. In addition to the health and social challenges flowing from substance abuse, local governments must deal with the safety and security problems arising from the black market trade in illicit drugs. It is not surprising, therefore, that in the United States the impetus for innovative programs to reduce the health consequences of illegal drug use—such as syringe exchange programs and drug overdose prevention interventions—tends to come from the local levels.<sup>45</sup> From the perspective of

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41. Karin E. Tobin et al., *Calling Emergency Medical Services During Drug Overdose: An Examination of Individual, Social and Setting Correlates*, 100 ADDICTION 397, 402–03 (2005); Melissa Tracy et al., *Circumstances of Witnessed Drug Overdose in New York City: Implications for Intervention*, 79 DRUG & ALCOHOL DEPENDENCE 181, 183–85 (2005).

42. See sources cited *supra* note 34.

43. William A. Hunt et al., *Relapse Rates in Addiction Programs*, 27 J. CLINICAL PSYCHOL. 455 (1971); see also M. Douglas Anglin et al., *Drug Addiction and Treatment Careers Among Clients in the Drug Abuse Treatment Outcomes Study (DATOS)*, 11 PSYCHOL. ADDICTIVE BEHAV. 308 (1997).

44. See M. Connock et al., *Methadone and Buprenorphine for the Management of Opioid Dependence: A Systematic Review and Economic Evaluation*, HEALTH TECH. ASSESSMENT, Mar. 2007, at 1, 61–62, available at <http://www.hta.ac.uk/fullmono/mon1109.pdf>; Richard H. Needle et al., *Effectiveness of Community-Based Outreach in Preventing HIV/AIDS Among Injecting Drug Users*, 16 INT'L J. DRUG POL'Y S45 (2005); Alex Wodak & Annie Cooney, *Effectiveness of Sterile Needle and Syringe Programmes*, 16 INT'L J. DRUG POL'Y S31 (2005).

45. See Scott Burris et al., *The Legal Strategies Used in Operating Syringe Exchange Programs in the United States*, 86 AM. J. PUB. HEALTH 1161 (1996); Daliah I. Heller & Sharon Stancliff, *Providing Naloxone to Substance Users for Secondary Administration to Reduce Overdose Mortality in New York City*, 122 PUB. HEALTH REP. 393 (2007); Sarz Maxwell et al., *Prescribing Naloxone to Actively Injecting Heroin Users: A Program to Reduce Heroin Overdose Deaths*, 25 J. ADDICTIVE DISEASES 89 (2006); Karen H. Seal et al., *Naloxone Distribution and*

legal architecture, however, this apt civic experimentalism runs squarely into the limited control that cities, and even states, have over the policy framework for addressing illicit drug use and its collateral impact.

The SIF question looks to be following the same pattern. Recognizing the need among some IDUs for more intensive interventions,<sup>46</sup> some thirty-eight cities across the globe have introduced facilities where drugs can be injected or otherwise consumed in a hygienic manner.<sup>47</sup> An SIF is a place where IDUs inject drugs they obtain elsewhere under the supervision of healthcare providers.<sup>48</sup> Facility staff members do not directly assist in injection, but are present to provide sterile injection supplies, answer questions on safe injection practices, administer first aid, and monitor for overdose.<sup>49</sup> Importantly, SIF staff also offer general medical advice and referrals to drug treatment and other social support programs.<sup>50</sup> In addition to reducing the health risks of drug use and serving as a bridge to treatment and other key services, SIFs are designed to reduce the externalities of public drug use in the communities they serve.<sup>51</sup>

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*Cardiopulmonary Resuscitation Training for Injection Drug Users to Prevent Heroin Overdose Death: A Pilot Intervention Study*, 82 J. URB. HEALTH 303 (2005).

46. Kate Ksobiech, *Beyond Needle Sharing: Meta-Analyses of Social Context Risk Behaviors of Injection Drug Users Attending Needle Exchange Programs*, 41 SUBSTANCE USE & MISUSE 1379 (2006); see also Kora DeBeck et al., *Public Injection Settings in Vancouver: Physical Environment, Social Context and Risk*, 18 INT'L J. DRUG POL'Y 27 (2007).

47. DAGMAR HEDRICH, EUROPEAN MONITORING CTR. FOR DRUGS & DRUG ADDICTION, EUROPEAN REPORT ON DRUG CONSUMPTION ROOMS 19 (2004), available at [www.emcdda.europa.eu/index.cfm?fuseaction=public.AttachmentDownload&nNodeID=2944&slanguageISO=EN](http://www.emcdda.europa.eu/index.cfm?fuseaction=public.AttachmentDownload&nNodeID=2944&slanguageISO=EN); see also Thomas Kerr et al., Editorial, *Drug Use Settings: An Emerging Focus for Research and Intervention*, 18 INT'L J. DRUG POL'Y 1 (2007); Malkin, *supra* note 15.

48. Malkin, *supra* note 15, at 681–82.

49. *Id.* at 682, 692; Evan Wood et al., *Service Uptake and Characteristics of Injection Drug Users Utilizing North America's First Medically Supervised Safer Injecting Facility*, 96 AM. J. PUB. HEALTH 770, 770 (2006). Most SIFs operate under the same general procedures. IDUs must first register and provide written consent to participate. See HEDRICH, *supra* note 47, at 10 tbl.2, 13. Facilities have different registration requirements. *Id.* at 10. Once an IDU has registered and entered the facility during its hours of operation, the IDU sits at a table, either alone or with other IDUs, and injects under the supervision of a health professional. KATE DOLAN & ALEX WODAK, DRUG POLICY ALLIANCE, FINAL REPORT ON INJECTING ROOMS IN SWITZERLAND (1996), <http://www.lindesmith.org/library/dolan2.cfm>. The rooms are well-stocked with sterile needles, cotton swabs, band aids, and other injection supplies. *Id.* SIF staff give advice on vein care and injection advice regarding, for example, the proper way to use a tourniquet. See *id.*; Malkin, *supra* note 15, at 692. In addition to providing guidance and emergency treatment in the case of overdose, staff also record and track a number of statistics, including the transmission of disease, the frequency of visits, and the number of medical and counseling referrals. See DOLAN & WODAK, *supra*.

50. Nat M.J. Wright & Charlotte N.E. Tompkins, *Supervised Injecting Centres*, 328 BRIT. MED. J. 100, 100–01 (2004).

51. Robert S. Broadhead et al., *Safer Injection Facilities in North America: Their Place in Public Policy and Health Initiatives*, 32 J. DRUG ISSUES 329, 347–48 (2002); Benedikt Fischer et

Studies of existing SIFs have generally reported beneficial results for clients and positive or neutral results for the site neighborhood.<sup>52</sup> Such facilities have been operating in Europe since the 1980s. Reviews that collate available evidence report that SIFs have consistently led to less risky injection behavior and fewer overdose deaths among clients,<sup>53</sup> increased client enrollment in drug treatment services, reduced nuisances associated with public injection, such as discarded needles and public intoxication,<sup>54</sup> and saved public resources.<sup>55</sup>

Perhaps most applicable to the U.S. context is the experience of SIFs in Australia and Canada. In 2001, after several years of public deliberation and the closure of a short-lived illegal facility, a pilot program opened in Sydney, Australia.<sup>56</sup> This facility functions under a license issued by the state government of New South Wales, not through national authorization.<sup>57</sup> Soon after, in 2003, the Canadian federal government created a special carve-out in its drug laws to allow the experimental operation of a pilot SIF in Vancouver, British Columbia.<sup>58</sup> There, too, there had been considerable debate about public health innovations coming in conflict with traditional drug enforcement strategies, since activists had for a time operated an unauthorized facility.<sup>59</sup> The debate in Canada recently went to court, where a decision by the Supreme

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al., *Safer Injection Facilities (SIFs) for Injection Drug Users (IDUs) in Canada: A Review and Call for an Evidence-Focused Pilot Trial*, 93 CAN. J. PUB. HEALTH 336 (2002); Craig L. Fry et al., Editorial, *The Place of Supervised Injecting Facilities Within Harm Reduction: Evidence, Ethics and Policy*, 101 ADDICTION 465 (2006).

52. See *infra* notes 75–79 and accompanying text.

53. Demonstrating a community-level impact is difficult, however, because many programs have been “pilots” with limited coverage, sometimes operating under counterproductive regulations. See generally HEDRICH, *supra* note 47; JO KIMBER ET AL., NAT’L DRUG & ALCOHOL RESEARCH CTR. UNIV. OF N.S.W., INTERNATIONAL SURVEY OF SUPERVISED INJECTING CENTRES (1999–2000) (2001); J. Kimber et al., *Drug Consumption Facilities: An Update Since 2000*, 22 DRUG & ALCOHOL REV. 227 (2003).

54. See *infra* notes 77–79 and accompanying text.

55. See Kerr et al., *supra* note 47; Dan Small, Commentary, *Fools Rush in Where Angels Fear to Tread: Playing God with Vancouver’s Supervised Injection Facility in the Political Borderland*, 18 INT’L J. DRUG POL’Y 18, 24 (2007).

56. MEDICALLY SUPERVISED INJECTION CTR. EVALUATION COMM., FINAL REPORT OF THE EVALUATION OF THE SYDNEY MEDICALLY SUPERVISED INJECTING CENTRE 3 (2003) [hereinafter MSIC EVALUATION COMM.].

57. See *id.*

58. Evan Wood et al., *Rationale for Evaluating North America’s First Medically Supervised Safer-Injecting Facility*, 4 LANCET INFECTIOUS DISEASES 301, 301 (2004).

59. Alex Wodak et al., *The Role of Civil Disobedience in Drug Policy Reform: How an Illegal Safer Injection Room Led to a Sanctioned, “Medically Supervised Injection Center,”* 33 J. DRUG ISSUES 609 (2003); see also Small, *supra* note 55.

Court of British Columbia upheld the locally operated SIF against an effort by the federal government to close the facility.<sup>60</sup> That decision is now on appeal.

Both facilities have been extensively and carefully evaluated. In epidemiological analyses of a large cohort of IDUs in Vancouver, SIF clients were less likely to reuse or share needles than non-clients.<sup>61</sup> Compared with HIV-positive drug users not using the facility, infected clients were significantly less likely to lend their syringes to others.<sup>62</sup> SIF clients used clean water for injection,<sup>63</sup> filtered drugs prior to injecting,<sup>64</sup> and injected in a clean location more frequently than non-clients.<sup>65</sup> These and related evaluation data demonstrate marked reductions in risky practices, suggesting long-term public health benefits to the injectors as well as the community at large.<sup>66</sup> In Sydney, 41% of SIF clients reported adopting at least one safer injection technique since using the facility.<sup>67</sup> A series of three annual neighborhood surveys found that SIF clients were more likely to use new syringes than non-clients and less likely to share injection equipment other than syringes.<sup>68</sup>

Overdoses do occur in SIFs, shedding some light onto the rates of overdose among IDUs at large.<sup>69</sup> In contrast with the troublingly high and rising numbers of fatal heroin-related overdose deaths in areas where heroin use is widespread,<sup>70</sup> the controlled environment and the presence of medical

60. PHS Comty. Servs. v. Att'y Gen. Can., [2008] BCSC 661 (Can.); *see infra* note 188 and accompanying text.

61. Evan Wood et al., *Summary of Findings from the Evaluation of a Pilot Medically Supervised Safer Injecting Facility*, 175 CAN. MED. ASS'N J. 1399, 1402 (2006), available at <http://www.cmaj.ca/cgi/content/full/175/11/1399> (reporting statistically significant differences between SIF clients and non-clients on this data point).

62. *Id.*

63. *Id.*

64. See Thomas Kerr et al., *A Micro-Environmental Intervention to Reduce the Harms Associated with Drug-Related Overdose: Evidence from the Evaluation of Vancouver's Safer Injection Facility*, 18 INT'L J. DRUG POL'Y 37, 41 (2007).

65. See Fry et al., *supra* note 51, at 465.

66. See Wood et al., *supra* note 61.

67. MSIC EVALUATION COMM., *supra* note 56, at 95 tbl.5.5.

68. *But see id.* at 92–93 (noting that some of these differences were not statistically significant).

69. See, e.g., Wood et al., *supra* note 61, at 1402 (reporting a rate of approximately 1.3 overdoses per 1000 injections).

70. See Darke & Zador, *supra* note 32 (reviewing international data on heroin overdose); Wayne Hall & Shane Darke, *Trends in Opiate Overdose Deaths in Australia 1979–1995*, 52 DRUG & ALCOHOL DEPENDENCE 71 (1998) (reviewing the same data for Australia); Leonard J. Paulozzi et al., *Increasing Deaths from Opioid Analgesics in the United States*, 15 PHARMACOEPIDEMIOLOGY & DRUG SAFETY 618, 624 (2006) (noting the role of heroin and other illicit drugs as a significant contributor to the growing number of fatal drug poisonings in the United States); Leonard J. Paulozzi, *Opioid Analgesic Involvement in Drug Abuse Deaths in American Metropolitan Areas*, 96 AM. J. PUB. HEALTH 1755, 1755 (2006).

assistance account for the complete lack of any reported overdose deaths in any SIF.<sup>71</sup> This data alone suggests overdose deaths are avoidable and that SIFs are—in this sense—a life-saving intervention for chronic IDUs.

Many of the advocates opposing SIFs argue that, in condoning drug use, these facilities promote or at least enable continued addiction. Evidence points toward the opposite result, however, suggesting that these programs provide a rare opportunity to engage hardcore users on a path to recovery. Both the Sydney and Vancouver facilities proved to be effective gateways for addiction treatment, counseling, and other health and social services.<sup>72</sup> By the third annual survey, Sydney SIF clients were significantly more likely to report starting drug treatment in the previous year than non-clients (38% versus 21%).<sup>73</sup> In Vancouver, SIF attendance and contact with an SIF addiction counselor were each associated with a greater willingness to enter a detoxification program.<sup>74</sup>

Both the Vancouver and Sydney evaluations found some positive and no negative effects on the surrounding community. In both cities, there was a significant reduction in observed instances of public injection in the neighborhood following the opening of the facility.<sup>75</sup> The numbers of discarded syringes and the amount of injection-related litter in the vicinity of the program's offices also declined substantially.<sup>76</sup> In neither instance was there an increase in crime or drug dealing within a close radius of the facility.<sup>77</sup> A series of surveys in Sydney found that area residents and business owners reported a sustained decline in public injection and discarded syringes following the opening of the SIF.<sup>78</sup> Overall, evaluators sought, but did not

71. Wood et al., *supra* note 61, at 1402–03; *see also* MSIC EVALUATION COMM., *supra* note 56, at 59; Thomas Kerr et al., *Drug-Related Overdoses Within a Medically Supervised Safer Injection Facility*, 17 INT'L J. DRUG POL'Y 436, 438 (2006); Kerr et al., *supra* note 64, at 42; Wright & Tompkins, *supra* note 50, at 101.

72. *See* MSIC EVALUATION COMM., *supra* note 56, at 207; Wood et al., *supra* note 61, at 1403.

73. MSIC EVALUATION COMM., *supra* note 56, at 98.

74. *See* Evan Wood et al., *Attendance at Supervised Injecting Facilities and Use of Detoxification Services*, 354 NEW ENG. J. MED. 2512, 2513 (2006).

75. MSIC EVALUATION COMM., *supra* note 56, at 102; Wood, et al., *supra* note 61, at 1401.

76. Wood et al., *supra* note 61, at 1401.

77. *Id.*; MSIC EVALUATION COMM., *supra* note 56, at 102; *see also* Karen Freeman et al., *The Impact of the Sydney Medically Supervised Injecting Centre (MSIC) on Crime*, 24 DRUG & ALCOHOL REV. 173 (2005) (noting that, although no crime increase occurred in Sydney, there was a slight increase in the level of loitering around the SIF).

78. MSIC EVALUATION COMM., *supra* note 56, at 109–13; *see also* Evan Wood et al., *Changes in Public Order After the Opening of a Medically Supervised Safer Injecting Facility for Illicit Injection Drug Users*, 171 CAN. MED. ASS'N J. 731, 733 (2004) (finding similar results following the opening of the SIF in Vancouver).

find, any evidence that the SIFs had encouraged new drug use or discouraged its cessation.<sup>79</sup>

As they provide a mechanism for functionally addressing long-standing public health problems, SIFs may save public funds by preventing death, disease, and crime. Fiscal benefits in the form of lower ambulance and hospital utilization may be significant given the evidence that SIFs prevent wound infections and successfully treat large numbers of overdoses on-site.<sup>80</sup> Moreover, SIFs generally attract the most disorganized individuals with the most chronic public injection habits and an above-average risk for infections and overdose. In this respect, the SIF arguably falls into an emerging category of social interventions that adopt a “power law” or Pareto conception of the distribution of social costs.<sup>81</sup> Rather than positing a “normal,” or bell-curve, distribution of social costs among drug users, the power-law approach posits that a relatively small proportion of individuals account for the large majority of the social costs.<sup>82</sup> On this view, investing in extra services for this population, even expensive extra services, can actually produce a substantial net savings in social service and health care expenditures.<sup>83</sup>

79. See MSIC EVALUATION COMM., *supra* note 56, at 39; Wood et al., *supra* note 61, at 1401.

80. See HEDRICH, *supra* note 47, at 50, 55–56; MSIC EVALUATION COMM., *supra* note 56, at 186–87; see also Ahmed M. Bayoumi & Gregory S. Zaric, *The Cost-Effectiveness of Vancouver’s Supervised Injection Facility*, 179 CAN. MED. ASS’N J. 1143, 1143 (2008) (projecting that, even according to the most conservative estimates, the Vancouver SIF will save the Canadian taxpayer over 14 million Canadian dollars over the next decade).

81. See Gladwell, *supra* note 12, at 98–99 (discussing the power law concept in the context of homelessness).

82. See *id.*

83. See *id.* at 97–99. Gladwell describes the experiences of two police officers in Reno, Nevada, who spend at least half their time dealing with homeless individuals and who decided to see how expensive some of the individuals they most frequently assisted were in terms of public expenditures:

When someone passed out on the street, there was a “One down” call to the paramedics. There were four people in an ambulance, and the patient sometimes stayed at the hospital for days, because living on the streets in a state of almost constant intoxication was a reliable way of getting sick. None of that, surely, could be cheap.

[The officers] called someone they knew at an ambulance service and then contacted the local hospitals. “We came up with three names that were some of our chronic inebriates in the downtown area, that got arrested the most often,” [Officer] O’Bryan said. “We tracked those three individuals through just one of our two hospitals. One of the guys had been in jail previously, so he’d only been on the streets for six months. In those six months, he had accumulated a bill of a hundred thousand dollars—and that’s at the smaller of the two hospitals near downtown Reno. It’s pretty reasonable to assume that the other hospital had an even larger bill. Another individual came from Portland and had been in Reno for three months. In those three months, he had accumulated a bill for sixty-five thousand dollars. The third individual actually had some periods of being sober, and had accumulated a bill of fifty thousand.”



## II. STATE AUTHORITY TO CREATE AN SIF

Authorization of an SIF is, legally if not politically, the easy part. States have the authority to regulate a vast spectrum of activity within their borders. This authority, called the “police power,” predates the founding of the nation<sup>84</sup> and has remained one of the central features of our federal system. State regulation of public health is perhaps the classic example of state police power,<sup>85</sup> with continuing practical and philosophical importance.<sup>86</sup> The police power certainly encompasses a wide range of measures to control drug dependency and misuse.<sup>87</sup> The authority for state police power is enshrined in

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*Id.* at 97; see also Dennis P. Culhane et al., *Testing a Typology of Family Homelessness Based on Patterns of Public Shelter Utilization in Four U.S. Jurisdictions: Implications for Policy and Program Planning*, 18 HOUSING POL’Y DEBATE 1 (2007). It must be noted, however, that the economic analysis of SIF costs and benefits has yet to produce definitive findings. See HEDRICH, *supra* note 47, at 28; MSIC EVALUATION COMM., *supra* note 56, at 195–99; Kerr et al., *supra* note 47, at 2.

84. LAWRENCE O. GOSTIN, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* 26–27, 205, 211 (2000) (noting that states and municipalities handled disease outbreaks and other public health issues in the colonial period and that by the time the states joined together under the Constitution, local governments and states had become proficient in handling these issues, which the Constitution recognized by creating a federal government of limited powers and by not enumerating a specific federal interest in public health).

85. See, e.g., *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 203 (1824) (declaring that the state police power is an “immense mass of legislation, which embraces every thing within the territory of a State, not surrendered to the general government: . . . [i]nspection laws, quarantine laws, health laws of every description, . . . are component parts of this mass”).

86. See generally PARMET, *supra* note 5 (describing the central place of public health in U.S. constitutional order).

87. See, for example, *Robinson v. California*, 370 U.S. 660 (1962), stating:

The broad power of a State to regulate the narcotic drugs traffic within its borders is not here in issue. More than forty years ago, in *Whipple v. Martinson*, this Court explicitly recognized the validity of that power: “There can be no question of the authority of the State in the exercise of its police power to regulate the administration, sale, prescription and use of dangerous and habit-forming drugs . . . . The right to exercise this power is so manifest in the interest of the public health and welfare, that it is unnecessary to enter upon a discussion of it beyond saying that it is too firmly established to be successfully called in question.”

Such regulation, it can be assumed, could take a variety of valid forms. A State might impose criminal sanctions, for example, against the unauthorized manufacture, prescription, sale, purchase, or possession of narcotics within its borders. In the interest of discouraging the violation of such laws, or in the interest of the general health or welfare of its inhabitants, a State might establish a program of compulsory treatment for those addicted to narcotics. Such a program of treatment might require periods of involuntary confinement. And penal sanctions might be imposed for failure to comply with established compulsory treatment procedures. Or a State might choose to attack the evils of narcotics traffic on broader fronts also—through public health education, for example, or by efforts to ameliorate the economic and social conditions under which those evils might be thought to flourish. In short, the range of valid choice which a State might

the Tenth Amendment, which reserves to the states all powers that are neither prohibited by the Constitution nor granted under the Constitution to the federal government.<sup>88</sup>

Given the evidence discussed in Part I, a state could view an SIF as a reasonable public health measure with the potential to address a host of stubborn and costly problems by decreasing the individual and communal harms associated with public injection drug use. Authorizing an SIF would therefore be a logical and prudent exercise of the police power.<sup>89</sup> This authority could be invoked through a variety of mechanisms that we briefly canvass in this part.<sup>90</sup>

#### A. *Legislative Authorization*

There is no question that state legislatures have the power to modify state law to explicitly remove legal impediments to SIF operation that might exist under state law. Where such impediments are present, explicit authorization by a state legislature is, in the absence of positive action at the federal level, the optimal method of SIF authorization. Properly drafted state legislative authorization would eliminate uncertainty about the legality of the facility under potentially conflicting state laws and provide the SIF operators and

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make in this area is undoubtedly a wide one, and the wisdom of any particular choice within the allowable spectrum is not for us to decide.

*Id.* at 664–65 (alteration in original) (footnote omitted) (citations omitted).

88. U.S. CONST. amend. X; GOSTIN, *supra* note 84, at 26–27, 48.

89. *See Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905). This is not to say that no federal law affects state-authorized SIFs, only that states are not prevented from authorizing an SIF as an initial matter. This is a fine and potentially confusing distinction, which is best illustrated by the instance of medical marijuana regulation in California, discussed briefly in Part III.A. California was able to authorize the use of marijuana for medical purposes under its state police powers because the power to legalize or prohibit activities with controlled substances is neither delegated to the federal government as an enumerated provision of the Constitution, nor prohibited to the states in a provision of the Constitution or in a federal statute. Whether states have the authority under their police powers to authorize an SIF (the question answered in this section) is a different question than the question we take up in Part III: Whether a federal challenge to a state acting within its police powers should be upheld as a matter of conflicting state and federal laws?

90. We have chosen to focus on state authorization because federal authorization of an SIF is currently unlikely due to prevailing socio-political realities surrounding drug use in national policy circles. Should circumstances change, authorization options at the federal level would closely follow the methods discussed in this part. Further, the Attorney General could promulgate a regulation under the CSA, carving out special exemptions for the staff, management, and clients enrolled in the facility. *See* 21 U.S.C. § 871(b) (2006). This would support a policy directive for federal law enforcement agents to abstain from persecuting clientele while on premises (and perhaps, even en route) to SIF programs. Finally, the Secretary of the Department of Health and Human Services or the Attorney General could approve an exemption scheme applicable to pilot SIF programs under the provision of the CSA authorizing research. *See* 21 U.S.C. § 872(e).

clients with protection against informal police pressure or other interference.<sup>91</sup> The legislative process also affords an opportunity for SIF proponents to place the evidence in favor of such facilities on the public record and to address the concerns of dissenters and community stakeholders. In addition, legislative authorization would also insulate an SIF from community challenges based on nuisance<sup>92</sup> or other land-use laws.<sup>93</sup> Finally, state legislative authorization puts the SIF on its strongest footing against a challenge from the federal government.

Legislative authorization of an SIF would surely generate lively debate, but state legislation establishing politically controversial public health interventions at odds with federal drug policy is not unprecedented. Furthermore, there is no doctrinal barrier to states authorizing activity under state law that is prohibited under federal law or disfavored by federal policymakers. Since 1996, four state legislatures have enacted laws permitting the use of medicinal marijuana, a Schedule I drug under federal law, by qualified patients.<sup>94</sup> Since the beginning of the HIV epidemic, seventeen states have passed laws expressly authorizing syringe exchange programs (SEPs), over-the-counter (OTC) syringe sales, or both.<sup>95</sup>

It is also within the authority of many municipal legislatures to authorize an SIF. City and county governments bear the brunt of the burden of service

91. However, an explicit police order based on administrative state authorization of a syringe exchange program (SEP) was not enough to control street-level action against SEPs by New York City police. *Roe v. City of New York*, 232 F. Supp. 2d 240, 244–45, 249 (S.D.N.Y. 2002). Ultimately, litigation and an injunction were needed. *See id.* at 260 (forbidding police interference with SEPs).

92. Legislative authorization would provide a strong legal bulwark against so-called “Not In My Back Yard (NIMBY) actions,” which are often predicated on public nuisance grounds. For example, New York nuisance law prohibits activity that either unreasonably endangers the safety of others or involves a property being used for unlawful conduct. N.Y. PENAL LAW § 240.45 (McKinney 2008). However, if the state authorized an SIF, the employees and the IDUs would not be engaging in “unlawful conduct” and the premises would not be maintained for the purpose of engaging in unlawful conduct.

93. Real Property Law often provides the statutory authority to void leases and remove tenants and owners who use their residences for proscribed activities. *See, e.g.*, N.Y. REAL PROP. LAW § 231(1) (McKinney 2006) (stating that leases may be voided if the premises are used for illegal trade or illegal activity); N.Y. REAL PROP. ACTS. LAW § 715 (McKinney 1979) (“An owner or tenant . . . of any premises . . . used . . . for purposes of . . . any illegal trade, business . . . [may be removed].”). State authorization of an SIF would render these types of provisions inapplicable by establishing the SIF as lawful under state law.

94. MARIJUANA POLICY PROJECT, STATE-BY-STATE MEDICAL MARIJUANA LAWS: HOW TO REMOVE THE THREAT OF ARREST 11 (2007), available at [http://www.mpp.org/assets/pdfs/general/SBSR\\_2007.pdf](http://www.mpp.org/assets/pdfs/general/SBSR_2007.pdf).

95. Scott Burris et al., The Project on Harm Reduction in the Health Care System: Non-Prescription Access to Sterile Syringes, <http://www.temple.edu/lawschool/phrhcs/otc.htm> (last visited Apr. 28, 2009).

delivery and emergency response to drug abuse and may be best able to judge the necessity and effectiveness of locally implemented interventions.<sup>96</sup> They may therefore be willing to take legislative initiatives to combat the public health threat of public injection. In fact, health leaders in several U.S. cities have already expressed interest in operating SIFs.<sup>97</sup> Local authorization has advantages, clustered around the fact that there may be greater cultural and political homogeneity relative to the intervention, but local authorization is necessarily mediated by political decisions at the state and national level, the varying authority granted to municipalities to legislate in the arena of public health, and the vagaries of state drug law.

Most local governments have been delegated some police power to protect public health,<sup>98</sup> and have the discretion to implement programs that are supported by reasonable evidence of efficacy in combating health threats.<sup>99</sup> In a locality with such power, a city's legislature (such as a city council) could enact an ordinance to create an SIF. Such a move would fit squarely within a strong tradition of local policy innovation as it has flourished in the realms of public health (e.g. smoking bans),<sup>100</sup> environmental protection (e.g. recycling

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96. Richard Briffault, *Home Rule for the Twenty-First Century*, 36 URB. LAW. 253, 256–57 (2004).

97. See *supra* note 16.

98. Typical of legislation delegating such authority is Pennsylvania's First Class City Home Rule Act, 53 PA. CONS. STAT. ANN. § 13131 (West 1998) (granting qualified cities authority of local self-government, including "complete powers of legislation and administration in relation to its municipal functions") and its enabling legislation, 53 PA. CONS. STAT. ANN. § 2961 (West 1997), providing 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."

99. See C. DALLAS SANDS ET AL., LOCAL GOVERNMENT LAW § 14.19, at 102–03 (2001). Over the course of the last century the level of autonomy granted to local entities has steadily increased. Local governmental power has been viewed since the 1860s through the prism of Dillon's Rule, which holds that local power is very narrow and absolutely limited by state authority. See *City of Clinton v. Cedar Rapids*, 24 Iowa 455, 478–80 (1868) (establishing the "Rule" in a decision by John Forrest Dillon); David J. Barron, *The Promise of Cooley's City: Traces of Local Constitutionalism*, 147 U. PA. L. REV. 487, 506–09 (1999). The alternative to Dillon's Rule is home rule, in which states transfer many powers of self-rule to localities. See Briffault, *supra* note 96, at 257. Home Rule localities have been steadily increasing in recent decades. See John E. Lopatka, *State Action and Municipal Antitrust Immunity: An Economic Approach*, 53 FORDHAM L. REV. 23, 75 & n.323 (1984). Many localities with concentrated injection drug use populations are large metropolitan areas, which are now typically home rule entities that enjoy broad powers to regulate within their boundaries.

100. See 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) (suggesting that local innovation on regulation of smoking in public venues has been relatively successful in defeating industry challenges that are based on state preemption grounds (winning in 60% of the cases surveyed), moving the national agenda on that issue as a result).

programs, carbon off-set markets),<sup>101</sup> and civil rights (e.g. partner benefits for gay and lesbian couples).<sup>102</sup>

However, while local innovation is an important facet of American policy,<sup>103</sup> the authority of localities is limited in comparison with that of states.<sup>104</sup> A locally-authorized SIF would be open to claims that it conflicted with—or was preempted by—state law. For example, Atlantic City, New Jersey’s effort to implement an SEP by local ordinance without state authorization was successfully challenged in court by the local state prosecutor, who argued that it was prohibited by state drug law.<sup>105</sup> To be effective in practice, a local government would have to establish that an SIF did not violate any state laws, or have a reliable expectation of non-enforcement where it was arguably in violation.

### B. *Administrative Authorization*

An SIF might also be authorized through administrative action, which can take a number of forms, including executive orders from state governors, rules and regulations from specialized state agencies like departments of health, and actions by local health agencies.

101. Several city-based environmental innovations have recently developed, including “green alleys” in Chicago, *see* Clay Risen, *Cool Alleys*, N.Y. TIMES MAG., Apr. 20, 2008, at 50, and a municipal carbon off-set trading scheme in San Francisco, *see* Dashka Slater, *Working Offsets*, N.Y. TIMES MAG., Apr. 20, 2008, at 50.

102. *See, e.g.*, Press Release, Office of the City Att’y of S.F., Decisive Win for Equal Benefits: San Francisco’s Landmark Equal Benefits Ordinance Is Upheld in U.S. Court of Appeals (July 29, 2003) (on file with *Saint Louis University Law Journal*) (“In 1997, San Francisco became the first jurisdiction in the country to require employers with city contracts to offer equal benefits to their employees’ domestic partners. Since then, five other localities have followed suit: Los Angeles; Seattle; Berkeley, Calif.; San Mateo County, Calif.; and Tumwater, Wash.”).

103. The role of states in such regulation is widely heralded, but localities—especially home-rule entities—take an increasingly avant-garde role in policy innovation. *See generally* Paul Diller, *Intrastate Preemption*, 87 B.U. L. REV. 1113, 1119 (2007) (“These examples illustrate a widespread pattern of policy innovation: a policy first embraced by a city proves itself manageable and popular at the local level before percolating ‘out’ to other cities and ‘up’ to the state level. Without the possibility of city experimentation, these policies might have never been embraced by other jurisdictions.”).

104. The United States Constitution makes no reference to localities, and courts tend to interpret grants of local power narrowly, focusing instead on the expansive authority of states to pursue their sovereign goals. Briffault, *supra* note 96, at 257, 264.

105. *State v. City of Atlantic City*, 879 A.2d 1206, 1207 (N.J. Super. Ct. App. Div. 2005) (finding that an Atlantic City ordinance establishing a needle exchange program, under which municipal officials are authorized to distribute sterile hypodermic syringes to drug addicts for use in injecting drugs, conflicts with and therefore, is pre-empted by “the provisions of the Code of Criminal Justice that prohibit persons from using or assisting others in using controlled dangerous substances”).

Although the scope of their power varies, health agencies in all states have rule-making authority to protect public health, and often have the authority under their general authorizing legislation to undertake interventions necessary to protect public health.<sup>106</sup> Demonstrating the need for and defining the terms of an SIF would be well within the traditional policy competencies of a health department.<sup>107</sup> Moreover, in some states, Health Commissioners have the discretion to authorize activity related to controlled substances that is otherwise prohibited under state penal law, a particularly useful authority to have in establishing a facility hosting illegal drug injection.<sup>108</sup>

State governors often have the authority to issue orders authorizing a range of activities within the general competence of the Executive Branch.<sup>109</sup> Authorization of an SIF under an executive order would carry some political weight, but such an authorization would also be subject to attack from numerous angles. Executive authority to alter criminal codes is generally narrow, so any executive order purporting to authorize the use or possession of controlled substances could be challenged as exceeding the executive's authority.<sup>110</sup> More broadly, such action could be portrayed as an illegitimate

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106. See, e.g., N.J. STAT. ANN. § 26:1A-7 (West 2007); see also ARTHUR EARL BONFIELD, STATE ADMINISTRATIVE RULE MAKING § 3.2.3, at 70–71 (1986). In some states, administrative authorization will have to navigate state laws regulating controlled substances. For example, the New York Controlled Substances Act (NYCSA) prohibits certain activities related to controlled substances. N.Y. PUB. HEALTH LAW § 3301(a) (McKinney 2002). However, the NYCSA contemplates a role for the health commissioner in determining what activities should be proscribed. *Id.* § 3308(2). The Commissioner also plays an important role in promoting the medically legitimate use of controlled substances under section 3300-a of the NYCSA, which permits the state health authority to facilitate appropriate healthcare and research with controlled substances. See *id.* § 3325(1). In addition, the Commissioner has general discretion to create regulations “which in his judgment may be necessary or proper” to furtherance of health objectives. *Id.* § 3308(2). See generally Gostin et al., *supra* note 4, at 101–18 (describing state health powers).

107. For example, in New York, a Health Commissioner must be a physician with extensive practical experience. N.Y. PUB. HEALTH LAW § 203 (“The commissioner shall be a physician, a graduate of an incorporated college, of at least ten years’ experience in the actual practice of his profession, and of skill and experience in public health duties and sanitary science.”).

108. This was the case in New York when a district court held that administrative authorization of an SEP and formal police policies recognizing the SEP created immunity for IDUs participating in the authorized SEPs. See *L.B. v. Town of Chester*, 232 F. Supp. 2d 227, 234 (S.D.N.Y. 2002) (“Once an individual is authorized by the Commissioner, that ends their liability as an ‘unlawful’ possessor under the Penal Law [proscribing possession of controlled substances].”).

109. See Michael S. Herman, *Gubernatorial Executive Orders*, 30 RUTGERS L.J. 987 (1999) (examining executive order power in New Jersey); see, e.g., LA. REV. STAT. ANN. § 49:215 (Supp. 2008).

110. Such an objection was successfully raised in 2004 when the governor of New Jersey attempted to authorize SEPs through an executive order. See Letter from Albert Porroni, Legislative Counsel, N.J. Office of Legislative Servs., to Assemb. Joseph Pennachio (Nov. 15,

usurpation of legislative authority. However, if unchallenged or upheld, the effect of an executive authorization would be much the same as state legislative action.

Local executives and administrative agencies such as health departments often have significant independent regulatory power. SEPs authorized by local government executives or boards of health have successfully operated in several cities in Pennsylvania, California, and Ohio, without state authorization.<sup>111</sup> However, where it is accomplished by executive or regulatory action, local authorization would face even bigger obstacles if formally challenged than would the legislative mechanisms discussed in Section A above.<sup>112</sup> Administrative authorization at the city level can even be problematic with respect to other city agencies. In the case of Philadelphia's SEP, authorized by mayoral order and Board of Health declaration, the legal vulnerability of the operation has often made it harder to deal with cases of police interference with sites or clients.<sup>113</sup>

### C. *Authorization by Referendum*

Finally, twenty-four states have a ballot initiative mechanism which provides a framework for state-wide referenda on specific policy propositions.<sup>114</sup> By putting important policy questions directly before the voters, this system of direct democracy allows voters to circumvent the normal political process and (to some degree) the influence of special interests in electoral politics. For example, in 1996, Californians passed Proposition 215, authorizing the implementation of the state's Compassionate Use Act (CUA).<sup>115</sup> By creating a medical carve-out of state drug laws, this law decriminalized the possession and use of marijuana for medical purposes in the

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2004), available at <http://njlegallib.rutgers.edu/ols/ols20041115.html> (regarding Governor McGreevey's Executive Order No. 139).

111. See Burris et al., *supra* note 45, at 1162 tbl.1.

112. For example, a local prosecutor or police agency may feel even less bound by a health department or mayoral directive than by action by the local legislative body. Although this is not a legal distinction, it is an important political consideration.

113. See Corey S. Davis et al., *Effects of an Intensive Street-Level Police Intervention on Syringe Exchange Program Use in Philadelphia, Pa.*, 95 AM. J. PUB. HEALTH 233 (2005); Kumi Smith, *Effects of Deregulation of Syringe Access Laws on HIV Transmission and Implications for Global Implementation of Syringe Exchange Programs*, 8 J. INT'L POL'Y SOLUTIONS 31, 32 (2008).

114. Initiative & Referendum Inst., Univ. of S. Cal., State-by-State List of Initiative and Referendum Provisions, [http://www.iandrinstitute.org/statewide\\_i&r.htm](http://www.iandrinstitute.org/statewide_i&r.htm) (last visited Apr. 24, 2009).

115. Compassionate Use Act of 1996, CAL. HEALTH & SAFETY CODE § 11362.5 (West Supp. 2009). See generally Samuels, *supra* note 19, at 49 (discussing Proposition 215 in relation to the legalization of medical marijuana).

state.<sup>116</sup> An additional seven states have enacted effective medical marijuana laws through ballot initiative since 1996.<sup>117</sup>

Such governance innovations foster vitality, heterogeneity, and experimentation on issues where the lack of political will has stifled more sober and evidence-driven approaches to policy reform. If voters in ballot initiative states supported a similar carve-out for an SIF to operate in their state, this mechanism could provide a way to circumvent the lack of political will for nuanced drug policy among elected officials. Since such initiatives create or modify state law, they have the same legal effect as legislative action.

### III. FEDERAL OPPOSITION TO A STATE-AUTHORIZED SIF

A state can certainly authorize an SIF. The main legal and political question is whether the administration then in power in Washington would attempt to prohibit such a facility from opening or operating.<sup>118</sup> No federal law prohibits an SIF in so many words, but as with medical marijuana and physician-assisted suicide, the Controlled Substances Act<sup>119</sup> (CSA) would provide a basis for federal action against one. In Section A, below, we put the current case in context by briefly explaining the statutory authority for federal drug control activities. In Section B, we explain why federal drug possession laws are an unlikely avenue of federal enforcement against an SIF. In Section C, we identify the so-called “Crack House Statute”<sup>120</sup> as the federal drug law most likely to be invoked against an SIF, and provide a short legislative and judicial history of the provision. In Section D, we discuss in detail the complex legal issues that would confront a court in applying the Crack House Statute to a state-authorized SIF. Our discussion shows that, *ex ante*, states have a reasonable legal basis for proceeding with SIFs on the theory that they are not barred by federal law.

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116. CAL. HEALTH & SAFETY CODE § 11362.5

117. MARIJUANA POLICY PROJECT, *supra* note 94, at 1.

118. The Bush Administration muscularly pursued an expansion of centralized, federal power and closely aligned with abstinence-only policy. See, e.g., Mark Follman, *Canada's Safe Haven for Junkies*, SALON.COM, Sept. 8, 2003, <http://dir.salon.com/story/news/feature/2003/09/08/vancouver> (“The prospect of government-backed hard-drug use next door has the White House palpably unsettled: As soon as Vancouver’s planned site gained Canadian federal approval in late June [of 2003], U.S. drug czar John Walters went off. ‘It’s immoral to allow people to suffer and die from a disease we know how to treat,’ he told the Associated Press. ‘There are no safe-injection sites,’ he added, calling the policy ‘a lie’ and ‘state-sponsored personal suicide.’”). As we discuss below, things could very well differ under President Barack Obama’s Administration. See *infra* notes 246–47 and accompanying text.

119. 21 U.S.C. §§ 801–971 (2006).

120. *Id.* § 856.



### A. Federal Authority over Drug Policy: The Controlled Substances Act

Prior to the 1970s, the federal government's role in regulating illicit drug use, though significant, was modest in comparison to the present day. As with other criminal and public health issues, for most of the country's history, the regulation of controlled substances was accomplished primarily through state laws.<sup>121</sup> The notion of a "War on Drugs" was first voiced by Richard Nixon (in fact, the Nixon Administration showed a strong commitment to drug treatment as a more important tool than incarceration for addressing drug problems).<sup>122</sup> From the federal side, the new "war" was conducted through the rapid and expansive growth of federal criminal drug laws, including, most importantly, the enactment and subsequent amendment of the CSA<sup>123</sup> in 1970 and 1986, respectively.

The CSA regulates a wide spectrum of drug-related activity. Importantly for our analysis, however, the CSA does not displace the authority of states to regulate illicit drug use.<sup>124</sup> Rather, the expansion of federal power over illicit drug control created a dual system of regulation, in which state and federal laws generally proscribe the same basic activities, such as drug possession and distribution.<sup>125</sup> Federal law enforcement agencies like the Drug Enforcement Administration (DEA) do not have nearly enough resources to actually investigate and prosecute most federal offenses on a national basis.<sup>126</sup> Instead,

121. Sandra Guerra, *The Myth of Dual Sovereignty: Multijurisdictional Drug Law Enforcement and Double Jeopardy*, 73 N.C. L. REV. 1159, 1165–66 (1995) ("Early in United States history, most acts considered crimes were subject only to state criminal law. Federal criminal laws were limited to areas in which the Constitution gave Congress specifically enumerated powers. . . . Over time, Congress began to criminalize much ordinary criminal activity under the guise of regulating interstate commerce . . . . With the Controlled Substances Act of 1970, however, Congress established virtually unlimited federal jurisdiction for all drug offenses as a way to protect public morals—without even the pretense of regulating interstate commerce." (footnotes omitted)).

122. MICHAEL MASSING, *THE FIX* 112 (1998).

123. Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. No. 91-513, 84 Stat. 1236, amended by Anti-Drug Abuse Act of 1986, Pub. L. No. 99-570, 100 Stat. 2307 (codified as amended at 21 U.S.C. §§ 801–971 (2006)).

124. Under the Food, Drug and Cosmetic Act (FDCA), 21 U.S.C. §§ 301–399a, by contrast, the Federal Food and Drug Administration is the sole regulator of drugs marketed in the United States. *Id.* § 335.

125. See Guerra, *supra* note 121, at 1164–65.

126. As a general matter, federal law enforcement agencies rarely prosecute individuals for simple possession. U.S. SENTENCING COMM'N, 2005 SOURCEBOOK OF FEDERAL SENTENCING STATISTICS tbl.33 (2005), available at [http://www.ussc.gov/ANNRPT/2005/table33\\_post.pdf](http://www.ussc.gov/ANNRPT/2005/table33_post.pdf) (reporting that only 286 individuals (1.5% of all drug sentences) were sentenced for simple drug possession in fiscal year 2005). Moreover, of those recorded sentences for simple possession, a large percentage involve individuals who were known to be trafficking drugs but, against whom, for any number of evidentiary or other reasons, only simple possession charges were made, or who pled to simple possession (and possibly cooperated with ongoing investigations) to avoid

the DEA and other federal agencies focus on major drug trafficking offenses and rely upon voluntary partnerships with state and local law enforcement agencies, which, usually under state law, handle the more routine policing of local drug markets and drug users.

States are not required, however, to enforce federal drug laws.<sup>127</sup> This policy structure has created the confounding situation with medical marijuana in California, which has recently been the subject of so much popular and scholarly interest.<sup>128</sup> Today, close to 200,000 Californians have been granted prescriptions for medicinal marijuana that are authorized under California law,<sup>129</sup> but which are prohibited under the CSA.<sup>130</sup> Most, though not all, California police agencies follow the state law and decline to enforce the federal law.<sup>131</sup> Because the DEA does not have nearly enough resources to

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conviction on more serious drug offenses. See U.S. DEP'T OF JUSTICE, REPORT TO CONGRESS ON THE FEASIBILITY OF FEDERAL DRUG COURTS 16 (2006), available at [http://www.usdoj.gov/olp/pdf/drug\\_court\\_study.pdf](http://www.usdoj.gov/olp/pdf/drug_court_study.pdf).

127. See, e.g., *Printz v. United States*, 521 U.S. 898, 933–35 (1997) (holding that states are not required to implement provisions of the Brady Act, a federal gun regulation statute, as being forced to do so would have been an unconstitutional act of commandeering state resources for federal regulation).

128. For example, this was a recent story featured prominently in *The New Yorker* magazine. Samuels, *supra* note 19, at 48.

129. See Letter from Jonathon K. Renner, Cal. Deputy Att'y Gen., for Bill Lockyer, Cal. Att'y Gen., to Robert D. Tousignant, Deputy Dir. & Chief Counsel, Cal. Dep't of Health Servs. (July 15, 2005), available at [http://www.drugpolicy.org/docUploads/CA\\_Attorney\\_General\\_Letter.pdf](http://www.drugpolicy.org/docUploads/CA_Attorney_General_Letter.pdf) (advising the Department of Health Services that “the implementation of a program required by Health and Safety Code section 11362.7 et seq. to provide medical marijuana identification cards for the purpose of facilitating the possession or cultivation of medical marijuana” does not “violate any federal criminal statute” even after *Gonzalez v. Raich*, 545 U.S. 1 (2005), a Supreme Court decision upholding federal action against medical marijuana users).

130. Samuels, *supra* note 19, at 50.

131. California police have recently been rebuffed in instances when they tried to enforce the federal prohibition of marijuana rather than acting consistently with the state-sanctioned scheme of medicinal marijuana. *City of Garden Grove v. Superior Court*, 68 Cal. Rptr. 3d 656 (Cal. Ct. App. 2007) (holding that police must return marijuana seized in a traffic stop which was legally possessed under California state law over objections from local police that the return would constitute a crime under federal law); *County of San Diego v. San Diego NORML*, 81 Cal. Rptr. 3d 461 (Cal. Ct. App. 2008) (holding that California’s medicinal marijuana scheme is not preempted by federal law and consequently California localities and police may not rely on the federal law in refusing to adhere to the California scheme). Although California police may continue to harass state citizens acting legitimately under the California medicinal marijuana scheme based on the belief that such interference is warranted by federal law, cf. Samuels, *supra* note 19, at 50, 57 (noting state police interference with the state sanctioned use of medical marijuana), California courts have recognized that California police need not—and in this instance, may not—enforce the broad federal prohibition against marijuana. *County of San Diego*, 81 Cal. Rptr. 3d at 482–83 (“Counties also appear to assert the identification card laws present a significant obstacle to the CSA because the bearer of an identification card will not be arrested by California’s law enforcement officers despite being in violation of the CSA.

investigate and prosecute a significant number of individual users of medical marijuana, and because the DEA apparently believes that prosecuting prescribing doctors would generate too much negative publicity, it has instead prosecuted marijuana growers, pressured landlords who provide space to cannabis buyers' clubs, and made selective, high publicity raids on medicinal users.<sup>132</sup>

There are at least two theories under which an SIF could be attacked as violating the CSA. The first is that an SIF entails illegal possession of drugs not just by clients, but also by the operators and staff under the doctrine of "constructive possession." Possession laws arose in legal analysis of the SIFs in Canada and Australia but, for a variety of technical and practical reasons that we will briefly explore, these laws are unlikely to be the legal battleground in the United States. We deem it is much more likely that federal officials would rely upon another section of the CSA, the Crack House Statute, whose history and applicability to SIFs will be discussed at length.

### B. *Drug Possession*

Two federal provisions proscribe the unauthorized possession of controlled substances. Theoretically, laws against possession would enable federal officials to prosecute every person who appeared at a clinic carrying pre-obtained illegal drugs to inject. Section 841(a)(1) makes it a crime for an unauthorized individual to "possess with intent to manufacture, distribute, or dispense, a controlled substance."<sup>133</sup> Section 844 proscribes "simple

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However, the unstated predicate of this argument is that the federal government is entitled to conscript a state's law enforcement officers into enforcing federal enactments, over the objection of that state . . . . Th[is] argument falters on its own predicate because Congress does not have the authority to compel the states to direct their law enforcement personnel to enforce federal laws.").

132. See, e.g., *Raich*, 545 U.S. at 5–7 (explaining how, after California approved by referendum the legalization of medical marijuana for strictly medical purposes, federal officers stormed the house of Diane Monson, a California resident who grew her own marijuana to treat a variety of serious medical conditions); Samuels, *supra* note 19, at 50, 56 (describing DEA enforcement techniques).

133. 21 U.S.C. § 841(a)(1) (2006). To convict an individual under § 841(a)(1), the government must prove (1) knowing, (2) unauthorized possession of a controlled substance, (3) with intent to distribute it. *United States v. Wright*, 845 F. Supp. 1041, 1055 (D.N.J. 1994). Intent can be inferred from the amount of drugs recovered, even in the absence of other corroborating evidence. *United States v. Barrow*, 287 F.3d 733, 736–37 (8th Cir. 2002). However, § 841 would rarely be applicable to SIF clients, who normally would be carrying only a single dose. See *id.* at 736 ("[P]ossession of only a small quantity of illegal drugs does not justify an inference of [intent to distribute]."). Of course, an individual who tried to sell drugs within an SIF would be violating the facility's rules and presumably could be prosecuted even if the legality of the SIF was unquestioned.

possession” without intent to distribute.<sup>134</sup> Given the realities of DEA enforcement capacities and priorities, routine arrests at an SIF would be unusual, and in our assessment, unlikely.<sup>135</sup>

It would be more efficient to target the operators of the SIF, on the theory that they were actually in possession of the drugs on-site, but this argument is legally quite weak. SIF operators or staff never handle, hold, or control the drugs that clients bring in. “Constructive” possession exists when circumstantial evidence establishes that an individual who is not actually in possession nonetheless has dominion and control over contraband.<sup>136</sup> Mere association with those who possess drugs or mere presence near drugs is not enough to establish control.<sup>137</sup> Rather, it must be shown that the defendant had some right, accepted by those within the particular setting, to possess the drugs at issue or to determine their disposition.<sup>138</sup> SIF staff would make no such

134. 21 U.S.C. § 844 (“It shall be unlawful for any person knowingly or intentionally to possess a controlled substance unless such substance was obtained directly, or pursuant to a valid prescription or order, from a practitioner . . .”).

135. It is perhaps instructive that federal officials have not attempted to use possession laws to discourage clients from using SEPs, even though § 844 would provide a basis for prosecuting IDUs who carry drugs or used needles (that often contain residue of illicit controlled substances) into needle exchanges. Perhaps federal officials fear that using § 844 would be overturned by a court following the reasoning of similar challenges at the state level. *See, e.g.,* *Roe v. City of New York*, 232 F. Supp. 2d 240, 260 (S.D.N.Y. 2002) (holding that “there is no criminal liability under [New York] Penal Law [prohibiting possession of controlled substances] for possession of . . . the drug residue remaining in a used needle or syringe” for an SEP participant); *Doe v. Bridgeport Police Dep’t*, 198 F.R.D. 325, 350 (D. Conn. 2001). Or, the reluctance to invoke § 844 against SEPs might simply result from an unwillingness to generate potentially overwhelmingly negative publicity.

136. *United States v. Salinas-Salinas*, 555 F.2d 470, 473 (5th Cir. 1977); *United States v. Bethea*, 442 F.2d 790, 793 (D.C. Cir. 1971). Control, in the context of constructive possession analysis, has been likened to the ability to “use and remove” controlled substances. *See, e.g.,* *United States v. Schocket*, 753 F.2d 336, 340 (4th Cir. 1985); *United States v. White*, 660 F.2d 1178, 1181 (7th Cir. 1981) (“Use of a portion of narcotics by a defendant is relevant . . . to the extent of his control over the larger quantity.”).

137. *United States v. Rodriguez*, 761 F.2d 1339, 1341 (9th Cir. 1985) (“Mere proximity to contraband, presence on property where it is found, and association with a person or persons having control of it are all insufficient to establish constructive possession.”).

138. *United States v. Manzella*, 791 F.2d 1263, 1266 (7th Cir. 1986) (“[T]he essential point [in determining constructive possession] is that the defendant have the ultimate control over the drugs. He need not have them literally in his hands or on premises that he occupies but he must have the right (not the legal right, but the recognized authority in his criminal milieu) to possess them . . .”); *see also White*, 660 F.2d at 1182 (noting that setting a schedule for sale of drugs provides supporting evidence of constructive possession). Some courts have adopted the language of “joint venture” in determining when and if associated persons possess contraband. *United States v. Smith*, 962 F.2d 923, 929 (9th Cir. 1992) (“[C]onstructive possession may be demonstrated if the defendant . . . is a participant in a joint venture, thereby sharing dominion and control over the drug with the other participants.”).

claim as against drug users, and indeed would explicitly disclaim it; nor would clients continue to attend the SIF if their drugs were subject to confiscation.<sup>139</sup> In any event, there is no particular need for prosecutors to strain drug possession law to construct a case against an SIF operator: the act of providing a space for illegal drug use, broadly stated, is addressed explicitly in the Crack House Statute, to which we now turn.

### C. *The Crack House Statute (§ 856): History*

During the explosion of public concern about crack cocaine use in the mid 1980s, Congress added 21 U.S.C. § 856 to the CSA to enable prosecution of property owners who intentionally allowed their property to be used for the purpose of distributing or using drugs.<sup>140</sup> In the words of one legislator, the so-called Crack House Statute was created to “[o]utlaw[] operation of houses or buildings, so called ‘crack houses’, where ‘crack’, cocaine and other drugs are manufactured and used.”<sup>141</sup> The statute itself was broadly drafted to prohibit managing, maintaining, or opening any place “for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance.”<sup>142</sup>

139. Using § 841(a)(1) would present the same problem on stilts. Not only would it be necessary for federal prosecutors to show that the operator was able to exercise dominion and control over any drugs in the facility but also, in order to accumulate the required amount to support an inference of intent to distribute, *United States v. Ramirez-Rodriguez*, 552 F.2d 883, 884 (9th Cir. 1977) (“It is well-established, that intent to distribute may in the proper circumstances be inferred from the amount seized.”), they would have to argue that the operator constructively possessed the aggregate amount of drugs that IDUs bring into the SIF. This would be difficult. First, larger quantities only create an inference of an intention to distribute or dispense; in the case of an SIF, such inferences could be easily rebutted. Second, courts do not simply aggregate amounts of drugs held by various individuals or in various containers. Rather, courts look at the totality of the circumstances to judge whether the drugs were intended for distribution, considering, for example, whether the drugs are packaged for sale. *See United States v. Hollman*, 541 F.2d 196, 200 (8th Cir. 1976) (suggesting that many similar, individualized packages of drugs supported the inference of intent to distribute rather than personal use).

140. 21 U.S.C. § 856(a) (2006); *see also* U.S. Drug Enforcement Admin., FAQs About the Illicit Drug Anti-Proliferation Act, [http://www.usdoj.gov/dea/ongoing/anti-proliferation\\_act.html](http://www.usdoj.gov/dea/ongoing/anti-proliferation_act.html) (last visited Apr. 24, 2009).

141. 132 CONG. REC. 26,474 (1986) (excerpt of Senate Amendment No. 3034 to H.R. 5484, 99th Cong. (1986)).

142. As originally enacted, the statute made it an offense to:

- (1) knowingly open or maintain any place for the purpose of manufacturing, distributing, or using any controlled substance;
- (2) manage or control any building, room, or enclosure, either as an owner, lessee, agent, employee, or mortgagee, and knowingly and intentionally rent, lease, or make available for use, with or without compensation, the building, room, or enclosure for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance.

Anti-Drug Abuse Act of 1986, Pub. L. No. 99-570, § 1841(a), 100 Stat. 3207, 3207–52.

The term “crack house” does not appear in the statute, though it tended to guide the initial interpretation of the statute by law enforcement agents as well as judges. In one early decision interpreting the Crack House Statute, a court relied on a police officer’s definition of a crack house as:

A crack house can be a house or an apartment that’s main purpose is used to ingest crack. In these houses, the people who are crack users will come in just for the purpose of ingesting it.

Now in those houses . . . some small sales may also be made . . . [M]aybe 20 or 30 people at a time . . . congregate and sit around and smoke the crack.

. . . [S]omebody in the kitchen might also be making some more crack, and also, if you go to one of the other rooms, there will be acts of prostitution also going on in there.

Also most of these houses are very dirty and unkempt, and if you have a crack house in your neighborhood, they aren’t very hard to spot at all, because you would just watch for a while, you’d notice activity going on by and around the house 24 hours a day, people going in and out 24 hours a day . . .<sup>143</sup>

And indeed, the Crack House Statute provided a powerful tool in the 1980s and early 1990s for combating these “drug dens.”<sup>144</sup>

While § 856 was frequently and successfully used to target actual crack houses in its infancy,<sup>145</sup> in time, the courts upheld the use of the statute in punishing the operators and owners of drug-involved places that did not fit into the stereotype of a crack house. In these instances, courts inferred from the plain language of § 856 a purpose beyond eradicating crack houses: preventing a building from being used instrumentally in drug profiteering.<sup>146</sup> For

143. *United States v. Lancaster*, 968 F.2d 1250, 1254 n.3 (D.C. Cir. 1992).

144. Michael V. Sachdev, *The Party’s Over: Why the Illicit Drug Anti-Proliferation Act Abridges Economic Liberties*, 37 COLUM. J.L. & SOC. PROBS. 585, 588 (2004) (“[The Crack House Statute] had a fervent childhood, nailing a number of crack-cocaine distribution rings and detoxifying urban America by punishing absentee slumlords for allowing their blighted urban properties to become drug dens.” (citing Am. Council for Drug Educ., *Basic Facts About Drugs: Cocaine*, <http://www.acde.org/common/Cocaine.htm> (last visited Apr. 24, 2009))).

145. Section 856 cases involving typical crack houses are straightforward and have generally involved residences or abandoned buildings that are being used for the sale, manufacture, or non-recreational use of illicit drugs. *See e.g.*, *United States v. Morgan*, 117 F.3d 849, 855–57 (5th Cir. 1997); *United States v. Verners*, 53 F.3d 291, 295–97 (10th Cir. 1995); *United States v. Cabbell*, 35 F.3d 1255, 1261–62 (8th Cir. 1994); *United States v. Church*, 970 F.2d 401, 405–06 (7th Cir. 1992).

146. *See, e.g.*, *United States v. Becker*, 230 F.3d 1224, 1227 (10th Cir. 2000) (defendant manufactured methamphetamine in his home); *United States v. Moore*, 184 F.3d 790, 792–93 (8th Cir. 1999) (defendant unloaded drug shipments and used his home for storage facility in drug conspiracy); *United States v. Bilis*, 170 F.3d 88, 89–90 (1st Cir. 1999) (defendant bar owner purchased drugs and warned drug dealers of police surveillance); *United States v. Soto-Silva*, 129 F.3d 340, 342–43 (5th Cir. 1997) (defendant handled money for drug-trafficking enterprise,

example, the statute was used against hotel owners who were knowingly renting rooms for drug sales, loaning money for drug purchases, and warning dealers of police presence;<sup>147</sup> and against a car dealership owner selling cocaine out of his dealership.<sup>148</sup> In the case of the car dealership, the court acknowledged that the establishment was not a “crack house” in the common sense of the term, but held that it fell within the plain language of the statute because the defendant was “manufacturing, storing, distributing or using a controlled substance” on the premises.<sup>149</sup>

In time the fear of a crack epidemic was supplanted on the drug war agenda by a new source of panic: the use of “ecstasy” by young people at “rave” parties. In 2002, then-Senator Joseph Biden introduced the Reducing Americans Vulnerability against Ecstasy Act (RAVE Act), which was, he explained, intended (in spite of the dramatic title) merely to accomplish a technical change to the Crack House Statute that would ensure that it could be applied to “rogue promoters” who were knowingly using property episodically or on a one-time basis for illegal drug purposes.<sup>150</sup> Biden’s first bill succumbed to a groundswell of criticism over its name and its indiscriminate

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smuggled drugs, and provided her property for packaging); *United States v. Cooper*, 966 F.2d 936, 937–39 (5th Cir. 1992) (defendant distributed crack out of his private club); *Lancaster*, 968 F.2d at 1251–52 (defendant arranged for drug sales on his property); *United States v. Clavis*, 956 F.2d 1079, 1083–84 (11th Cir. 1992) (defendant used his home for temporary storage of drugs and distribution to drug sellers); *United States v. Tamez*, 941 F.2d 770, 772–73 (9th Cir. 1991) (defendant used car dealership for cocaine trafficking, used cocaine, and purchased cars for business with proceeds from illegal drug activity); *United States v. Chen*, 913 F.2d 183, 186 (5th Cir. 1990) (defendant motel owner alerted drug sellers of police presence, stored drugs on premises, and loaned money for the purchase of drugs for resale).

147. *Chen*, 913 F.2d at 186.

148. *Tamez*, 941 F.2d at 772–73.

149. *Id.* at 773.

150. 149 CONG. REC. 1846–47 (2003) (statement of Sen. Biden). During the debate about the RAVE Act and in response to concerns about widening the traditional scope of § 856, Senator Biden stated:

Our bill provides Federal prosecutors the tools needed to combat the manufacture, distribution or use of any controlled substance at any venue whose purpose is to engage in illegal narcotics activity. Rather than create a new law, our bill merely amends a well-established statute to make clear that anyone who knowingly and intentionally uses their property, or allows another person to use their property, for the purpose of distributing or manufacturing or using illegal drugs can be held accountable, regardless of whether the drug use is ongoing or occurs at a single event . . . .

. . . .

. . . . The purpose of my legislation is not to prosecute legitimate, law-abiding managers of stadiums, arenas, performing arts centers, licensed beverage facilities and other venues because of incidental drug use at their events . . . . My bill would help in the prosecution of rogue promoters who not only know that there is drug use at their event but also hold the event for the purpose of illegal drug use or distribution.

*Id.*

demonization of raves,<sup>151</sup> but then he successfully inserted the same statutory language, *sans* the inflammatory title, in a larger bill.<sup>152</sup> The amendments brought within the Crack House Statute's coverage occasional property users, but did not change its focus: the manufacture, distribution, or use of any controlled substance at any venue whose purpose is to engage in illegal narcotics activity.<sup>153</sup> The 2003 amendments reaffirmed the dual historical and legislative purpose of the Crack House Statute in targeting places that are maintained for illegal drug use and striking at those who profit from such places.

*D. Applying the Crack House Statute (§ 856) to an SIF: Statutory and Constitutional Complexities*

Federal opponents of an SIF would surely seek to cast its illegality as a simple case. Unlike other health facilities, SIFs host *illegal* drug use, which Congress plainly and intentionally prohibited in § 856. The argument has the virtue of simplicity, but not of analytic rigor, and its force diminishes steadily as one acknowledges the legitimate medical purposes animating the SIF, and the reasonableness of a government decision to sponsor the intervention in light of the evidence available today. The CSA is concerned with health and health care, not just the control of illicit drug use, and it explicitly respects the state role in crafting drug-related policy.<sup>154</sup> Indeed, a decision by the federal government to use the CSA to shut down so reasonable an exercise of the police power would afford the Supreme Court an interesting opportunity to set a clear outer bound on the Commerce power.

151. Sachdev, *supra* note 144, at 587.

152. Illicit Drug Anti-Proliferation Act of 2003, Pub. L. No. 108-21, § 608, 117 Stat. 650, 691 (2003) (codified as amended at 21 U.S.C. § 856 (2006)); *see also* Sachdev, *supra* note 144, at 595 & n.68 (discussing the passage of the Illicit Drug Anti-Proliferation Act within the Amber Alert Bill).

153. The amendments altered the original statute as follows:

(1) knowingly ~~open or maintain any place~~ 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 ~~building, room, or enclosure~~ 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 ~~building, room, or enclosure~~ place for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance.

§ 608(b), 117 Stat. at 691.

154. 21 U.S.C. § 903 (2006).



### 1. Construing the Crack House Statute

The current version of § 856(a) makes it illegal, “except as authorized by this subchapter,” 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.<sup>155</sup>

It is not perfectly clear, as a threshold matter, which section would apply to the sort of SIF we hypothesize. Many courts have grappled with distinguishing and defining the provisions, their relationship,<sup>156</sup> and the degree to which the provisions can simultaneously apply.<sup>157</sup> Some have read the two subsections as effectively prohibiting the same general activity, except that subsection (a)(2) requires the additional element of having made the premises available to others.<sup>158</sup> Other courts have reasoned that the provisions prohibit the same activity, just by different actors.<sup>159</sup> The most common interpretation of the two provisions—and the one that now appears to be prevailing—is that subsection (a)(1) is aimed at those individuals who own and operate crack houses and subsection (a)(2) is aimed at those individuals who may not have opened or maintained the premises, but who knowingly allowed others to make the premises available for illegal purposes.<sup>160</sup> For reasons that we hope will become clear, there is a reasonable basis for the position that § 856 does not bar a state-authorized SIF regardless of which subsection comes into play. We

155. *Id.* § 856(a).

156. There has been some confusion about the extent to which the two provisions differ. Richard Belfiore, Annotation, *Validity, Construction, and Application of Federal “Crack-House Statute” Criminalizing Maintaining Place for Purpose of Making, Distributing, or Using Controlled Drugs (21 USCS § 856)*, 116 A.L.R. Fed. 345 (1993 & Supp. 2008–2009).

157. *See id.* (discussing decisions holding that § 856(a)(1) and (a)(2) are duplicative and therefore, the convictions to the lesser included offenses must be vacated).

158. *See e.g.*, *United States v. Morehead*, 959 F.2d 1489, 1507 (10th Cir. 1992) (holding that although subsection (a)(2) requires an additional element—making the premises available to others—the offenses are multiplicitous, and thus, in instances where a defendant is charged with both subsections, the subsection (a)(1) charge should be dismissed as the lesser-included offense).

159. *United States v. Chen*, 913 F.2d 183, 190 (5th Cir. 1990) (finding that subsection (a)(1) applies to lessees or people who actively maintain a place for the proscribed activity while subsection (a)(2) applies to lessors or a person “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” (alteration in original) (quoting 21 U.S.C. § 856 (a)(2))).

160. *See, e.g.*, *United States v. Wilson*, 503 F.3d 195, 197–98 (2d Cir. 2007).

assume for the following discussion that a state has undertaken to operate the SIF itself, on its own premises, and that a challenge would be raised under subsection (a)(1). We also assume, for narrative convenience, that adverse federal action would be initiated by the Attorney General. This adverse action could take the form of an injunction proceeding, criminal indictments referred through the corresponding U.S. Attorney's Office,<sup>161</sup> or an action to strip the licenses of SIF operators. We view this last option as the least likely in light of precedent discussed below.<sup>162</sup>

Courts have applied § 856 to a wide variety of places<sup>163</sup> that have been used for illegal drug activity.<sup>164</sup> The argument that an SIF should likewise be

161. The Attorney General has the authority to initiate injunction proceedings against persons deemed to be in violation of § 856 and other provisions of the subchapter. 21 U.S.C. § 882 (2006). In trials concerning alleged violations of injunctions, defendants are statutorily entitled to trial by jury. *Id.* § 882(b). Jury trials are of course provided in federal criminal actions of the type that would result from prosecution under the Crack House Statute. This is perhaps as good an opportunity as any to recall the potential impact of jury nullification. Given the sharp disconnect between the legislative intent of § 856 and its potential use in prosecuting state actors working in good faith for betterment of public health, jury nullification could possibly provide some political cover to federal officials who feel compelled to honor the culture of prohibitionist absolutism. This is, however, ultimately a thin reed to rely on for front-line SIF operators facing potentially severe penalties, notwithstanding the resurgence of jury nullification in popular and scholarly circles. *See, e.g.,* Nancy J. King, *Silencing Nullification Advocacy Inside the Jury Room and Outside the Courtroom*, 65 U. CHI. L. REV. 433, 434–35, 448 (1998) (discussing the nullification advocacy and moderately increased academic support for jury nullification).

162. For a discussion of *Gonzales v. Oregon*, see *infra* Part III.D.2. It is difficult to see how the Supreme Court could allow the Attorney General to prevent non-licensed or non-prescribing health care providers from caring for infections and providing counseling at an SIF given the *Gonzales* decision striking down Attorney General Ashcroft's authority to prohibit DEA-licensed physicians from prescribing lethal doses of controlled substances. The fact that there is no prescribing of controlled substances involved in the primary work of an SIF would further attenuate this approach to control, as would the fact that most staff would probably not have DEA licenses in the first place.

163. *See, e.g.,* *United States v. Hurt*, 137 Fed. App'x 192 (10th Cir. 2005) (applying the statute to an apartment building); *United States v. Becker*, 230 F.3d 1224 (10th Cir. 2000) (to a home); *United States v. Meshack*, 225 F.3d 556 (5th Cir. 2000) (a restaurant); *United States v. Bilis*, 170 F.3d 88 (1st Cir. 1999) (a bar); *United States v. Cooper*, 966 F.2d 936 (5th Cir. 1992) (a private club); *United States v. Tamez*, 941 F.2d 770 (9th Cir. 1991) (a car dealership); *Chen*, 913 F.2d 183 (a motel).

164. The statute has also been applied against a wide spectrum of drug-involved activity, but rarely if ever where the only drug-related activity was personal use. The list of activities includes manufacturing, *see, e.g., Becker*, 230 F.3d 1224 (defendant manufactured methamphetamine in his home); packaging drugs for distribution, *see, e.g., United States v. Soto-Silva*, 129 F.3d 340 (5th Cir. 1997) (defendant handled money for drug-trafficking enterprise, smuggled drugs, and provided her property for packaging); storing of drugs, *see, e.g., United States v. Moore*, 184 F.3d 790 (8th Cir. 1999) (defendant unloaded drug shipments, used his home for storage facility in drug conspiracy); *United States v. Clavis*, 956 F.2d 1079 (11th Cir. 1992) (defendant used his home for temporary storage of drugs, distribution to drug sellers); distributing or trafficking

seen merely as a place “maintain[ed] . . . for the purpose of . . . using any controlled substance,”<sup>165</sup> would, however, necessarily invite the court to ignore the difference between drug dealers using a place in the course of an illicit commercial activity aimed at generating profits and licensed health care providers working under state auspices to reduce the individual and social costs of drug consumption and encourage treatment and rehabilitation of drug users.<sup>166</sup> This is the plainest of plain language arguments: *read it fast, don’t think too hard and don’t read it again*. At the first sign of judicial reflection, the Attorney General’s lawyers can fall back on an equally simplistic argument about the policy underlying the CSA: *drugs bad; prosecution good*.<sup>167</sup> If, despite the asserted clarity of the statutory text, congressional intent somehow came into the analysis,<sup>168</sup> the result would not change: Congress, the

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controlled substances, *see, e.g., Cooper*, 966 F.2d 936 (defendant distributed crack out of his private club); actively making drug sales, *see, e.g., United States v. Williams*, 923 F.2d 1397 (10th Cir. 1990); facilitating drug sales, *see, e.g., Chen*, 913 F.2d 183 (defendant motel owner alerted drug sellers of police presence, stored drugs on premises, loaned money for the purchase of drugs for resale); and widespread and routine using in combination with drug distribution, *see, e.g., United States v. Lancaster*, 968 F.2d 1250 (D.C. Cir. 1992) (over a number of months, large groups of individuals consistently gathered in the house to use crack cocaine, undercover officers were able to purchase crack cocaine, and witnesses testified to the ready availability of drugs on the premises for sale). Courts have indicated that the application of § 856(a)(1) would be inappropriate in the instance of “the ‘casual’ drug user . . . because he does not maintain his house for the purpose of using drugs but rather for the purpose of residence, the consumption of drugs therein being merely incidental to that purpose.” *Lancaster*, 968 F.2d at 1253.

165. 21 U.S.C. § 856(a) (2006).

166. Critics of the statute’s broad sweep have, to some degree, been reassured by prosecutorial practice. Testifying before Congress, Graham Boyd, Director of the ACLU Drug Policy Litigation Project, said that the statute’s “saving grace . . . has been a uniform practice of targeting only those business owners who commit substantive drug offenses or conspire with those that are committing drug offenses—in other words, criminals who distribute drugs.” *Reducing Americans’ Vulnerability to Ecstasy Act of 2002: Hearing on H.R. 5519 Before the H. Judiciary Subcomm. on Crime, Terrorism, and Homeland Security of the H. Comm. on the Judiciary*, 107th Cong. 49 (2002), available at <http://www.aclu.org/drugpolicy/raves/10725leg20021010.html>.

167. This is not to concede that an SIF would fail within a simplistic war-on-drugs analysis. Despite the conventional view that harm reduction programs are in derogation of a zero-tolerance, abstinence-only framework of drug control, it is plausible to see harm reduction, for better or worse, as a continuation of the war on drugs by other means. Although harm reduction programs do not demand abstinence or set it as a goal, an SEP or SIF might as well be a billboard for the dangers of illegal drug use. The focus of the program, enacted daily in countless encounters with clients, is on the bad things that can happen to people when they use drugs. Thus, do harm reduction programs spread the message of drugs’ dangers in a means calculated to reach people undeterred by DARE and public service announcements on late night TV.

168. Strictly speaking, textual ambiguity is a precondition for consideration of legislative intent in traditional statutory construction. *See, e.g., Conn. Nat’l Bank v. Germain*, 503 U.S. 249, 253 (1992) (“[W]hen the words of a statute are unambiguous, then, this first canon is also the last: judicial inquiry is complete.”); *INS v. Cardozo-Fonseca*, 480 U.S. 421, 452 (1987) (Scalia, J.,

government would argue, always intends to take the hardest possible line on illicit drug use, and would therefore make no distinction between a crack den and some misguided state simulacrum of one.

Can it be that simple? We think not. The plain language of the statute can be plausibly read to exclude bona fide health facilities authorized under state law. If a court turns for guidance to legislative intent, it will find no support for applying the statute to an evidence-based public health intervention conducted by licensed health care providers pursuant to state authorization—unless it simply imputes to Congress an abstract commitment to arrest and prosecution as the sole means of addressing illicit drugs. This is clearly not the case: Congress is clear that “[t]he success of Federal drug abuse programs and activities requires a recognition that education, treatment, rehabilitation, research, trainings and law enforcement efforts are interrelated” and that “[c]ontrol of drug abuse requires . . . both effective law enforcement . . . and effective health programs.”<sup>169</sup> The CSA is a health promotion and drug treatment statute, not just a warrant for arresting drug traffickers. In preemption terms, Congress has not made the requisite clear statement of an intention to displace the state’s regulation of what constitutes proper health care for and public health interventions among drug users. The CSA itself recognizes and protects local policy making in its savings clause, which protects state laws that do not create a positive conflict with a CSA provision.<sup>170</sup> Unlike California’s medical marijuana scheme, which created an unavoidable Supremacy Clause conflict with the CSA, the Crack House Statute can only be applied to a state SIF through the sort of regulatory over-reaching by the federal government that the Supreme Court rejected in the Oregon Death with Dignity case.<sup>171</sup> Ultimately, federal suppression of a state SIF would pose a serious question about Congress’s authority under the Commerce Clause.

The climb down from the heights of rhetorical abstraction might as well begin with the language of the statute. Section 856 does not apply to any activity authorized under Subchapter I of the statute.<sup>172</sup> This subchapter generally deals with the licit medical and scientific uses of controlled substances, which is why the broad language of § 856 does not sweep in hospitals and doctors’ offices and the landlords who rent to them. The

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concurring) (“Judges interpret laws rather than reconstruct legislator’s intentions. Where the language of those laws is clear, we are not free to replace it with an unenacted legislative intent.”).

169. 21 USC § 1101 (2006).

170. *Id.* § 903.

171. *Gonzales v. Oregon*, 546 U.S. 243 (2006).

172. 21 U.S.C. §§ 801–904.

subchapter also includes a general savings provision specifying Congress's intentions with respect to state law in the drug field:

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*.<sup>173</sup>

If § 903 affirms the validity of state drug-related legislation that is not patently incompatible with federal law, then a valid state authorization of an SIF would constitute authorization under the subchapter and therefore remove the SIF from the coverage of § 856—unless the authorization creates such a positive conflict with § 856 that the two “cannot consistently stand together.”<sup>174</sup> This might at first blush look circular, but in fact we are presented with a perfectly linear, though hardly simple, question of statutory interpretation that cannot be answered by pretending the relevant language is plain. By its structure, § 856 excludes bona fide medical and scientific interventions involving controlled drugs, which it defines by reference to those activities authorized under the subchapter.<sup>175</sup> The SIF we hypothesize would be a health care facility, serving as an instrument of public health and helping to reduce the disorder and other social costs associated with drug dependency. It would be authorized as such under state law. That it might be described as a place “knowingly . . . maintain[ed] . . . for the purpose of . . . using any controlled substance,” no more resolves the matter than it would in the case of a pain clinic or a hospice.

Thus we may turn to legislative intent to show that a public health intervention like an SIF would not have been seen as conflicting with § 856 or the CSA as a whole.<sup>176</sup> The CSA is not simply a declaration of criminal

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173. *Id.* § 903 (emphasis added).

174. *Id.*

175. Of course, if the staff of a hospital or clinic were to provide controlled substances without a legitimate medical purpose in the usual course of practice, they would no longer be within the definitional safe harbor, and would be subject to prosecution for distribution. In that case, the hospital or clinic or office could be prosecuted as a crack house—if those responsible were aware of the illegal activity. See, e.g., Robin Fitzgerald, *Three Given Bond in ‘Pill Mill’ Case, Ruling on Doctor Pending*, SUN HERALD, Aug. 12, 2008, at A1.

176. The application of § 856 to an SIF might well prove to be the occasion for another Supreme Court debate about textualism versus “contextualism” in federal statutory construction. See, e.g., *Almedarez-Torres v. United States*, 523 U.S. 224, 228–39 (1998). For a discussion of the various permutations of statutory interpretive theories over the last century, see also Jonathan T. Molot, *The Rise and Fall of Textualism*, 106 COLUM. L. REV. 1 (2006); John F. Manning, *Textualism and the Equity of the Statute*, 101 COLUM. L. REV. 1 (2001); Caleb Nelson, *What Is Textualism?*, 91 VA. L. REV. 347 (2005). One must assume that both the text of the statute and legislative intent—divined from some combination of “the statute’s language, structure, subject

justice's war on drugs.<sup>177</sup> Consistent with our international treaty obligations,<sup>178</sup> the CSA creates a regime that deals comprehensively with the control and appropriate use of dangerous drugs, which requires balancing the control of trafficking and illicit possession with the legitimate use of controlled drugs for health purposes. The chapter of which it is a part also has the purpose of supporting and facilitating drug treatment and rehabilitation.<sup>179</sup> The

matter, context, and history," *Almendarez-Torres*, 523 U.S. at 228—will be salient in any court's analysis.

177. See, e.g., *Gonzales v. Oregon*, 546 U.S. 243, 288–89 (Scalia, J., dissenting) (describing the broad sweep of the CSA beyond controlling drug abuse).

178. The United States is a signatory to the three main international drug treaties. See United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, Dec. 20, 1988, 28 I.L.M. 493 [hereinafter Convention on Narcotic Drugs]; Single Convention on Narcotic Drugs, March 30, 1961, T.I.A.S. No. 6298, 520 U.N.T.S. 204, *amended* by Protocol Amending the Single Convention on Narcotic Drugs, 1961, March 25, 1972, T.I.A.S. 8118 [hereinafter Single Convention]; Convention on Psychotropic Substances, Feb. 21, 1971, T.I.A.S. No. 9725, 1019 U.N.T.S. 175. All were enacted before the HIV/AIDS epidemic made the transmission of blood-borne disease through drug injection a major international health problem, but all include provisions in their preambles and their substantive provisions affirming the obligation of signatories to address the needs of people with drug dependence for drug treatment and other health and social services. See, e.g., Single Convention, *supra*, art. 38 ("Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved . . ."); Convention on Narcotic Drugs, *supra*, art. 14 & 12 (requiring that "Parties [to the Convention] shall adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances, with a view to reducing human suffering" which includes interventions to counteract the social and health consequences of drug abuse); Convention on Psychotropic Substances, *supra* ("The Parties, being concerned with the health and welfare of mankind, [agree to] . . . recogniz[e] that the use of psychotropic substances for medical and scientific purposes is indispensable and that their availability for such purposes should not be unduly restricted."). As Ian Malkin has argued, the interpretation of terms like "rehabilitation," "treatment," and "social reintegration" is left to the parties, see Malkin, *supra* note 15, at 715–17, and the UNODC's lawyers have opined that an SIF could fit well within those terms, see U.N. Int'l Drug Control Programme [UNDCP], Legal Affairs Section, *Flexibility of Treaty Provisions as Regards Harm Reduction Approaches*, ¶¶ 23–24, U.N. Doc E/INCB/2002/W.13/SS.5 (Sept. 30, 2002) [hereinafter UNDCP, *Flexibility of Treaty Provisions*].

179. In the late 1980s, scholars in the United States began to comprehensively study how efforts to stem diversion undermine the availability of controlled substances for legitimate purposes such as the treatment of pain. See, e.g., David E. Joranson & June L. Dahl, *Achieving Balance in Drug Policy: The Wisconsin Model*, in 11 ADVANCES IN PAIN RESEARCH AND THERAPY 197 (C. Stratton Hill, Jr. & William S. Fields eds., 1989). This scholarship reinvigorated the idea—seldom appreciated and increasingly marginalized in developing policy circles at the time—that treaty obligations of the United States, see sources *supra* note 178, require that efforts to reduce diversion of controlled substances be balanced against the need to provide access to controlled substances for medical care. The salience of this "principle of balance" is evident by the fact that the CSA explicitly implements the treaties from which the principle derives and by the multifaceted nature of the CSA itself as a framework that furthers a wide range of health-related objectives. The bill that created the CSA listed diversion efforts as

same is true specifically of the legislation that added § 856 to the CSA.<sup>180</sup> Thus, it is not enough to contend that an SIF tolerates or facilitates illegal drug

one of three important objectives in “dealing with the growing menace of drug abuse” by stating its aims as:

- (1) . . . providing authority for increased efforts in drug abuse prevention and rehabilitation of users, (2) . . . providing more effective means for law enforcement aspects of drug abuse prevention and control, and (3) by providing for an overall balanced scheme of criminal penalties for offenses involving drugs.

Comprehensive Drug Abuse Prevention and Control Act of 1970, H.R. 18583, 91st Cong. (1970), H.R. Rep. No. 1444 (1970), *as reprinted in* 1970 U.S.C.C.A.N. 4566, 4567.

The CSA itself includes introductory language noting that “many of the drugs . . . [regulated under it] have a useful and legitimate medical purpose and are necessary to maintain the health and general welfare of the American people.” 21 U.S.C. § 801(1) (2006). As a result, “[i]n implementing the Convention on Psychotropic Substances, the Congress intends” to ensure that:

- (A) the availability of psychotropic substances to manufacturers, distributors, dispensers, and researchers for useful and legitimate medical and scientific purposes will not be unduly restricted; (B) nothing in the Convention will interfere with bona fide research activities; and (C) nothing in the Convention will interfere with ethical medical practice in this country as determined by the Secretary of Health and Human Services on the basis of a consensus of the views of the American medical and scientific community.

21 U.S.C. § 801a(3), *cited with approval in Gonzales*, 546 U.S. at 266–67.

Along the way, various other health-based amendments have been added to the CSA. *See, e.g.*, Drug Addiction Treatment Act of 2000, Pub. L. No. 106-310, tit XXXV, 114 Stat. 1222 (codified as amended at 21 U.S.C. § 823(g) (2006)).

180. As one court noted while interpreting § 856(a):

Section 856 was part of comprehensive drug legislation passed in October 1986, designed “to strengthen Federal efforts to encourage foreign cooperation in eradicating illicit drug crops and in halting international drug traffic, to improve enforcement of Federal drug laws and enhance interdiction of illicit drug shipments, to provide strong Federal leadership in establishing effective drug abuse prevention and education programs, to expand Federal support for drug abuse treatment and rehabilitation efforts, and for other purposes.”

*United States v. Chen*, 913 F.2d 183, 188 (5th Cir. 1990) (quoting H.R. 5484, 99th Cong. (1986), 132 Cong. Rec. S13779 (daily ed. Sept. 26, 1986)). Indeed, numerous provisions of the 1986 legislation creating the Crack House Statute were focused on improving treatment of drug addiction and ameliorating the public health harms associated with drug abuse, beyond simply proscribing and prosecuting use. Sections in the 1986 bill provided massive funding for drug treatment programs and drug treatment centers, Anti-Drug Abuse Act of 1986, Pub. L. No. 99-570, § 4002, 100 Stat. 3207-102 (codified as amended at 21 U.S.C. § 801 (2006)) (Special Alcohol Abuse and Drug Abuse Programs); provided funding for vocational training, job counseling, and education equivalency programs to alcohol abusers and drug abusers in need of such services, *id.*; modified the mandate and structure of the Alcohol, Drug Abuse, and Mental Health Administration, *id.* § 4003, 100 Stat. 3207-106 (codified as amended at 42 U.S.C. 290aa (2000)); provided funding for the training of professional students in the identification and treatment of alcohol and drug abuse, *id.*; provided funding for educating the public with respect to the health hazards of alcoholism, alcohol abuse, and drug abuse, and ensuring the widespread dissemination of current publications of the National Institute on Alcohol Abuse and Alcoholism

use, though this is certainly a true fact. The question of the SIF's character as a treatment and rehabilitation intervention must also be taken seriously.<sup>181</sup> The CSA is explicit in recognizing that many controlled substances with the potential for abuse have legitimate medical uses.<sup>182</sup> Moreover, the CSA explicitly states that "nothing in the Convention will interfere with ethical medical practice in this country."<sup>183</sup> What exactly constitutes legitimate medical practice has been much debated in recent years, including during the Court's disposition of *Gonzales v. Oregon*,<sup>184</sup> but certainly encompasses "the prevention, cure, or alleviation of disease."<sup>185</sup> Traditional treatment for drug abuse and the care and treatment of injection-related infections are certainly encompassed within "medical practice"; given the increasingly widespread appreciation for harm reduction services, the preventive activities of SIFs (providing clean needles and paraphernalia, offering guidance, etc.) may be reasonably viewed as medical practice as well.

Lawyers are already grappling with this issue at the international level and in other countries. In 2002, for example, the lawyers at the United Nations International Drug Control Programme (now the UN Office on Drugs and Crime) prepared an opinion for discussion at the 75th session of the

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and the National Institute on Drug Abuse, *id.*; established an Office for Substance Abuse Prevention, *id.* § 4005, 100 Stat. 3207-111 (codified as amended at 42 U.S.C. 290aa (2000)); established a clearinghouse for alcohol and drug abuse information to assure the widespread dissemination of such information to States, *id.*; and provided grants for public and nonprofit private entities for projects to demonstrate effective models for the prevention, treatment, and rehabilitation of drug abuse and alcohol abuse among high risk youth, *id.*

181. The CSA facilitates rehabilitation and treatment by providing for the registration and regulation of physicians that dispense controlled substances for maintenance or detoxification treatment. 21 U.S.C. § 823(g) (2006). The CSA also implicates the practice of medical care in how it impacts the use of controlled substances in areas outside of addiction, including the treatment of pain and palliative care. In light of concerns that the CSA overly burdens access to opiates and other controlled substances needed in the treatment of pain, *see supra* note 179, federal agencies have re-affirmed their role in ensuring that anti-diversion efforts do not compromise the provision of medical care. *See, e.g.*, Dispensing Controlled Substances for the Treatment of Pain Notice, 71 Fed. Reg. 52,716, 52,719-20 (Sept. 6, 2006) ("DEA takes just as seriously its obligation to ensure that there is no interference with the dispensing of controlled substances to the American public in accordance with the sound medical judgment of their physicians.").

182. Indeed, the first finding upon which the statute is founded notes that the CSA regulates many drugs that "have a useful and legitimate medical purpose and are necessary to maintain the health and general welfare of the American people." 21 U.S.C. § 801(1) (2006).

183. *Id.* § 801a(3). This section goes on, "as determined by the Secretary of Health and Human Services on the basis of a consensus of the views of the American medical and scientific community." *Id.*

184. *Gonzales*, 546 U.S. 243. For a discussion of *Gonzales* as it relates to the broader question at hand in the Article, *see infra* notes 203-21 and accompanying text.

185. *Gonzales*, 546 U.S. at 285 (Scalia, J., dissenting) (quoting WEBSTER'S NEW INTERNATIONAL DICTIONARY 1527 (2d ed. 1950)) (internal quotation marks omitted).



International Narcotics Control Board.<sup>186</sup> It described how an SIF—even an SIF that included prescription of the client’s drug—could be harmonized with the international drug control treaties:

It might be claimed that this approach is incompatible with the obligations to prevent the abuse of drugs, derived from article 38 of the 1961 Convention and article 20 of the 1971 Convention. It should not be forgotten, however, that the same provisions create an obligation to treat, rehabilitate and reintegrate drug addicts, whose implementation depends largely on the interpretation by the Parties of the terms in question. If, for example, the purpose of *treatment* is not only to cure a pathology, but also to reduce the suffering associated with it (like in severe-pain management), then reducing IV drug abusers exposure to pathogen agents often associated with their abuse patterns (like those causing HIV-AIDS, or hepatitis B) should perhaps be considered as treatment. In this light, even supplying a drug addict with the drug he depends on could be seen as a sort of rehabilitation and social reintegration, assuming that once his drug requirements are taken care of, he will not need to involve himself in criminal activities to finance his dependence.<sup>187</sup>

As the Supreme Court of British Columbia found in the case of the Vancouver SIF:

While users do not use Insite 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.<sup>188</sup>

To argue plausibly from congressional intent would require some notice of the ways an SIF could, based on current evidence, promote the statutes’ public health goals, as well as at least some consideration of the international data and experience to date, which suggest that SIFs do not have a significant adverse impact on drug control efforts.<sup>189</sup> In short, a court sincerely devoted to

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186. See UNDCP, *Flexibility of Treaty Provisions*, *supra* note 178.

187. *Id.* ¶ 23.

188. PHS Cmty. Servs. Soc’y v. Att’y General of Can., [2008] B.C.S.C. 661, ¶ 136 (Can.).

189. The intent problem here brings to mind the analogous issue of whether or not drug paraphernalia laws prohibit state-authorized syringe exchange programs. Drug paraphernalia laws generally prohibit the distribution of any item of any kind with knowledge that it will be used for illegal drug consumption. SEPs entail distributing syringes, cookers, cotton, water, and often bleach with the purpose of preventing HIV transmission but with knowledge that the items will be used for illegal drug consumption. In order to eliminate any possible uncertainty about the applicability of drug paraphernalia laws, a number of states simply amended their paraphernalia laws or otherwise positively authorized syringe exchange programs. In a few places, however, local governments took the position that SEPs did not violate the paraphernalia laws in the first place. The argument was one of intent: paraphernalia laws, though quite broad in their terms, were passed to deal with head shops—commercial operations benefiting financially from selling items for illegal drug use—and were never meant to interfere with bona fide public

determining whether § 856 was meant to reach a state public health measure would have to grapple candidly with the same considerations of epidemiology, evaluation data, behavioral research, health care costs, and public order that convinced the state to authorize the SEP in the first place. And to determine that the SIF was illegal on this view, it would have to decide that Congress intended to significantly constrain states in the exercise of their traditional police powers.<sup>190</sup>

If we do not start with the conclusion—i.e., with the premise that a public health SIF is merely a state-sponsored crack den—we have to take seriously the question of why a state-authorized medical facility for preventing public health harms of drug use would be treated differently than other facilities authorized under the CSA. Clearly some construction is required here. Many cases apply § 856 to settings that depart from the stereotype of the crack house, but every single one is a site where illegal drug business has been transacted for gain, so past cases give us no guidance as to how we distinguish places that legally operate to support use of controlled substances and those that do so illegally. In contrast to other health care facilities, the drugs consumed at an SIF are illicit, but that apparently stark difference begins to fade when placed against the background of the many other ways in which an SIF is indistinguishable in mission, culture, and mode of operation from any other health clinic.

Consider the text and the case law on the state of mind necessary to establish a violation. Conviction under the statute requires that the operation of the facility be “for the *purpose* of manufacturing, distributing, or using” a

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health measures. There has been almost no litigation on this question, but the one published opinion to reach the issue, a decision of the Washington Supreme Court, accepted this view. The case arose when a county health department proposed an SEP and the state attorney general opined that they were illegal under the paraphernalia law. The Court concluded:

It is undisputed the needles at issue in this case are “drug paraphernalia.” Those distributing the needles know they will be used to inject controlled substances unlawfully. Nevertheless, plaintiffs argue, the needle exchange program is authorized under the Washington Constitution, statutes granting broad powers to local health officials, and the omnibus AIDS act. Therefore, they conclude, the drug paraphernalia act, which is aimed at criminal conduct, simply does not apply to their actions. We agree, finding the [Spokane County Health Department]’s needle exchange program permissible under the constitution and statutes of this state.

*Spokane County Health District v. Brockett*, 839 P.2d 324, 328 (Wash. 1992).

190. Congress does from time to time do just that, *see, e.g.*, *United States v. Carolene Products Co.*, 304 U.S. 144 (1938) (upholding the congressional prohibition of “filled milk” despite the fact that the regulation of food was at the time predominantly within the traditional sphere of state regulation), but the presumption is that it does not without clearly stating the intention to do so. *See discussion supra* Part II.D.2. *See generally* PARMET, *supra* note 5 (analyzing the treatment of health measures by courts).

controlled substance.<sup>191</sup> Case law has noted that “purpose” and “knowledge” are separate elements.<sup>192</sup> A reasonable interpretation of “purpose” provides a fair and legitimate means of distinguishing between criminal enterprises using property as part of an illicit commercial drug venture and public or health care enterprises deploying controlled substances for therapeutic purposes or, as in the case of an SIF, allowing the use of drugs for therapeutic reasons. Just as a hospital is operated to treat patients, not to facilitate the use of controlled substances, and a methadone clinic is operated to treat drug dependency, not to facilitate the use of controlled substances, an SIF is operated to reduce the individual and social costs of drug injection, not to facilitate the use of controlled substances.

The interpretation of “purpose” in this way is quite familiar to students of the CSA: it is the same means used to solve the identical problem of distinguishing between legal and illegal provision of controlled substances by doctors.<sup>193</sup> The CSA regulates the medical use of controlled substances primarily “to prevent diversion of medically useful dangerous drugs into illegitimate channels.”<sup>194</sup> The line between the dedicated physician treating a patient and the doctor turned drug pusher is therefore whether the drug has been provided for “a legitimate medical purpose” in the “usual course of professional practice,” or has simply been sold without any medical justification in order to make money.<sup>195</sup> A doctor who is treating a real illness in a manner accepted as appropriate by her peers, who is maintaining proper records, monitoring the patient’s progress, making necessary referrals and otherwise behaving in a customary and transparent manner satisfies this standard.<sup>196</sup> A doctor who is selling prescriptions with no or cursory

191. 21 U.S.C. § 856(a)(1) (2006) (emphasis added).

192. *United States v. Chen*, 913 F.2d 183, 190 & n.9 (5th Cir. 1990).

193. *See* 21 U.S.C. § 830(b)(3)(A)(ii) (2006); *United States v. Moore*, 423 U.S. 122, 138–43 (1975).

194. 116 CONG. REC. 996 (1970) (statement of Sen. Dodd); *see also Moore*, 423 U.S. at 135; S. REP. NO. 91-613, at 4 (1969) (“The control drug abuse and of both the legitimate and illegitimate traffic in drugs is the main objective of the bill S. 3246.”). Congress was aware that physicians, who have the greatest access to controlled substances, were in some instances also the source of drugs diverted into illegal markets. *See Moore*, 423 U.S. at 135; 116 CONG. REC. 998, 1663 (respective statements of Sens. Griffin and Hruska). The only substantive rule of medical practice in the CSA is that physicians may not ordinarily prescribe controlled substances merely to satisfy an addiction. 21 U.S.C. § 829(c) (2006) (“No controlled substance in schedule V which is a drug may be distributed or dispensed other than for a medical purpose.”). Neither this issue nor the diversion concern is implicated by SIFs.

195. *Moore*, 423 U.S. at 135–38, 136 n.2 (quoting 21 C.F.R. § 306.04(a) (1973) (redesignated as 21 C.F.R. § 1306.04(a) (1975))).

196. *Id.* at 140–42.

examination, keeping no or useless records, and not seriously treating the patient, has crossed the line.<sup>197</sup>

By this test, the SIF surely looks legal. To start with, there is no question of prescribing controlled substances. The operation would be run on standard clinical lines: clients (patients) register; records are kept documenting progress; care is provided based on examination and clear medical need; and patients are referred to specialists for their addiction, HIV, or other needs. The basic medical care offered at the clinic, first aid and care for minor wounds and infection, is obviously proper and well-accepted. Perhaps the most “edgy” form of clinical intervention—advising people how to avoid infections or other injuries when injecting illegal drugs—is already done (albeit in the abstract) by SEPs and other forms of IDU outreach and education, and fares well when put to the *Moore* test: there is a legitimate medical purpose—preventing infection or injury—untainted by any commercial purpose or personal gain; the advice comes as part of a comprehensive clinical intervention, is based on individual need, and is documented.<sup>198</sup> It is not different, apart from the substance to be injected, than giving the same care to an insulin patient. Even if we accept that the SIF as a comprehensive intervention is novel, and therefore not common medical practice as a whole, the public health evidence and the state’s authorization amply support the conclusion that its purpose is legitimate.<sup>199</sup>

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197. See, e.g., *id.* at 142–43. In *Moore* the Court found the evidence sufficient to establish that defendant’s conduct “exceeded the bounds of ‘professional practice’” when he failed to give adequate physical examinations or gave none at all, ignored the results of the tests he did make, widely distributed methadone prescriptions at the clinic without taking precautions against its misuse and diversion or regulating the dosage at all, prescribing as much and as frequently as the patient demanded, and charging patients based on the number of tablets desired rather than medical services. *Id.* (“In practical effect, he acted as a large-scale ‘pusher’—not as a physician.”); see also *United States v. Hurwitz*, 459 F.3d 463, 474 (4th Cir. 2006) (finding enough evidence to sustain probable cause of illicit practice when given that defendant “had a reputation in the drug community for his practice of prescribing high amounts of narcotics,” demanding \$1000 cash “initiation fees” and \$250 cash monthly “maintenance fees,” allegations that defendant “made a common practice of fronting drugs rather than practicing medicine”); *United States v. Nelson*, 383 F.3d 1227 (10th Cir. 2004) (holding that a jury could find defendant’s practice of selling controlled prescription drugs over the internet without examining patients outside the course of usual professional practice); *United States v. Steele*, 147 F.3d 1316, 1317 (11th Cir. 1998) (noting that defendant was found on numerous occasions to have “dispensed controlled substances pursuant to prescriptions he knew to be forged”).

198. See discussion *supra* note 197.

199. In making this argument, we do not argue that a court would actually be interpreting the provisions of the CSA governing prescriptions, because no prescribing, dispensing or administering of controlled substances is involved in the operating of an SIF. We are simply drawing upon, and suggesting that a court would draw upon, the case law standards on “legitimate medical purpose” to interpret § 856. We assume here that there has been no specific regulation or interpretive guidance promulgated by the Attorney General defining the operation of

Like a hospital or a methadone clinic (and unlike a crack house) an SIF is operated with the staff of licensed health care providers for a therapeutic and preventive health purpose. To be sure, “purpose” is a word that is normally not construed to mean “sole” purpose. In at least one case, government lawyers have conceded that it requires “specific purpose,” but in another, a court has ruled that “sole purpose” is not required.<sup>200</sup> Still, previous cases dealing with this issue under § 856 have all dealt with it in regards to places being used in drug dealings, and the “other” purposes offered to defeat conviction were things like the ownership or control over the dwelling or participation in the drug trafficking.<sup>201</sup> 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. 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. Reading the statute to require an illegal purpose, and defining that in terms of directly or indirectly seeking to profit from illegal drug activity, provides a fairly bright line that distinguishes crack dens and shooting galleries from pharmaceutical factories, hospitals—and SIFs. By contrast, if the mere knowledge that drugs will be used on the premises is enough to establish that such use is the “purpose” of the defendant, then the “purpose” element adds nothing to the scienter requirement that is not already captured in the element of “knowingly.”<sup>202</sup>

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an SIF as being outside legitimate medical practice. We consider that possibility in our discussion of preemption, *infra* Part III.D.2.

200. *United States v. Chen*, 913 F.2d 183, 188 (5th Cir. 1990) (finding that the “for the purpose of” language contained in 21 U.S.C. § 856(a)(1) applies to the person who opens or maintains the place for the illegal activity and therefore, the person who manages or controls the building and then rents to others need not have the express purpose in doing so that drug related activity take place; rather, such activity is engaged in by others (others have the purpose)); *but see United States v. Roberts*, 913 F.2d 211, 220 (5th Cir. 1990) (holding that the defendant, who was convicted of aiding and abetting the maintenance of a place for the purpose of manufacturing “crack” cocaine in violation of 21 U.S.C. § 856(a)(1), was not entitled to have “primary” added to a jury instruction regarding “purpose” because the phrase in § 856(a)(1) making it “an offense to maintain a place for ‘the purpose’ of manufacturing or distributing cocaine . . . [was] within the common understanding of jurors and [required] no further elaboration”).

201. *See, e.g., United States v. Banks*, 987 F.2d 463 (7th Cir. 1993). The court in *Banks* held that it had been sufficiently shown that the defendant maintained a house as proscribed under § 856(a) where the defendant owned the house, fed the actual seller of crack, identified callers for the seller, and notified the seller of potential sales. *Id.* at 466. The court so found despite the fact that two other individuals were the supervisors of the crack house and the entrepreneurs who supplied the crack. *Id.* at 466–67. According to the court, the defendant’s role was “a step beyond a mere underling and a step beyond a mere landlord and therefore could be viewed as maintaining a managerial or supervisory role.” *Id.* at 467.

202. On this point, analogies with nuisance law are apt. In general, law prohibits activity that either unreasonably endangers the safety of others or involves a property being used for unlawful

The argument presented here provides a solid basis for deciding that a state-authorized SIF would not conflict with the purposes or language of § 856, and therefore that the savings provision of § 903 would be sufficient to constitute the authorization “under this subchapter” that excludes an activity from the coverage of § 856.

## 2. Preemption? The CSA Savings Clause and the Clear Statement Rule

The uncertainty around the application of § 856 implicates another way of looking at the question, one which the Attorney General might rely on if the going got tough. Rather than asking whether the doctors and nurses operating the SIF, or the state agency sponsoring it, are “criminals”—which after all no one really believes—the question can be posed in the more sterile terms of preemption: the state has, it would be argued, passed a law—authorizing an SIF—that purports to regulate an issue over which Congress has asserted sole jurisdiction. CSA regulates the area of controlled substances; while neither § 856 nor the CSA explicitly or implicitly “occupy the field,” § 856 does prohibit the operation of places that use drugs, and the CSA overall is aimed at stopping illegal drug use. Thus, a law that allows what § 856 prohibits is in direct conflict and undermines the CSA’s basic purpose, and state law authorizing an SIF is preempted by § 856.

The preemption perspective highlights how close this case is to *Gonzales v. Oregon*, but that hardly simplifies a prediction of the Court’s analysis.<sup>203</sup> The matter turns initially on whether the issue is simply the meaning of § 856 (or the meaning of “legitimate medical purpose”), or whether the Attorney General has issued some form of interpretive guidance or regulation formalizing her interpretation under one or both of these provisions. In the former situation we go straight to the preemption analysis; in the latter situation, as in *Gonzales*, there are the prior questions of whether the Attorney General has the authority to issue such an interpretation at all and, if so, what weight should be assigned it.

An unadorned preemption analysis is favorable to the state given the plausible interpretation of § 856 we have offered. Any form of preemption

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conduct. See, e.g., N.Y. PENAL LAW § 240.45 (McKinney 2008). Absent state authorization, an SIF would almost certainly run afoul of this type of provision. However, if the state authorized an SIF, the employees and the IDUs would not be engaging in “unlawful conduct,” and the premises would not be maintained for the purpose of engaging in unlawful conduct. Similarly, state authorization should give SIF operators a reasonable claim of “lawfulness” against a federal statute like § 856(a) that is predicated on knowingly maintaining a place for the purpose of unlawful—if unlawfulness is concededly read into the statute—drug activity.

203. There is no real preemption issue if the federal law clearly prohibits what the state purports to authorize; that is simply a matter of the Supremacy Clause (assuming the prohibition is within the federal government’s power), but as we have argued this case is not that easy.

analysis<sup>204</sup> begins with a presumption against finding that Congress intended to override state law in areas of traditional state regulation.<sup>205</sup> In service of this presumption, the Court requires the intent to preempt be, if not explicit, unmistakable: federalism dictates that “the historic police powers of the States [are] not to be superseded by [a federal law] unless that was the *clear and manifest* purpose of Congress.”<sup>206</sup> In the case of the CSA, Congress made explicit its intent to limit the preemptive effect of the statute in § 903.<sup>207</sup>

The *Gonzales* Court was emphatic about the limited scope of the CSA in relation to medical practice:

The statute and our case law amply support the conclusion that Congress regulates medical practice 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. Beyond this, however, the statute manifests no intent to regulate the practice of medicine generally. The 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.”<sup>208</sup>

The SIF has nothing to do with the prescribing of controlled substances. It is quite possible that no one involved in operating it would even have a DEA license. We have shown that the applicability of § 856 to the SIF is not clear, let alone manifest. If there are serious plain-language and legislative-intent arguments as to the inapplicability of the statute, and no doubt as to the modest intentions of Congress with respect to state health and medical regulation, the

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204. Although the concept can be difficult, *see, e.g.*, Stephen A. Gardbaum, *The Nature of Preemption*, 79 CORNELL L. REV. 767 (1994) (noting Congress’s power to preempt state law is unquestionable, yet “[t]he apparent precision, orderliness, and axiomatic quality of this black-letter position, however, conceals fundamental confusion in the thinking of judges and scholars alike about the underlying nature of preemption”), in general, preemption may be classified as express, conflict, or field. *Gade v. Nat’l Solid Waste Mgmt. Ass’n*, 505 U.S. 88, 108 (1992) (“Pre-emption may be either expressed or implied, and is compelled whether Congress’ command is explicitly stated in the statute’s language or implicitly contained in its structure and purpose. Absent explicit pre-emptive language, we have recognized at least two types of implied pre-emption: field pre-emption, where the scheme of federal regulation is so pervasive as to make reasonable the inference that Congress left no room for the States to supplement it, and conflict pre-emption, where compliance with both federal and state regulations is a physical impossibility . . . .” (citations omitted) (internal quotation marks omitted)). *See also* *English v. Gen. Elec. Co.*, 496 U.S. 72, 79 n.5 (1990) (“[F]ield pre-emption may be understood as a species of conflict pre-emption: A state law that falls within a pre-empted field conflicts with Congress’ intent (either express or plainly implied) to exclude state regulation.”).

205. *See English*, 496 U.S. at 79; *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977).

206. *See, e.g.*, *Wis. Pub. Intervenor v. Mortier*, 501 U.S. 597, 605 (1991); *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947) (emphasis added).

207. 21 U.S.C. § 903 (2006).

208. *Gonzales v. Oregon*, 546 U.S. 243, 269–70 (2006) (quoting *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996)) (internal quotation marks omitted).

general presumption against preemption and the CSA's "positive conflict" rule both militate against finding preemption.<sup>209</sup>

But matters are not likely to be that simple. As a preemption case, the SIF matter would begin to look like a re-try of *Gonzales*. If the Attorney General elects to take on the state, she might start by laying out her views in a formal document along the lines of the "Interpretive Rule" John Ashcroft issued concerning physician-assisted death.<sup>210</sup> In this document, he purported to find that prescribing controlled substances for purposes of assisting a suicide under Oregon law was not a legitimate medical practice, and announced that he therefore would act to revoke the federal controlled substances licenses of doctors who did so.<sup>211</sup> The promulgation of such guidance would require an analytic detour through questions of the Attorney General's authority under the CSA, and the degree of deference due her interpretations in this context. In this detour, we will follow the map provided by *Gonzales*.

The Court in *Gonzales* took the position that the CSA does not give the Attorney General authority to issue rules governing the practice of medicine generally.<sup>212</sup> Aside from authority over scheduling, the relevant portion of the CSA has two provisions authorizing the Attorney General to promulgate rules. 21 U.S.C. § 821 provides that she may "promulgate rules . . . relating to the registration and control of the manufacture, distribution, and dispensing of controlled substances." 21 U.S.C. § 871(b) authorizes the Attorney General to "promulgate and enforce any rules, regulations, and procedures which he may deem necessary and appropriate for the efficient execution of his functions under this subchapter." The Supreme Court interpreted these apparently capacious authorizations quite strictly in *Gonzales*, finding it "evident" that "Congress did not delegate to the Attorney General authority to carry out or effect all provisions of the CSA. Rather, he can promulgate rules relating only to 'registration' and 'control,' and 'for the efficient execution of his functions'

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209. The case could be further complicated by reconsidering the essential nature of § 856. As we have suggested above, the Crack House Statute looks much more like a nuisance provision than a drug control law. See discussion *supra* notes 92, 93 & 202. In this respect, then, we can frame the case as a conflict between state and federal law on the matter of what constitutes a nuisance. The SIF authorization constitutes the state's determination that a health care facility providing treatment and preventive services to IDUs is not a nuisance, and § 856 purports to say it is. The exercise of state police power through the device of nuisance might be said to be one of the most venerable regulatory practices in our constitutional history. See, e.g., ERNST FREUND, *THE POLICE POWER: PUBLIC POLICY AND CONSTITUTIONAL RIGHTS* 29 (1904). This perspective adds weight to the proposition that an unambiguously clear and manifest statement of preemptive intent is required—and certainly not to be found in § 856 or anywhere else in the CSA.

210. Dispensing of Controlled Substances to Assist Suicide, 66 Fed.Reg. 56,607 (Nov. 9, 2001).

211. *Id.*

212. *Gonzales*, 546 U.S. at 258.



under the statute.”<sup>213</sup> These provisions do not empower the Attorney General “to make a rule declaring illegitimate a medical standard for care and treatment of patients that is specifically authorized under state law.”<sup>214</sup> In his dissent, Justice Scalia argued passionately that the majority was willfully misreading the statute, and many commentators have agreed with him.<sup>215</sup> The immediate consequence of accepting Scalia’s interpretation would have been the triggering of a deferential rule of review,<sup>216</sup> which would at least have made it more difficult for the Court to reach its conclusion. For our purposes, the force of Scalia’s argument goes to the question of whether different facts might produce a different result.

Would things be different in an SIF case? Putting aside changes in the composition of the Court, *stare decisis* suggests that if the Attorney General lacks the authority to define a legitimate medical purpose with respect to doctors treating terminally ill patients, she would have no greater authority over health care providers treating drug users. But the analogy is complicated by a few differences in both facts and law. We are, first of all, dealing with the interpretation of § 856, which does not on its face concern health care, and so the Court might construe the Attorney General’s “control” power more expansively. This argument, though consistent with deference to government in the war on drugs, would not find support in *Gonzales* or the facts. In *Gonzales*, over Scalia’s heated objections,<sup>217</sup> the Court drew upon 21 U.S.C.

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213. *Id.* at 259. According to the Court, there was no grant in either provision of a power to declare illegal a practice authorized by state law and not clearly prohibited in the CSA. The limits on the Attorney General’s authority under § 821 are discussed further below. As to § 871, the Court wrote:

This section allows the Attorney General to best determine how to execute “his functions.” It is quite a different matter, however, to say that the Attorney General can define the substantive standards of medical practice as part of his authority. To find a delegation of this extent in § 871 would put that part of the statute in considerable tension with the narrowly defined delegation concerning control and registration. It would go, moreover, against the plain language of the text to treat a delegation for the “execution” of his functions as a further delegation to define other functions well beyond the statute’s specific grants of authority.

*Id.* at 264–65.

214. *Id.* at 258.

215. *Id.* at 275–86 (Scalia, J. dissenting).

216. If the case presented an interpretation of the CSA by the Attorney General, *Chevron* deference would apply. *Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842–45 (1984). Were the Attorney General interpreting a CSA regulation, deference would be required under the *Auer* line of cases. *Auer v. Robbins*, 519 U.S. 452 (1997) (holding that an administrative rule interpreting the issuing agency’s own ambiguous regulation may receive substantial deference).

217. *Gonzales*, 546 U.S. at 275 (Scalia, J., dissenting) (“The Court concludes that the Attorney General lacked authority to declare assisted suicide illicit under the Controlled Substances Act (CSA), because the CSA is concerned only with ‘illicit drug dealing and

§ 802 for a quite narrow, technical definition of “control”: “The term ‘control’ means to add a drug or other substance, or immediate precursor, to a schedule under part B of this subchapter, whether by transfer from another schedule or otherwise.”<sup>218</sup> On this view, control has nothing to do with the situation in an SIF, but even if it were interpreted more broadly (as Justice Scalia suggests) the authority to promulgate regulations related to the “control of the manufacture, distribution, and dispensing of controlled substances” would not clearly encompass an SIF regulation, since no manufacture, distribution or dispensing occurs there, and the authority does not extend to control of “use.”<sup>219</sup> No doubt there is scope for using “relating to” to get the camel’s nose into the tent, but at that point the stretching has reached yogic levels.

The same problem arises if we conceptualize the matter as an interpretation of “legitimate medical purpose.” Certainly the Attorney General could (and on our interpretation of § 856 would have to) contend that operating an SIF to reduce morbidity and mortality associated with injection drug use is not a lawful purpose. Just as in *Gonzales*, it could be argued that the Attorney General would thus be claiming the “extraordinary authority” to “declare an entire class of activity outside ‘the course of professional practice,’ and therefore a criminal violation of the CSA.”<sup>220</sup> Moreover, though it is logical to read a “legitimate medical purpose” criterion into § 856 in a case involving an SIF, the case would not actually involve the regulatory areas covered by the prescription provisions in which the standard is found: there is literally no prescribing, dispensing, or administering (let alone manufacturing or delivery) of controlled substances at an SIF. The Attorney General would be seeking to assert control over areas of medical practice and public health—wound care, disease prevention—over which he has no direct regulatory warrant on the

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trafficking.’ This question-begging conclusion is obscured by a flurry of arguments that distort the statute and disregard settled principles of our interpretive jurisprudence.” (citations omitted)).

218. *Id.* at 260 (majority opinion) (quoting 21 U.S.C. § 802(5) (2000 & Supp. V 2006) (internal quotation marks omitted)).

219. The Court itself considers the implications of a broader definition of “control” in *Gonzales*:

Even if “control” in § 821 were understood to signify something other than its statutory definition, it would not support the Interpretive Rule. The statutory references to “control” outside the scheduling context make clear that the Attorney General can establish controls “against diversion,” e.g., § 823(a)(1), but do not give him authority to define diversion based on his view of legitimate medical practice. As explained below, the CSA’s express limitations on the Attorney General’s authority, and other indications from the statutory scheme, belie any notion that the Attorney General has been granted this implicit authority. Indeed, if “control” were given the expansive meaning required to sustain the Interpretive Rule, it would transform the carefully described limits on the Attorney General’s authority over registration and scheduling into mere suggestions.

*Id.* at 260–61.

220. *Id.* at 262.

ground that it does not constitute legitimate medical practice. It is thus difficult to see how § 821, which the Court said did not give the Attorney General the authority to prohibit DEA-licensed physicians from prescribing lethal doses of controlled substances, would empower her to issue rules barring non-licensed or non-prescribing health care providers from caring for infections and providing counseling at an SIF.<sup>221</sup>

There are of course instances where Congress does step in to regulate medical practice, but they are as distinguishable in this instance as they are in *Gonzales*. Most notably, in *Gonzales v. Raich*, the Attorney General asserted that the cultivation and possession of marijuana for medical purposes, even if legal under California law, was explicitly barred by virtue of marijuana's inclusion in Schedule I of the CSA.<sup>222</sup> Drugs in Schedule I have been determined to have no legitimate medical use.<sup>223</sup> The *Raich* case therefore exhibited a clear conflict between two explicit and mutually exclusive laws at the state and federal level, a conflict easily resolved under the Supremacy Clause once the authority underlying the federal law was upheld.<sup>224</sup>

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221. The CSA does give the Attorney General authority to register (or deny registration to) practitioners to “conduct research with . . . controlled substances.” 21 U.S.C. § 823(f) (2006). This provision, however, only reaches research that entails the actual use of controlled substances as an intrinsic element of the study. *Id.* Observational research on drug use and drug users, of the sort that would surely be part of a pilot SIF evaluation, has never been thought to require registration, and is quite common. *See, e.g.*, Kerr et al., *supra* note 71; Wood et al., *supra* note 49.

222. The Court wrote in *Raich*:

The CSA designates marijuana as contraband for *any* purpose; in fact, by characterizing marijuana as a Schedule I drug, Congress expressly found that the drug has no acceptable medical uses. Moreover, the CSA is a comprehensive regulatory regime specifically designed to regulate which controlled substances can be utilized for medicinal purposes, and in what manner. Indeed, most of the substances classified in the CSA “have a useful and legitimate medical purpose.” 21 U.S.C. § 801(1). Thus, even if respondents are correct that marijuana does have accepted medical uses and thus should be redesignated as a lesser schedule drug, the CSA would still impose controls beyond what is required by California law. The CSA requires manufacturers, physicians, pharmacies, and other handlers of controlled substances to comply with statutory and regulatory provisions mandating registration with the DEA, compliance with specific production quotas, security controls to guard against diversion, recordkeeping and reporting obligations, and prescription requirements. *See* §§ 821–830; 21 CFR § 1301 *et seq.* (2004). Furthermore, the dispensing of new drugs, even when doctors approve their use, must await federal approval. *United States v. Rutherford*, 442 U.S. 544, 99 S.Ct. 2470, 61 L.Ed.2d 68 (1979). Accordingly, the mere fact that marijuana—like virtually every other controlled substance regulated by the CSA—is used for medicinal purposes cannot possibly serve to distinguish it from the core activities regulated by the CSA.

*Gonzales v. Raich*, 545 U.S. 1, 27–28 (2005) (footnote omitted).

223. *See id.* at 27.

224. The Court acknowledged that “evidence proffered by respondents in this case regarding the effective medical uses for marijuana, if found credible after trial, would cast serious doubt on

By now it should be clear that the illegality of an SIF under § 856 is open to serious doubt. We think legality is actually the stronger position, both from textual and legislative intent perspectives, but uncertainty alone is sufficient to trigger a cascade of other legal and policy considerations in favor of an SIF. There is, of course, the rule of lenity, the traditional practice of interpreting ambiguous criminal statutes in favor of the defendant.<sup>225</sup> More significantly, the consequence of interpreting the statute to bar a state public health measure would be, as we discuss below, to force the fundamental constitutional question of Congress's authority to impose such a prohibition. Courts anticipating such collisions are subject to the prudential tradition of avoiding deciding cases on constitutional grounds when an alternate, plausible interpretation of a statute is possible: "[W]here a statute is susceptible of two constructions, by one of which grave and doubtful constitutional questions arise and by the other of which such questions are avoided, our duty is to adopt the latter."<sup>226</sup> Collisions tending to occur despite rules of prudence, we turn now to the constitutional question.

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the accuracy of the findings that require marijuana to be listed in Schedule I," but pointed out that, as in the case of an SIF, the Court's task is to identify the correct decision-maker, not the correct decision: "[T]he possibility that the drug may be reclassified in the future has no relevance to the question whether Congress now has the power to regulate its production and distribution." *Id.* at 27 n.37.

225. *See, e.g.,* *Rewis v. United States*, 401 U.S. 808, 812 (1971) ("[A]mbiguity concerning the ambit of criminal statutes should be resolved in favor of lenity." (citing *Bell v. United States*, 349 U.S. 81, 83 (1955))); *McNally v. United States*, 483 U.S. 350, 359–60 (1987).

Along the same lines, there is a general judicial distaste for vague criminal statutes. Ambiguous criminal laws are objectionable on at least two grounds rooted in due process. There is a notice problem in prosecuting someone for an activity he could not reasonably be expected to know was proscribed. *See, e.g., Connally v. Gen. Const. Co.*, 269 U.S. 385, 391 (1926) ("[A] statute which either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application violates the first essential of due process of law."). There is also a problem of unfair and arbitrary application of the law by law enforcement agents in particular cases. *See, e.g., Kolender v. Lawson*, 461 U.S. 352, 358 (1983) ("[W]e have recognized recently that the more important aspect of the vagueness doctrine 'is . . . the requirement that a legislature establish minimal guidelines to govern law enforcement . . . .' Where the legislature fails to provide such minimal guidelines, a criminal statute may permit 'a standardless sweep [that] allows policemen, prosecutors, and juries to pursue their personal predilections.'" (citations omitted) (quoting *Smith v. Goguen*, 415 U.S. 566, 574–75 (1974))). Both sections of the Crack House Statute have survived vagueness challenges, but only in cases that involved egregious drug trafficking. *See, e.g., United States v. Lancaster*, 968 F.2d 1250, 1254 (D.C. Cir. 1992) (holding that § 856 is not an unconstitutionally vague prohibition in a case involving a typical crack house). In any event, proprietors of an SIF would not need to place primary or even explicit reliance on these principles to garner some benefit from them in litigation.

226. *Almendarez-Torres v. United States*, 523 U.S. 224, 250 (1998) (Scalia J., dissenting) (quoting *United States ex. rel. Attorney General v. Delaware & Hudson Co.*, 213 U.S. 366, 408 (1909)) (internal quotation marks omitted).

### 3. Congressional Overreach? The Commerce Clause as *Deus ex Machina*

The constitutional authority for the CSA derives from Congress's power to regulate interstate commerce under the Commerce Clause.<sup>227</sup> The Supreme Court has interpreted this power expansively,<sup>228</sup> to the point that challenges to the exercise of the Commerce power are virtually never successful. In two recent instances, however, the Court has invalidated federal statutes as being insufficiently related to interstate commerce,<sup>229</sup> and if ever there was a case that presented a reasonable hope of being the third, it would be the case of a state-authorized SIF.<sup>230</sup>

227. U.S. CONST. art. I, § 8 ("Congress shall have [the] power . . . [t]o regulate commerce . . . among the several states . . .").

228. See, e.g., KATHLEEN M. SULLIVAN & GERALD GUNTHER, CONSTITUTIONAL LAW 130 (14th ed. 2001) (noting how the Great Depression and the Civil Rights movement altered the balance of federal and state regulatory power).

229. In *United States v. Lopez*, 514 U.S. 549, 567 (1995), the Court struck down a provision of the Gun-Free School Zones Act as an unconstitutional exercise of Commerce Clause authority. In *United States v. Morrison*, 529 U.S. 598, 613 (2000), the Court held that a federal statute that provided a civil remedy for the victims of gender-motivated violence was not regulation of activity that substantially affected interstate commerce. In *Morrison*, the Court announced a four-factor test for determining if a purely intrastate activity substantially affects interstate commerce. *Id.* at 609–13. Distilled from these two decisions, what became known as the "*Lopez-Morrison* test" considered: (1) the commercial nature of the activity; (2) the existence in the statute of a jurisdictional element that limits the statute's reach; (3) the existence of Congressional findings on the relationship; and (4) how attenuated the effects on commerce are. *Id.*

230. There has not been a major federalism case since Justice Alito and Chief Justice Roberts joined the Supreme Court. Chief Justice Rehnquist and Justice O'Connor were ardent states' rights proponents. A legal realist could just as easily find the same tendencies in the circuit level rulings of Justices Alito and Roberts; both Alito and Roberts had major and controversial federalism dissents (pre-*Raich* but applying the wounded, but breathing, *Lopez* holding) arguing for more circumscribed regulatory power under the Commerce Clause. *Rancho Viejo, LLC v. Norton*, 334 F.3d 1158, 1160 (D.C. Cir. 2003) (Roberts, J., dissenting from denial of rehearing en banc) ("The panel's opinion in effect asks whether the challenged *regulation* substantially affects interstate commerce, rather than whether the *activity* being regulated does so. Thus, the panel sustains the application of the Act in this case because Rancho Viejo's commercial development constitutes interstate commerce and the regulation impinges on that development, not because the incidental taking of arroyo toads can be said to be interstate commerce . . . . Such an approach seems inconsistent with the Supreme Court's holdings in *United States v. Lopez* and *United States v. Morrison*." (citations omitted)); *United States v. Rybar*, 103 F.3d 273, 287 (3d Cir. 1996) (Alito, J., dissenting) ("In other words, the majority argues in effect that the private, purely intrastate possession of machine guns has a substantial effect on the interstate machine gun market. This theory, if accepted, would go far toward converting Congress's authority to regulate interstate commerce into 'a plenary police power.' If there is any sort of interstate market for a commodity—and I think that it is safe to assume that there is some sort of interstate market for practically everything—then the purely intrastate possession of that item will have an effect on that market, and outlawing private possession of the item will presumably have a substantial effect. Consequently, the majority's theory leads to the conclusion that Congress may ban the

If they do nothing else, the Court's decisions in *Lopez* and *Morrison* resurrect the idea that there can be activity that is not economic for Commerce Clause purposes, and that the distinction between economic and non-economic activity marks an actual line Congress may not cross. The essence of the state's argument would be that an SIF is a purely non-commercial activity whose impact on interstate commerce, if any impact, falls below even the very low threshold set by the Court in its case law. This is not a bad argument as far as it goes. It is fair to say that there is no economic activity whatsoever in an SIF, at least as economic activity is commonly understood. No one buys anything, no one sells anything, no one profits. Nothing is manufactured or warehoused. That said, Justice Stevens's opinion in *Raich* defines "commerce" in dicta to include "consumption,"<sup>231</sup> which is undeniable at an SIF. Though not a market or supplying a market, the SIF is connected to a market: if clients do not buy illegal drugs, they have nothing to inject at the SIF. The empirical data support the argument that the existence or non-existence of the SIF has no impact on the volume of these purchases, but that argument may or may not prevail.

*Wickard v. Filburn*<sup>232</sup> is often cited as the case that shows how little economic activity is enough to justify congressional regulation. A comparison is favorable to the legality of an SIF. Filburn was a farmer who planted wheat beyond his federal allotment, but, he claimed, it was exclusively for his own use, not for sale.<sup>233</sup> The Court declined to treat Filburn as an atom. In a move that any public health person would not only approve but regard as indispensable to rational regulation aimed at controlling the national wheat crop as a whole, the Court treated him as a part of a national population: "That appellee's own contribution to the demand for wheat may be trivial by itself is not enough to remove him from the scope of federal regulation where, as here, his contribution, taken together with that of many others similarly situated, is far from trivial."<sup>234</sup> To say that the Congress could not regulate Filburn's wheat crop because it is just a tiny fraction of the total crop would be like saying that the City of Cambridge could not impose smallpox vaccination

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purely intrastate possession of just about anything. But if *Lopez* means anything, it is that Congress's power under the Commerce Clause must have some limits. . . . In sum, we are left with no congressional findings and no appreciable empirical support for the proposition that the purely intrastate possession of machine guns, by facilitating the commission of certain crimes, has a substantial effect on interstate commerce, and without such support I do not see how the statutory provision at issue here can be sustained—unless, contrary to the lesson that I take from *Lopez*, the 'substantial effects' test is to be drained of all practical significance." (citations omitted)).

231. *Gonzales v. Raich*, 545 U.S. 1, 25–26 (2005).

232. 317 U.S. 111, 128–29 (1942).

233. *See id.* at 114, 128–29.

234. *Id.* at 127–28; *accord* *Katzenbach v. McClung*, 379 U.S. 294, 300–01 (1964).

because Mr. Jacobson was just one of thousands of citizens of Cambridge.<sup>235</sup> Likewise, in *Raich*, the “market” for medical marijuana was neither small nor isolated from the larger illegal market.<sup>236</sup>

Yet the principle is one of aggregation, not multiplication. Nothing in the Commerce Clause, nor epidemiological methods for that matter, justifies treating a sui generis activity as if it were common. Both farmer Filburn and patient Raich were individuals who were like, if not typical of, thousands of others in the same market. The case was a clear and immediate test of the regulatory regime. The SIF we hypothesize, by contrast, is a unique, or one of a few specialized public health interventions highly unlikely, for reasons of need, cost and politics, ever to exist in substantial numbers. There are few if any “others similarly situated.” It would be difficult for the Attorney General to prove, or even assert with a straight face, that one or a few SIFs would imperil the CSA drug control scheme by altering the market for controlled substances. Indeed, SIFs can reasonably be expected to *reduce* the demand for illegal drugs. Surely this case would take the Commerce Clause beyond its long-standing high-water mark.<sup>237</sup>

The difficulties with the case for SIF proponents are, nonetheless, many and various. *Morrison* and *Lopez* aside, the odds of winning any claim based on an argument that “Congress lacks the power to regulate this activity” are slim. The Court wields its Commerce Clause doctrine with an eye not just on the “illiction returns,”<sup>238</sup> but also the tectonic dynamics of ideology, the

235. *Jacobson v. Massachusetts*, 197 U.S. 11, 37–38 (1905) (“We are not prepared to hold that a minority, residing or remaining in any city or town where smallpox is prevalent, and enjoying the general protection afforded by an organized local government, may thus defy the will of its constituted authorities, acting in good faith for all, under the legislative sanction of the state. If such be the privilege of a minority, then a like privilege would belong to each individual of the community, and the spectacle would be presented of the welfare and safety of an entire population being subordinated to the notions of a single individual who chooses to remain a part of that population. We are unwilling to hold it to be an element in the liberty secured by the Constitution of the United States that one person, or a minority of persons, residing in any community and enjoying the benefits of its local government, should have the power thus to dominate the majority when supported in their action by the authority of the state.”).

236. *Raich*, 545 U.S. at 30 (“Indeed, that the California exemptions will have a significant impact on both the supply and demand sides of the market for marijuana is not just ‘plausible’ as the principal dissent concedes, . . . it is readily apparent.” (citation omitted)).

237. One commentator has opined: “[*Wickard v. Filburn*’s] aggregation principle remains nominally good law, but it operates only when the actors or activities at issue are commercial. Gun possession or sex-motivated violence will not qualify, at least when they lack any visible connection to overtly economic activity.” Jim Chen, *The Story of Wickard v. Filburn: Agriculture, Aggregation, and Congressional Power over Commerce*, in CONSTITUTIONAL LAW STORIES 104 (Michael C. Dorf ed., 2d ed. forthcoming 2009) (manuscript at 26, on file with authors).

238. See generally John B. Taylor, *The Supreme Court and Political Eras: A Perspective on Judicial Power in a Democratic Polity*, 54 REV. POL. 345, 345–46 (1992) (“The Supreme Court,

Court's authority, and regulatory reality. In doctrinal terms alone, the state faces several hurdles. Consumption may be enough to make this "commerce," and even were it not, Justice Scalia's theory that the Necessary and Proper Clause justifies regulation of non-commercial activity necessary to vindicate Congress's Commerce Clause goals may find more votes.<sup>239</sup> It will be easy enough to argue, alas in spite of any evidence or even rigorous thinking, that an SIF "encourages" drug abuse or is a "symbol" of government endorsement. A Court that accepts such "public relations" arguments would have no difficulty finding that it was necessary and proper to prohibit SIFs as an adjunct to the clearly constitutional regulation of the illegal drug trade.<sup>240</sup>

If our analysis of a possible § 856 and preemption case is speculation, consideration of the Commerce Clause issue is speculation on stilts. The purpose of this exercise is not to predict a particular result, but rather to demonstrate through close legal analysis that there is more than ample doubt about the illegality of a state-authorized SIF—indeed, a quite robust basis for concluding that such an intervention is legal. This allows a reasonable government lawyer, executive, or legislator to ethically and prudently move forward on a test of this potentially life-saving (and money-saving) intervention. If the Attorney General seeks to enjoin the measure, or is herself subject to an injunctive action to forestall some interference, the likelihood of prevailing equation could well come out to the state's advantage. By the time the matter was resolved, the data on the SIF would probably be enough to negate many of the Attorney General's direst claims—or show that the intervention is not worthwhile anyway.

#### 4. Never Mind: Political Paths Around the Courts

The politics of drug control and harm reduction do not always play themselves out in court. If the federal government takes no formal action against—or even supports—a state-approved SIF, the fact that some people can make arguments that the SIF is illegal will not have any practical impact on the experiment. Conversely, the power of the purse gives congressional opponents of an SIF a powerful way to express their feelings. The federal ban on funding syringe exchanges did not prevent them from spreading, but has

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proclaimed Mr. Dooley, follows the election returns." (citing FINLEY PETER DUNNE, MR. DOOLEY AT HIS BEST 77 (1938))).

239. See *Gonzales v. Raich* 545 U.S. 1, 34 (2002) (Scalia, J., concurring); see also *supra* notes 215–19 and accompanying text.

240. Some have gone so far as to argue that *Raich* signaled the death-knell for "as-applied" challenges to a congressional exercise of Commerce Clause authority. Alex Kreit, *Rights, Rules, and Raich*, 108 W. VA. L. REV. 705, 706 (2006) ("After *Raich* . . . facial challenges appear to be the only type of Commerce Clause challenge that remains viable.").



certainly been an impediment to scale-up. Congress could also go further, by limiting some forms of federal funding to jurisdictions that operate SIFs.

A confrontation is by no means inevitable. We have so far assumed that the legal career of an SIF would track that of medical marijuana, with the innovating state facing active attempts at suppression from the federal government. But the SIF may in practice look more—and be treated—like an SEP, which federal drug control agencies have never attacked. The SIF, after all, is a marginal expansion of the basic services provided by an SEP—a needle exchange with chairs. On that view, the DEA might not even be tempted to act. If the DEA showed signs of interfering, the Attorney General could simply instruct the agency and other federal law enforcement personnel to ignore the SIF, either because she interprets the CSA to allow SIFs or in the exercise of prosecutorial discretion.

The case of Oregon's Death with Dignity Act<sup>241</sup> illustrates this approach. John Ashcroft was not the first U.S. Attorney General to consider whether prescribing lethal doses of controlled substances under the statute presented a federal legal issue. After Oregon voters authorized the practice in 1994,<sup>242</sup> Attorney General Janet Reno determined that the CSA gave her no power to “displace the states as the primary regulators of the medical profession, or to override a state's determination as to what constitutes legitimate medical practice.”<sup>243</sup> On her orders, no federal threats against, or arrests or prosecutions of doctors involved in this program took place.<sup>244</sup> The issue only became a federal case when the administration changed in 2000.<sup>245</sup>

Moreover, the election of President Barack Obama and the deterioration of state fiscal conditions may significantly alter the cultural atmosphere surrounding drug regulation. During the campaign, President Obama signaled a willingness to value science over tradition in drug policy. When questioned whether he would stop DEA medical marijuana raids, then-Senator Obama noted:

I would because I think our federal agents have better things to do, like catching criminals and preventing terrorism. The way I want to approach the issue of medical marijuana is to base it on science. And if there is sound science that supports the use of medical marijuana and if it is controlled and

241. The Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.800–.995 (2007).

242. *Id.* (noting that certain provisions of the statute were enacted as part of Ballot Measure 16 (1994)).

243. Press Release, U.S. Dep't of Justice, Statement of Attorney General Reno on Oregon's Death with Dignity Act (June 5, 1998), available at <http://www.usdoj.gov/opa/pr/1998/June/259ag.htm.html>.

244. Lindsay R. Kandra, Comment, *Questioning the Foundation of Attorney General Ashcroft's Attempt to Invalidate Oregon's Death with Dignity Act*, 81 OR. L. REV. 505, 517 (2002).

245. *See Gonzales v. Oregon*, 546 U.S. 243 (2006).

prescribed in a way that other medicine is prescribed, then it's something we should consider.<sup>246</sup>

Despite concern that his commitment to this approach would dissolve or dissipate as President Obama installed his drug enforcement agencies, early indications suggest that his belief in scientific reappraisal remains robust as confirmed by his recently appointed Attorney General.<sup>247</sup> The practicality of this philosophical position is buttressed by the cost of investigating and prosecuting such activities and the growing constraints on state funding.

The legislative branch may signal its disapproval through the power of the purse at its disposal.<sup>248</sup> As it did in the case of syringe exchange, Congress could forbid the use of any federal funds in the operation of an SIF. This would not stop a state from going forward, but it would put the political weight of Congress on the side of opponents in other states watching the experiment, and would to some extent chill NIH and CDC funding for SIF research and evaluation. Although highly unlikely, Congress could, in theory, go further, by limiting or entirely cutting off federal funds to any program, agency, or entire jurisdiction that operated an SIF. The barriers to such extreme measures are more political than legal: although the Court has suggested that there is some limit to the exercise of this power—"in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion'"<sup>249</sup>—no federalism challenge to Congress's spending power has succeeded in the last sixty-five years.<sup>250</sup> After

246. James Pitkin, *Six Minutes with Barack*, WILLAMETTE WK., May 14, 2008, <http://www.week.com/editorial/3427/10974/>.

247. When questioned whether he disagreed with President Obama's medical marijuana campaign pledge, recently appointed Attorney General Eric Holder replied:

No. . . . What the president said during the campaign, you'll be surprised to know, will be consistent with what we'll be doing in law enforcement. He was my boss during the campaign. He is formally and technically and by law my boss now. What he said during the campaign is now American policy.

Ryan Grim, *Holder Vows to End Raids on Medical Marijuana Clubs*, HUFFINGTON POST, Feb. 26, 2009, [http://www.huffingtonpost.com/2009/02/26/holder-vows-to-end-raids\\_n\\_170119.html](http://www.huffingtonpost.com/2009/02/26/holder-vows-to-end-raids_n_170119.html) (internal quotation marks omitted).

248. The Spending Clause, U.S. CONST. art. 1, § 8, cl. 1 ("The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States . . ."), allows Congress to spend money, and Congress may condition grants on states and localities complying with certain requirements.

249. *South Dakota v. Dole*, 483 U.S. 203, 211 (1987) (quoting *Steward Machine Co. v. Davis*, 301 U.S. 548, 590 (1937)).

250. See, e.g., *Rumsfeld v. Forum for Academic & Institutional Rights, Inc.*, 547 U.S. 47 (2006) (upholding the Solomon Amendment, which not only withholds all Defense Department funds to all departments of "offending institutions," but also funds administered by the Departments of Transportation, Labor, Health and Human Services, and Education).

news emerged that San Francisco was considering the opening of such a facility, there was an effort in the House to impose just such a limitation.<sup>251</sup>

#### CONCLUSION: FEDERALISM, EVIDENCE, AND LEARNING-BASED POLICY

The SIF is a promising public health intervention. If it works, it could prevent many overdose deaths, reduce the spread of infectious disease, promote the initiation of treatment among hard-core addicts, control costs associated with emergency room visits and requests for first responder assistance, lessen the frequency of improperly discarded syringes, and diminish the visibility of public injection. In addition, the SIF represents a unique research environment for scientists studying a hard-to-reach population. The available evidence from trials in other countries, and our own national experience with SEPs, provides reasonable assurance that SIFs will not be harmful. The SIF, in short, is the sort of innovation that ought to be explored within a rational system of regulating drugs and their health consequences.

The structure of our federal form of government is, on its face, quite favorable to the exploration of new policies of this kind.<sup>252</sup> Successful policies developed locally have routinely spread both vertically (local-to-state-to-federal) and horizontally (local-to-local or state-to-state).<sup>253</sup> In matters of health, the Constitution leaves a great store of police power in the states.<sup>254</sup> Though the federal role in internal public health matters has properly and necessarily grown, the day-to-day responsibility for dealing with HIV, overdose, and drug dependency remains on the shoulders of state and local

251. H.R. 3043, 110th Cong. (2007) (engrossed amendment as passed by Senate, Oct. 23, 2007) (barring the distribution of Federal funds to cities that provide safe haven to illegal drug users through the use of illegal drug injection facilities); H.R. REP. NO. 110-424, at 214 (2007) (Conf. Rep.) (“The conference agreement deletes without prejudice a general provision proposed by the Senate that prohibits funds in the Act from being allocated, directed, or otherwise made available to cities that provide safe haven to illegal drug users through the use of illegal drug injection facilities. The House bill did not include a similar provision.”).

252. See *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) (“Denial of the right to experiment may be fraught with serious consequences to the Nation. It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”). But see Stephen M. Griffin, *Stop Federalism Before It Kills Again: Reflections on Hurricane Katrina*, 21 ST. JOHN’S J. LEGAL COMMENT. 527 (2007) (describing a case of federalism fostering poor practices and dysfunctional governance).

253. See Roderick M. Hills, Jr., *Against Preemption: How Federalism Can Improve the National Legislative Process*, 82 N.Y.U. L. REV. 1, 21 (2007). Cf. JAMES MANOR, *THE POLITICAL ECONOMY OF DEMOCRATIC DECENTRALIZATION* (1999) (analyzing importance of decentralized government in development); Wolfgang Kerber & Martina Eckardt, *Policy Learning in Europe: The Open Method of Co-Ordination and Laboratory Federalism*, 14 J. EUROPEAN PUB. POL’Y 227 (2007) (discussing federalist policy processes in the EU).

254. See GOSTIN, *supra* note 84.

governments. Our federal structure creates the conditions for the happy exploitation of comparative advantage. Just as the CDC's role as a federal health agency gives it an ability to concentrate expertise and coordinate a network of health agencies that no state or local health department can rival, so state and local health agencies have, by virtue of their work at the coalface, a unique ability to identify and test new, creative approaches. Yet, as this Article has shown, neither the need to innovate nor the formal legal structure supportive of innovation is enough to guarantee that policy experimentation will go forward. Much will depend upon how health officials and advocates at the state level cope with the uncertainties, unintended consequences, and looming menace of federal drug control policy.

Thus, we return to Professor Johnson's argument.<sup>255</sup> Plenty of people in public health and harm reduction are prepared to regard the CSA, at least in so far as it grounds a "war on drugs," as a "bad law" in her terms. Even if one accepts the formal proposition of prohibitionist drug control as outlined in the law, in practice the "shadow system" of large scale imprisonment of drug users and small-time dealers seems to confound any therapeutic intent.<sup>256</sup> To the extent it enshrines in law a cultural "euphoriphobia,"<sup>257</sup> or targets substances (marijuana, for example) that are no more, and arguably less, harmful than currently legal ones (tobacco, for example), it is merely arbitrary. To the extent it is meant to reduce the aggregate individual and social harms of drug use, it simply fails.<sup>258</sup> How can it make any sense for a law that purports to protect society from the harms of drug dependency, to prohibit the testing of new public health programs that aim to do exactly that? Under what logic is research on health care for drug users equated with promoting drug use?

"Bad law" claims often signal real problems—and only a few die-hards could really insist that our current drug policy is free of them—but bad law claims are not prescriptions for reform. They do not begin to answer hard questions about what regulatory models would be better. One need only imagine a world in which tobacco or alcohol companies began to market cocaine to realize that replacing prohibition with regulation would bring daunting regulatory challenges all its own. Bad law claims are valuable, as Professor Johnson argues, because they convey important information that should be appreciated by policy-makers and stakeholders alike about how the

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255. See *supra* notes 1–5 and accompanying text.

256. Johnson, *supra* note 1, at 995–1005.

257. The term was coined by Don C. Des Jarlais, *Prospects for a Public Health Perspective on Psychoactive Drug Use*, Editorial, 90 AM. J. PUB. HEALTH 335, 336 (2000), to capture the extent to which drug policy seems to be driven by the belief that substances that give pleasure are bad even if they have few or no harmful effects.

258. MacCoun and Reuter usefully express the "total harm" of drug use with this equation: "Total Harm = Prevalence x Intensity x Harmfulness." MACCOUN & REUTER, *supra* note 6, at 10.

law is operating.<sup>259</sup> The willingness of actors within a regulatory system to accept and respond to this sort of information—to learn—ought also to be seen for what it is: a basic measure of a system’s health.<sup>260</sup>

Drug policy is a realm in which real learning has been rare.<sup>261</sup> The explicit goals, implicit assumptions, and effectiveness of the current policy have all become matters of dogma. It is entirely fitting that MacCoun and Reuter entitled their careful analysis of the evidence for the current system and possible alternatives *Drug War Heresies*.<sup>262</sup> Those who question the faith are castigated as apostates, and treated accordingly. Efforts to test any of the pillars of the faith, or, more importantly, to explore alternative paths, are opposed and, if possible, crushed with righteous indignation. The result is that the problem of how best to reduce the individual and social costs of drug consumption cannot be addressed by the method most likely, given our imperfect knowledge and cultural divisions, to lead us to a substantially different and more salubrious approach: incremental policy experimentation focused on applying specific regulatory tools to manageable elements of the problem.<sup>263</sup>

We do not speak in terms of “evidence-based policy.” The acquisition and critical use of evidence relevant to government policy choices and the evaluation of policies once enacted are certainly good things.<sup>264</sup> A certain amount of direct and analogous evidence was necessary before SIFs could even be considered worth trying. It took trials in other countries and more than a decade of experience with SEPs to get local health officials in U.S. cities to

259. Johnson, *supra* note 1, at 975–80.

260. The argument that learning, or inability to learn, is an important characteristic of regulatory systems is made in a number of interesting literatures. See, e.g., Gunther Teubner, *Juridification: Concepts, Aspects, Limits, Solutions*, in *JURIDIFICATION OF SOCIAL SPHERES: A COMPARATIVE ANALYSIS IN THE AREAS OF LABOR, CORPORATE, ANTITRUST AND SOCIAL AND WELFARE LAW* 3 (Gunther Teubner ed., 1987); Scott Burris et al., *Nodal Governance*, 30 AUSTL. J. LEGAL PHIL. 30 (2005); Rosie Cooney & Andrew T.F. Lang, *Taking Uncertainty Seriously: Adaptive Governance and International Trade*, 18 EUROPEAN J. INT’L L. 523, 523–24 (2007) (“[A]daptive governance accepts and responds to uncertainty by promoting learning in and through the policy-making process. It does so in a number of ways: by avoiding irreversible interventions and impacts, by encouraging constant monitoring of outcomes; by facilitating the participation of multiple voices in transparent policy-making processes; and by reflexively highlighting the limitations of the knowledge on which policy choices are based.”).

261. One need only compare the rich social science literature on tobacco and alcohol control with what is known about drug policy to see the difference. See Substance Abuse Policy Research Program, <http://www.saprp.org/> (Last visited Apr. 28, 2009).

262. See MACCOUN & REUTER, *supra* note 6.

263. Burris & Strathdee, *supra* note 13.

264. See, e.g., Mark Gibson, *When Good Information Truly Matters: Public Sector Decision Makers Acquiring and Using Research to Inform Their Decisions*, 14 J.L. & POL’Y 551 (2006); Ian Sanderson, *Evaluation, Policy Learning and Evidence-Based Policy Making*, 80 PUB. ADMIN. 1 (2002).

begin considering SIF trials. But the phrase “evidence-based policy” does not really capture the challenges of innovation in controversial domains like drug policy. Generally, people influence evidence more than evidence influences people; that is, we typically interpret evidence based on our prior beliefs or cultural associations rather than “objectively.”<sup>265</sup> Thus, resort to “evidence” is, often enough, merely the continuation of ideological warfare by other means,<sup>266</sup> and calling for “evidence-based policy” is, in important ways, just restating the problem of getting people to pay attention to evidence in the first place.

More specifically, a case like the SIF involves the deployment of new measures *in order to generate* evidence. To be fair (let alone logical), one can hardly demand that people put aside plausible consequentialist or internally consistent deontological concerns on the ground that the evidence that justifies the test also compels acceptance of the innovation.<sup>267</sup> While not inconsistent with “evidence-based” policy, “policy learning” provides in our view a better heuristic for defining the issues before us as a polity, and a better guide to what needs to be done and why.

“Policy learning” posits that developing effective policy is a cyclical process of experimentation, evaluation, and recalibration. It takes seriously what we don’t know and the limits of our ability to predict how well policies will work. It thus insists that policies be evaluated and that evaluation outcomes be used to adjust policies and implementation practices. An important difference between policy learning and evidence-based policy is the former’s greater emphasis on using the collection and interpretation of evidence as a way to promote its credibility, salience, and accessibility. In articulating a model of “adaptive governance,” Cooney and Lang put the matter like this:

[T]he *production* of knowledge [is] . . . always and inevitably in part a social and political process. And we understand science-based decision-making necessarily to involve fundamental value choices. To the extent that uncertainty results from the necessary incompleteness of any single vision of knowledge, and of human cognition generally, adaptive governance approaches therefore necessitate a pluralist approach to knowledge. In this context, the . . . policy-making is less about the attainment of a single optimal solution—as if ‘best practice’ were simply a question of efficiency—and more

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265. For example, there is accumulating evidence in relation to Dan Kahan’s theory of “cultural cognition.” See, e.g., Dan M. Kahan et al., *The Second National Risk and Culture Study: Making Sense of—and Making Progress in—the American Culture War of Fact* (Sept. 27, 2007) (unpublished manuscript, available at <http://ssrn.com/paper=1017189>).

266. Wendy E. Wagner, *The Science Charade in Toxic Risk Regulation*, 95 COLUM. L. REV. 1613, 1624 n.35 (1995) (describing how evidence is used politically).

267. See MACCOUN & REUTER, *supra* note 6, at 55–71.

about providing a forum for the ongoing creation of consensual knowledge and agreed processes to guide policy.<sup>268</sup>

A “pluralist approach to knowledge” entails open and transparent processes of planning, implementing, and evaluation, in which “broader participation in the production and deployment of knowledge” is accomplished through participatory research and analysis processes.<sup>269</sup> Participatory policy-making has its limits, not the least of which is that citizens and even direct stakeholders may be more willing to casually criticize than to invest in serious participation.<sup>270</sup> Nonetheless, with some planning and a little luck, the process of deciding whether to undertake a policy innovation can become a mechanism for competing interest groups to consider problems and policy options in a framework of evidence rather than ideology.

The idea of policy learning frames a question like the opening of an SIF not as a decision about whether or not SIFs should be integrated into drug policy, but as an inquiry into their potential value. As a process, it would aim to convene as many as possible of the key interest groups that have a stake in the public drug scene: homelessness, emergency health services, health care finance, harm reduction, public health, law enforcement, and drug treatment. Over a period of months, those stakeholders interested enough to participate would look together at the data defining the problems to be solved and the fit of various options, including SIFs, with those problems. Over time, the hope is that the effort becomes an exercise in specific problem solving that may or may not work, rather than a new front on the ideological war over drug policy.<sup>271</sup> Involving even those who disagree in the planning and evaluation of an SIF is a way to maximize the chances that the evidence gathered is attended to. Policy learning is not natural, but it can be fostered.

268. Cooney & Lang, *supra* note 260, at 538 (emphasis added) (footnotes omitted).

269. *Id.* at 538–39.

270. See, e.g., John Wright et al., *Participation in Health Impact Assessment: Objectives, Methods and Core Values*, 83 BULL. WORLD HEALTH ORG. 58 (2005) (describing limits of public participation in health planning work).

271. For an example of how this approach was taken in several cities on other matters of drug use, health, and policy, see JUSTYNA SOBEYKO ET AL., RAPID POLICY ASSESSMENT AND RESPONSE: SZCZECIN, FINAL REPORT AND RECOMMENDATIONS: BRIDGING THE GAPS BETWEEN NEEDS AND SERVICES IN THE HEALTH AND CRIMINAL JUSTICE SYSTEMS, (Scott Burris & Kristina Arvenitis trans., 2006), available at [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1276335](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1276335); INNA VYSHEMIRSKAYA ET AL., RAPID POLICY ASSESSMENT AND RESPONSE: KALININGRAD, HIV AND DRUG POLICY IN KALININGRAD: RISK, SILENCE AND THE GAP BETWEEN HUMAN NEEDS AND HEALTH SERVICES (Olga Danilova trans., Scott Burris ed., 2008), available at <http://ssrn.com/paper=1262798>; Richard H. Needle et al., *Rapid Assessment of the HIV/AIDS Crisis in Racial and Ethnic Minority Communities: An Approach for Timely Community Interventions*, 93 AM. J. PUB. HEALTH 970 (2003).

Local participatory research and decision-making processes are not a cure for ideology or interest group politics,<sup>272</sup> but they are an underutilized tool for getting reasonable consensus among interested stakeholders on particular measures in particular places. Nor is policy learning a particularly rigid heuristic. The typical processes of local political mobilization, outreach, and coalition building can operate in the same spirit and much the same way. Indeed, on occasion, even the legislative process takes on something of this approach. The career of syringe access policy in Connecticut is an illustration. The initial state bill to authorize a pilot SEP emerged from several years of local advocacy and education in New Haven.<sup>273</sup> There was no evidentiary question as to the severity of HIV in the city, but at the time there was no evidence on the utility of SEPs as HIV prevention that could compel a conclusion as to its effectiveness or side effects. Well-conducted political advocacy by proponents carried the day, but the 1990 law authorized SEP only as an experiment, and included a strong evaluation component.<sup>274</sup>

The learning followed. As the effects were studied and appeared positive,<sup>275</sup> health officials elsewhere in Connecticut and the United States began to visit, and people involved in the New Haven exchange began to speak around the country. Hartford started an SEP in 1991,<sup>276</sup> and in 1992, the state legislature reviewed the evidence from the New Haven evaluations and not only authorized more SEPs but also eliminated the prescription requirement for sale or possession of ten or fewer syringes.<sup>277</sup> In subsequent years, the Connecticut legislature raised the limit for non-prescription sale or possession to thirty, and removed syringes from the drug paraphernalia law altogether.<sup>278</sup>

272. See Scott Burris et al., *Emerging Strategies for Healthy Urban Governance*, 84 J. URB. HEALTH 154 (2007).

273. See Elaine O'Keefe, *Altering Public Policy on Needle Exchange: The Connecticut Experience*, 6 AIDS & PUB. POL'Y J. 159 (1991); Arthur Robinson Williams, IV, *State Policymaking and Syringe Deregulation: The Determinants of Successful Reform* (Apr. 5, 2004) (unpublished A.B. thesis, Princeton University) (manuscript at 55, on file with authors), available at <http://www.dogwoodcenter.org/references/Williams04.html>.

274. See sources cited *supra* note 273.

275. See, e.g., Robert Heimer et al., *Needle Exchange Decreases the Prevalence of HIV-1 Proviral DNA in Returned Syringes in New Haven, Connecticut*, 95 AM. J. MED. 214, 220 (1993); Edward H. Kaplan et al., *A Decline in HIV-Infected Needles Returned to New Haven's Needle Exchange Program: Client Shift or Needle Exchange?*, 84 AM. J. PUB. HEALTH 1991 (1994); Edward H. Kaplan & Robert Heimer, *HIV Incidence Among New Haven Needle Exchange Participants: Updated Estimates from Syringe Tracking and Testing Data*, 10 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES & HUM. RETROVIROLOGY 175 (1995); Robert Heimer et al., *Evaluating a Needle Exchange Programme: Models for Testing HIV-1 Risk Reduction*, 7 INT'L J. DRUG POL'Y 123, 129 (1996).

276. Williams, *supra* note 273 (manuscript at 52).

277. *Id.*

278. See Burris et al, *supra* note 45, at 831.



The New Haven data and Connecticut's policy learning process also probably helped the diffusion of SEPs elsewhere in the United States. To be sure, the pace of policy learning about SEPs has been painfully slow, lagging substantially behind the evidence. Only in 2006, for example, did New Jersey and Delaware—two states with chronic, serious epidemics of HIV among IDUs—even authorize SEPs,<sup>279</sup> though federal health authorities (and any number of expert bodies) had been affirming their effectiveness as far back as the Clinton administration.<sup>280</sup> The testing, diffusion, and scale-up of SEPs was tragically slow and, in that sense, no model for SIFs. Yet, the rise of SEPs in cities across the country does show that local policy learning can not only build an evidence base but result in substantial improvements in public health—provided the federal government does not act as a powerful retarding force.

The suitability of our federal system to this sort of incremental development of policy innovations is obvious, which is why the notion of states as laboratories for democracy has become a cliché. Yet, in spite of its vitality in practice, the Supreme Court's treatment of it in cases amounts too often to lip service. We do not, of course, propose adaptive governance as a rule of law, but we do see it as a value implicit in federalism that deserves some weight in the Court's analysis of cases like the SIF. Where a state or local government has undertaken a deliberate policy test, with reasonable basis to believe it will do no harm and with a serious plan to evaluate the outcome, the Court should apply rules of statutory construction, preemption, or Commerce Clause regulation with all the more prudence and caution.

To say that the protection of health is a fundamental duty of government ought likewise to be more than rhetoric. As Wendy Parmet argues, population health deserves weight as a norm in our public law. "All other things being equal," she writes, "legal decision-makers should consider the promotion of population health as a relevant factor in their analysis."<sup>281</sup> But that means more than talk. In giving content to this norm, she argues, judges and other legal decision-makers should accept, even internalize, public health methods, like the testing of plausible new interventions, and learn from the results.<sup>282</sup> If promoting population health is a goal of the law, it follows that "legal decision makers must understand the population health impact and context of the issues before them and the decisions they render. This requires that they have both a familiarity with epidemiology and medicine and a willingness to engage in empirical and probabilistic reasoning."<sup>283</sup> However ambitious this might be in

279. N.J. STAT. ANN. §§ 26:5C-25 to 26:5C-29 (West 2007); 75 Del. Laws 428 (2006) (to be codified at DEL. CODE ANN. TIT. 29, §§ 7990–7997).

280. Burris et al., *supra* note 45, at 818.

281. PARMET, *supra* note 5, at 56.

282. *Id.*

283. *Id.* at 58.

other matters, in the case of an SIF very little is required: officials and judges are asked merely to understand that public health proponents of an SIF are seeking to test an important hypothesis developed from plausible evidence. Questions of the effectiveness, cost-effectiveness, and unintended consequences of an SIF are empirical; to ask them is not to assert an answer.

Professor Johnson writes that “[d]octors frequently claim that the very law intended to improve the lot of their patients is instead making the doctors provide poor care.”<sup>284</sup> This happens, she persuasively argues, in substantial part because the claims of doctors—and in the case of harm reduction, other public health actors—are written off as the self-serving or ideologically driven make-weights of people concerned only for their own self-interested goals.<sup>285</sup> A dram of skepticism about human nature is healthy for individual judgment, but at the doses our polity has been taking, this sort of mistrust is tragically corrosive. Experimenting with new policies is the only way we will learn our way out of the present drug policy mess. We should encourage, facilitate, support, and fund those who propose to try.

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284. Johnson, *supra* note 1, at 2 (footnotes omitted).

285. *Id.*