

Overdose Prevention Center Feasibility Report

Massachusetts Department of Public Health

December 2023

I. Overview

As part of the Healey Administration's [Opioid Epidemic Strategy](#), the Department of Public Health (DPH) produced the following report outlining the feasibility of overdose prevention centers (OPCs). OPCs represent an intervention for addressing fatal overdose rates and decreasing the harms associated with drug use that has not yet been pursued in Massachusetts. DPH supported the findings and analysis in this report of harm reduction interventions and current approaches to OPC establishment with findings from the 2019 Massachusetts Harm Reduction Commission, a report authored by JSI Research and Training Institute, Inc. (JSI) with DPH support, and discussions with advocates and external partners.

Data released in December 2023 show that in 2022 there were 2,359 total confirmed and estimated opioid-related overdose deaths in Massachusetts.¹ The statewide overdose death rate in 2022 was 3% higher than 2021 and represents the most fatal opioid-related overdoses ever recorded in the Commonwealth. Communities of color are disparately impacted by this crisis, due in part to historic failures to support substance use services in these communities. Black, American Indian, and Hispanic populations experienced the largest percentage increase in opioid-related overdose death rates from 2018 to 2022, increasing by 227%, 66%, and 44%, respectively. Opioid-related overdose deaths are driven by the overwhelming presence of fentanyl in the drug supply, with over 93% of fatal opioid-related overdoses in the Commonwealth testing positive for fentanyl from January-April 2023.²

The growing presence of xylazine in the drug supply may also increase an individual's risk of fatal overdose and other harms.³ As a long-acting sedating medication, xylazine, especially in combination with other sedating drugs like opioids, can increase overdose risk and has been linked to serious injuries from long periods of over-sedation, as well as skin ulcers and infections. Since June of 2022, xylazine was routinely reported among opioid-related overdose deaths. In the first quarter of 2023, xylazine was present in 7% of opioid-related overdose deaths where toxicology screening was available.⁴ From January-June 2022, xylazine was detected in 28% of tested opioid samples throughout Massachusetts.⁵

Infections related to drug use (including HIV, hepatitis C, and skin and soft-tissue infections) necessitate health care and public health interventions, which are costly and tax an already overburdened system. Notably, several recent HIV outbreaks in Massachusetts have been directly linked to people who inject drugs and increases in local polysubstance and stimulant use.⁶

¹ Executive Office of Health and Human Services, Department of Public Health. Current Overdose Data. <https://www.mass.gov/lists/current-overdose-data>

² See fn. 1

³ National Institutes on Drug Abuse. <https://nida.nih.gov/research-topics/xylazine>

⁴ See fn. 1

⁵ Massachusetts Drug Supply Stream (MADDS). Community Drug Supply Alert: Xylazine Present in Opioids. July 2022. https://heller.brandeis.edu/opioid-policy/pdfs/xylazine-update-for-providers_community_july-2022.pdf

⁶ Massachusetts Department of Public Health Bureau of Infectious Disease and Laboratory Sciences. (2023, April). Massachusetts HIV Epidemiologic Profile: Data as of 1/1/2022, Population Report: Persons Who Inject Drugs. <https://www.mass.gov/doc/persons-who-inject-drugs-data-as-of-112022/download>

II. Harm Reduction Services in Massachusetts

Harm reduction interventions for people who use drugs (PWUD) aim to decrease the negative consequences associated with substance use by offering non-judgmental, person-centered care. Decades of research have shown that such harm reduction strategies work to prevent overdose deaths, prevent transmission of infectious diseases, and reduce emergency department visits and other healthcare costs while creating opportunities for connection and engagement to compassionate care.⁷

With leadership from the Healey-Driscoll Administration, support from the Legislature, and federal block grant dollars, DPH has invested in extensive evidence-based harm reduction programming to address fatal overdoses, increase awareness around the drug supply (including the widespread contamination of fentanyl), and increase access to low-threshold services including mobile addiction services, expanded access to syringe service programs, and increased distribution of naloxone and fentanyl test strips.

There are 60 state-funded Syringe Service Programs (SSPs) across the Commonwealth that offer sterile consumption supplies for people who use drugs and comprehensive services which may include: an Overdose Education and Naloxone Distribution (OEND) Program that conducts outreach and engagement via street outreach, mobile outreach or other strategies; testing for HIV, viral hepatitis, STIs and other infectious diseases; linkages to care; and navigation for prophylaxis against HIV. In partnership with host communities and public safety partners, the Department of Public Health has expanded drug checking using mass spectrometers in SSPs, enabling comprehensive public reporting on the contents of drug samples to track contaminations in the drug supply. DPH also funds public-private partnerships that provide mobile harm reduction outreach and engagement, preventative and primary care delivered by clinical staff, induction to buprenorphine (a medication for opioid use disorder) and referrals to ongoing care.

Since the start of the Healey-Driscoll Administration, DPH has funded and overseen the distribution of over 173,500 doses of naloxone, the overdose reversal antidote, to almost 52,000 individuals, resulting in at least 2,600 overdose reversals. First responders and schools have ordered an additional 35,200 doses of DPH-funded naloxone to use for emergency response. Since 2007, over 820,000 free doses of naloxone have been distributed to over 168,000 individuals, resulting in at least 36,000 overdose reversals. DPH has also distributed over 233,000 fentanyl test strips at no cost to consumers to encourage widespread knowledge of and access to home-drug checking supplies.

The Healey-Driscoll Administration funded the expansion of a 24/7 statewide hotline for individuals to call for overdose prevention, detection, crisis response and reversal services for people who use drugs. Helpline operators stay on the line with callers, alerting first responders only if the caller becomes unresponsive. From January-November 2023, the hotline supervised over 1,050 use events and detected 9 overdoses.

Despite the state investing over \$1.2B in substance use and harm reduction services from 2015-2022, the rate of opioid-related overdose deaths increased 8% over the same time frame.

III. Background and Evidence

Overdose prevention centers (OPCs) - sometimes called supervised injection/consumption facilities, harm reduction centers, or safe consumption sites - are evidence-based harm reduction facilities where people who use drugs (PWUD) can consume pre-obtained drugs under the supervision of trained staff. Services provided at OPCs commonly include access to sterile supplies and overdose reversal medication;

⁷ National Institute on Drug Abuse. <https://nida.nih.gov/research-topics/harm-reduction>

provision of harm reduction education; overdose monitoring; first aid administration; drug checking services, including analyzing samples and providing information back to people about the chemical composition; infectious disease testing; and referrals to health and social services including substance use disorder treatment.

OPCs are designed to reduce the negative health effects often associated with drug use including fatal overdose, infectious disease transmission, and skin and soft tissue infections. OPCs have operated for more than 30 years in Canada, Australia, and much of Europe; no overdose death has ever been reported at a sanctioned OPC. There is significant evidence on the positive impact of OPCs on mortality, health outcomes, addiction treatment, crime, and cost,^{8,9} including:

- Reduced overdose mortality by 35% in the two years following the OPC opening as compared the two years prior and reduced monthly overdose-related ambulance calls by 67% in the five years following the OPC opening as compared to the 3 years prior.^{10,11}
- Decreased harmful injection behaviors, such as syringe sharing and re-use, resulting in decreased HIV infections.¹²
- Increased uptake in addiction treatment referral, detoxification, and methadone therapy.¹³
- Decreased public injection, public syringe disposal, and other drug paraphernalia “litter” in the surrounding area.¹⁴
- No significant change in rates of crime or disorder in the surrounding neighborhoods.¹⁵
- Rebuilding service users’ connections with the health care system and other important services.¹⁶

A 2020 Institute for Clinical and Economic Review study found that if all Boston syringe service programs (SSPs) became SSP and OPC facilities, the average cost savings to taxpayers in Boston would be \$4 million each year, including 773 fewer ambulance rides, 551 fewer ED visits, and 264 fewer hospitalizations by preventing HIV, hepatitis C, hospitalizations for skin and soft-tissue infections and overdoses.¹⁷

[Recent polling](#) conducted by Massachusetts for Overdose Prevention Centers (MA4OPC) and Beacon Research suggests strong support for OPCs in the Commonwealth, with a majority (70%) of voters

⁸ Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse. [Overdose Prevention Centers](#). (In Vancouver, an OPC resulted in a 35% decrease in overdose deaths within its high-use neighborhood)

⁹ Potier C, et. al. [Supervised injection services: what has been demonstrated? A systematic literature review](#). Drug Alcohol Depend. 2014

¹⁰ Marshall BD, et. al. Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study. Lancet. 2011;377(9775):1429-1437.

¹¹ Ng J, Sutherland C, Kolber MR. Does evidence support supervised injection sites? Canadian family physician 2017;63(11):866.

¹² Wood E, Tyndall, et. al. [Summary of findings from the evaluation of a pilot medically supervised safer injecting facility](#). Canadian Medical Association journal 2006; Ickowicz S, Wood E, Dong H, et al. Association between public injecting and drug related harm among HIV-positive people who use injection drugs in a Canadian setting: A longitudinal analysis. Drug and alcohol dependence. 2017;180:33-38.

¹³ See fn. 9

¹⁴ Potier C, Laprévotte V, Dubois-Arber F, Cottencin O, Rolland B. Supervised injection services: what has been demonstrated? A systematic literature review. Drug Alcohol Depend. 2014;145:48-68. doi:10.1016/j.drugalcdep.2014.10.012

¹⁵ Chalfin, Aaron, Brandon Del Pozo, and David Mitre-Becerril. "Overdose Prevention Centers, Crime, and Disorder in New York City." JAMA Network Open 6.11 (2023): e2342228-e2342228.

¹⁶ Kerman, N., Manoni-Millar, S., Cormier, L., Cahill, T., & Sylvestre, J. (2020). "It's not just injecting drugs": Supervised consumption sites and the social determinants of health. Drug and alcohol dependence, 213, 108078. <https://doi.org/10.1016/j.drugalcdep.2020.108078>

¹⁷ Opioid Epidemic: Supervised Injection Facilities. ICER. Published December 2020. <https://icer.org/wp-content/uploads/2020/10/SIF-RAAG-010521.pdf>

surveyed supporting passage of legislation allowing cities and towns to establish overdose prevention centers. That support increased to 79% once respondents learned more about OPCs and the impact of the opioid crisis. Supporters identified the public safety benefits, the fact that OPCs facilitate recovery, the studies in support of OPCs, and the statistics about overdose deaths in Massachusetts as reasons to establish OPCs.

IV. Harm Reduction Commission Findings

The [Massachusetts Harm Reduction Commission](#), as established by Section 100 of Chapter 208 of the Acts of 2018, was charged with reviewing and making recommendations regarding harm reduction opportunities to address substance use disorder. The commission was comprised of policymakers, law enforcement officials, public health professionals, legal scholars, clinicians, and local residents. The commission based their recommendations on existing harm reduction services in Massachusetts and drew from strategies being implemented in other states and countries. Their [report](#), published in March 2019, recommended that the state develop a culture of harm reduction, expand harm reduction resources across the state, improve education of the public and health care providers, and pursue establishment of one or more overdose prevention centers (OPC).

The commission found that OPCs are an effective tool in countries where they have been implemented; these sites keep people who use drugs alive and help reduce disease transmission.^{18,19,20,21} The commission recommended that programs receive local approval, and that the Commonwealth address gaps in legal liability protections for organizations and individuals who staff an OPC, as well as those who utilize the site. The report also noted that widespread naloxone distribution, SSP expansion, and fentanyl testing are important harm reduction interventions to be implemented alongside OPCs.

V. JSI Findings on Massachusetts Harm Reduction Drop-In & Overdose Prevention Centers

JSI reviewed information submitted to the Department of Public Health from 22 harm reduction agencies and interviewed staff at six harm reduction drop-in centers to understand current opportunities and challenges in providing services. Harm reduction drop-in locations provide space for people who use drugs and those experiencing housing instability to access a safe and welcoming space to rest, eat, use the bathroom, take a shower, make a phone call, access services, and spend time with other members of their community.

Harm reduction agencies expressed interest in expanding current service offerings in drop-in centers to include OPC activities (monitored drug consumption) as well as low barrier housing, wound care clinics, mobile outreach services, and on-demand drug checking. Most agencies and their staff found that the biggest challenge to expanding current services was a lack of community support and funding, and stigma against people who use their services. Staff spoke about the need to ensure they are meeting the needs of participants from all populations, such as women, LGBTQ+ individuals, and women who engage in sex work.

JSI interviewed 356 participants of harm reduction drop-in services regarding their perspectives on existing and future service offerings. A majority (76 percent) of participants responded that they would go

¹⁸ [Presentation from Bonnie Henry, MD, MPH on supervised injection facilities and harm reduction in British Columbia.](#)

¹⁹ [Presentation from Paul Loo on supervised consumption services in Canada.](#)

²⁰ [Jessie Gaeta, MD presentation on supervised injection research.](#)

²¹ [Boston Users Union Presentation.](#)

to an OPC if one was available. Almost all participants cited that enabling staff to monitor consumption would prevent overdose deaths and would increase feelings of safety.

VI. OPCs in Other Jurisdictions

New York City

The nonprofit OnPoint NYC has operated two OPCs since 2021 without authorizing legislation or explicit support from the federal or state government. Prior to OPC establishment, Mayor DiBlasio obtained commitments from local law enforcement and district attorneys that there would be no criminal actions from the city against OnPoint NYC or their participants.²²

Since launching, the two [OnPoint facilities](#) have served 3,941 OPC participants who utilized the facility 93,695 times. Staff have intervened in 1,131 non-fatal overdoses and have collected over 2 million units of hazardous waste. A recent study found that the two OPCs did not increase crime or disorder in their New York City neighborhoods; crime and law enforcement activity in the surrounding area of the two OnPoint locations decreased as did the calls to 311, the city's information line, which often handles calls regarding complaints on drug use, syringes, noise, homelessness, and sanitary conditions.²³

As determined by state and federal law, eligible OnPoint OPC activities are funded primarily by the New York Department of Mental Health and Hygiene (DOHMH). The only activity ineligible for funding is the observation of drug consumption, which is provided using foundation and philanthropic funds. To best serve the needs of people who use drugs in their community, OnPoint has integrated clinical services into their harm reduction organization. A long-standing presence in the community, trusted program leadership, autonomy, and long contracts from funders have been helpful supports to promote sustainability of their OPCs.²⁴

While New York City's approach has successfully enabled the establishment of OPCs, without legislative authorization the OPC's operators, participants, and staff are exposed to legal risk and liability. DOHMH has released [guidelines for OPCs](#), but the city and state do not procure, regulate, or fund OPC activities. This creates additional limitations on city and state oversight and data reporting.

Rhode Island

The Rhode Island Legislature authorized establishment of a two-year pilot OPC, which is anticipated to run from 2024 - 2026. Legislation created a framework for an advisory committee to inform the regulatory process, authorized the Department of Health to promulgate regulations, and set forth legal protections.²⁵ Specifically, the bill offered protections for property owners, managers, employees, volunteers, clients, participants, and state, city or town employees against arrest, charges, or prosecution pursuant to their state's Controlled Substances Act and protected healthcare professionals from any civil administrative penalty, including disciplinary action by a professional licensing board.²⁶ Regulations

²² Giglio, Rebecca E., et al. "The Nation's First Publicly Recognized Overdose Prevention Centers: Lessons Learned in New York City." *Journal of Urban Health* 100.2 (2023): 245-254.

²³ See fn. 15

²⁴ JSI Research and Training Institute, Inc. "We save each other every day": Massachusetts Harm Reduction Drop-In & Overdose Prevention Centers. December 2023.

²⁵ State of Rhode Island General Laws. Chapter 12.10 Harm Reduction Center Advisory Committee and Pilot Program.

²⁶ Chapter 12.10 § 23-12.10-4. Liability protections. Notwithstanding any other law to the contrary, a person or entity, including, but not limited to, property owners, managers, employees, volunteers, clients or participants, and state, city, or town government employees acting in the course and scope of employment, shall not be arrested, charged, or prosecuted pursuant to § 21-28-4.01(c)(1), § 21-28-4.06, § 21-28-4.08, § 21-28-5.06, or § 21-28.5-2, including for attempting, aiding and abetting, or conspiracy to commit a violation of any of those sections; nor have their property subject to forfeiture; nor be subject to any civil or administrative penalty, including, but not limited to, disciplinary action by a professional licensing board, credentialing restrictions, contractual or civil liability, or medical staff or other

were passed in 2022 and set forth licensing procedures, management of services, physical plant requirements, and practices and procedures, among other expectations.²⁷ Rhode Island's Department of Health since released a [procurement](#) containing guiding principles and awarded a contract to [Project Weber/RENEW](#), in partnership with CODAC Behavioral Healthcare, which is on track to open in early 2024 in Providence.

Rhode Island is utilizing [opioid settlement funds](#) to establish the site - to date, \$2.25M of opioid settlement dollars have been allocated for this purpose.

Minnesota

In 2023, the Minnesota Legislature required their Commissioner of Human Services to issue grants to establish "safe recovery sites." The appropriations language includes \$14M of state funding for start-up and capacity building grants and does not include language offering liability protections for OPC activities.²⁸

Minnesota's Health and Human Services has not yet created standards for the sites or awarded funding, but without legal protections, those participating in, funding, working at and operating an OPC would remain at significant legal risk.

Philadelphia

The nonprofit SafeHouse was sued by the U.S. Department of Justice (USDOJ) under the Trump Administration for pursuing establishment of an OPC in 2019.²⁹ SafeHouse pursued establishment of an OPC without authorizing legislation or an explicit location. Litigation is ongoing, and in 2021, the Third Circuit Court of Appeals found that offering medically supervised consumption violated federal law.³⁰ Under the Biden administration, the USDOJ and SafeHouse entered settlement discussions, which have not resolved. In 2023, Safehouse filed amended counterclaims against USDOJ, and USDOJ has moved to dismiss the counterclaims.³¹

VII. Legal Considerations

Federal Law

Federal law prohibits the possession of illegal drugs by persons (21 U.S.C. § 844), prohibits organizations or spaces that facilitate drug use (21 U.S.C. § 856), provides for criminal penalties associated with conspiracy to violate the federal Controlled Substance Act (CSA) (21 U.S.C. § 846) and for committing continued controlled substance violations that results in substantial income or resources (21 U.S.C. § 848). Controlled substances offenses may also implicate laws on criminal forfeiture (21 U.S.C. § 853), denial of federal benefits (21 U.S.C. § 862), and conspiracy under the federal RICO statute for supporting illegal activity (*See Appendix A*).

employment action; nor be denied any right or privilege for actions, conduct, or omissions relating to the approval or operation of a harm reduction center in compliance with this chapter and any rules and regulations promulgated pursuant to this chapter.

²⁷ Rhode Island State Rules and Regulations. Harm Reduction Centers (216-RICR-40-10-25). <https://rules.sos.ri.gov/regulations/part/216-40-10-25>

²⁸ Minnesota Session Laws. 2023, Regular Session Chapter 61. <https://www.revisor.mn.gov/laws/2023/0/Session+Law/Chapter/61/>

²⁹ U.S. Attorney's Office, Eastern District of Philadelphia. Civil Lawsuit Filed to Seek Judicial Declaration that Drug Injection site is Illegal Under Federal Law. 2019. <https://www.justice.gov/usao-edpa/pr/civil-lawsuit-filed-seek-judicial-declaration-drug-injection-site-illegal-under-federal>

³⁰ *Safehouse v. Department of Justice*, 142 S. Ct. 345 (October 2021) (Cert. denied); *United States v. Safehouse*, 991 F.3d 503 (March 2021) (Denying rehearing and rehearing en Banc); *United States v. Safehouse*, 985 F.3d 225 (3rd Cir. 2021) (finding that proposed medically supervised consumption would violate 21 U.S.C. § 856).

³¹ <https://whyy.org/articles/safehouse-supervised-injection-suit-department-justice-dismiss/>

Although the Biden Administration has embraced harm reduction methods as a core principle and approach in [the National Drug Control Strategy](#), it has not explicitly endorsed the use of OPCs. Absent a federal policy or statutory change, enforcement of federal law against OPCs is in the discretion of federal law enforcement officials and actions have a five-year statute of limitations.

State Law and Licensing

In Massachusetts, it is a crime to manufacture, dispense or possess certain controlled substances without authorization. Clients accessing an OPC to use previously obtained illicit substances could face criminal possession charges. Staff and volunteers could also face criminal prosecution, either for possessing controlled substances during drug checking, or generally, as their actions could be interpreted as a conspiracy to violate MGL 94C. Under MGL c. 271A, OPC activities could be considered a criminal enterprise. Additionally, MGL 94C requires that all real property used to commit or facilitate the commission of a violation must be forfeited to the Commonwealth. Absent state legislative criminal and civil liability protections, those participating in, funding, working at and operating an OPC are at significant criminal legal risk, with both state and local authorities having the ability to charge, arrest and convict for drug offenses or for conspiracy to violate the state Controlled Substances Act.

Professional licensure boards generally prohibit by regulation either committing or aiding a person in performing any act prohibited by applicable federal and state law or regulation (e.g., using illicit substances).³² State legislation could protect health care professionals from disciplinary action by professional licensing boards. Absent legislation, DPH could revise professional licensing boards' regulations or issue a guidance or waiver stating that professional licensing boards will not enforce certain provisions as they relate to OPCs. This is not without precedent - DPH and BORIM were recently required via [Executive Order](#) to issue guidance regarding the provision of reproductive health care services "provided that any such use, prescribing, dispensing, or administration is done in accordance with the acceptable standards of care and utilizing sound medical judgment".³³

VIII. Currently Filed Legislation

[H.1981/S.1242](#), *An Act relative to preventing overdose deaths and increasing access to treatment*, is currently pending before the legislature. These companion bills create a framework that would allow oversight and operation of OPCs, while reducing legal and other risk. If passed, the bills would require DPH to promulgate regulations and establish a licensure process for authorization of a 10-year OPC pilot program. The bills additionally set forth legal protections, minimum standards, and required data collection expectations. The liability protections established in H.1981/S.1242 are in alignment with the approach in other states, exempting providers, staff and participants from state civil, criminal, and professional licensure consequences resulting solely from engaging in OPC activities.³⁴ Without this

³² 244 CMR 9.03(7).

³³ While the Boards and BORIM could have issued guidance on their own, a mandate from the Governor via Executive Order does not require legislative approval.

³⁴ S.1242/H.1981 "Notwithstanding any general or special law or rule or regulation to the contrary, the following persons shall not be arrested, charged, or prosecuted for any criminal offense, including, but not limited to, charges pursuant to sections 13, 32I, 34, 43 or 47 of chapter 94C of the General Laws, or be subject to any civil or administrative penalty, including seizure or forfeiture of data records, assets or property or disciplinary action by a professional licensing board, credentialing restriction, contractual liability, and action against clinical staff or other employment action, or be denied any right or privilege, solely for participation or involvement in an overdose prevention center licensed by the department of public health pursuant to this section: (i) a participant; (ii) a staff member or administrator of a licensed overdose prevention center, including a health-care professional, manager, employee, or volunteer; (iii) a property owner

language, individuals utilizing or participating in OPCs would be exposed to significant legal and professional licensure risk.

IX. Feasibility and Findings

Faced with the urgency of the overdose crisis, OPCs represent an evidence-based, life-saving tool that is aligned with a comprehensive, public health approach to reducing harm and improving wellbeing in the Commonwealth. OPCs are also well supported among people who use drugs, agencies and staff of existing harm reduction programs, and a majority of Commonwealth voters. After considering existing resources and capacity, DPH believes that OPC establishment is feasible and necessary, pending legislative action to extend legal protections, and recommends that OPCs be pursued as an additional tool to address the harms of substance use.

Unless there are changes to federal law, OPC activities will remain prohibited at the federal level and subject to the discretion of federal law enforcement. However, enacting a state law that expressly permits OPCs may lead to federal policy development that will reduce exposure to federal enforcement or potentially to changes in federal law as with the legalization of marijuana. Notably, OPCs have operated in NYC since 2021 without federal enforcement intervention and Rhode Island plans to open its first state-regulated OPC in March 2024.

Absent this legislation, individuals and entities face significant exposure to both civil and criminal liability as well as risk to their professional licensure. This proposal significantly reduces those risks and provides a viable pathway for these sites to operate.

For these reasons, DPH recommends that Massachusetts enact statutory language offering protection against arrest, charges, or prosecution of property owners, managers, employees, volunteers, clients or participants, and state, city or town government employees acting in the course and scope of employment pursuant to §32, §32A-D, 32I, § 34 § 40 of M.G.L. c. 94C or § 1-3 of M.G.L. c. 271A, including for attempting, aiding and abetting, or conspiring to commit a violation of any of those sections. Additionally, individuals and entities should be protected from property forfeiture and civil and administrative penalty, including, but not limited to disciplinary action by a professional licensing board, credentialing restrictions, contractual or civil liability, or other employment action. Protection should not extend to gross negligence or willful or wanton misconduct, and should relate solely to the approval, participation, or operation of an OPC.

The statutory protections described would allow a municipal or private entity to operate an OPC without the threat of state enforcement solely for conducting approved activities and would allow participants and staff to access and deliver services without fear of state legal action. Without such protection, people who use drugs and utilize a site could be subject to arrest for possession of substances that they use/intended to use at an OPC. Staff, volunteers, property owners, operating entities, funders, and state, city and town employees could be subject to charges related to the operation of a site that enables illicit substance use, including criminal conspiracy. Moreover, the property used to provide OPC services could be permanently seized by state law enforcement. Professionally licensed individuals providing services at an OPC could have their licenses revoked or suspended for assisting participants in committing prohibited drug use. Without legal protections, state law enforcement could terminate operations at an OPC at any time, discouraging other interested entities from opening new OPCs. People who use drugs face immense barriers in accessing needed services, and along with protecting staff, volunteers, funders, operators, and

who owns property at which a licensed overdose prevention center is located and operates, (iv) the entity operating the licensed overdose prevention center. Entering or exiting a licensed overdose prevention center cannot serve as the basis for, or a fact contributing to the existence of, reasonable suspicion or probable cause to conduct a search or seizure.”

participants from legal action, legal protections are necessary to expand the harm reduction services available to a stigmatized population. It is DPH's position that OPC activities are a life-saving intervention and a component of healthcare, and that these activities should be protected as such.

It is critical that any statutory language also require DPH to regulate and approve overdose prevention centers, as it provides the ability for DPH to set forth minimum standards and reporting requirements. BSAS' regulatory oversight currently includes all licensed substance use treatment programs in the Commonwealth, where they have established evidence-based and enforceable minimum standards to ensure quality treatment for individuals accessing substance use disorder treatment. Without additional regulations, DPH's only oversight and enforcement mechanism would be set forth through contracts with OPCs; however, OPCs could operate without contracting through DPH. In that case, DPH would have no mechanism to enforce minimum standards or collect data and information. Regulations allow DPH to standardize OPC activities, ensure quality of care, and mandate the reporting of key data points.

X. Conclusion

Overdose deaths are preventable. Despite significant investment in harm reduction services, the Commonwealth continues to observe missed opportunities to adequately engage people who use drugs, meet their needs, and prevent fatal overdoses, with devastating impacts to our residents. Establishing OPCs would enable the Commonwealth to reach individuals who may not otherwise be accessing healthcare services, reduce disease transmission, and prevent deaths.

The Healey-Driscoll Administration, the Legislature, advocates, and harm reduction providers and institutional partners have shown continued resolve in addressing the overdose crisis. Individuals across the Commonwealth have been impacted by substance use disorder. Collectively, we have ensured that there is a culture of harm reduction upon which to build and OPCs represent one additional tool to pursue to prevent overdose deaths.

Appendix A: Federal Statutes Potentially Applicable to OPC Operations

21 U.S. Code § 844 - Penalties for simple possession. It is illegal to possess a controlled substance unless it was obtained directly from a practitioner, or pursuant to a practitioner's legal prescription. Penalties include both fines and prison sentences of up to 3 years.

21 U.S.C. § 848 - Continuing criminal enterprise. A person engages in a continuing criminal enterprise if they commit a controlled substance felony, and the violation is part of a continuing series of controlled substance violations which are undertaken in concert with five or more people with a management structure. The person must also obtain substantial income or resources from the enterprise. Penalties for individuals include fines of up to \$2,000,000 and a prison term of 20 years to life; penalties for entities include fines of up to \$5,000,000.

21 U.S. Code § 853 - Criminal forfeitures. For any drug offense which resulted in a prison sentence of 1 year or more, any property associated with the offense can be subject to forfeiture, including houses, cars, and other personal belongings._

21 USC § 856 - Maintaining a Drug-Involved Premises. Twenty year maximum for opening, leasing, renting, or maintain a premises for drug manufacturing, use or distribution. Penalties for persons include fines of up to \$500,000 and imprisonment of up to 20 years; penalties for entities – fines up to \$2,000,000.

21 U.S.C. 862 - Denial of Federal Benefits. An individual convicted of a federal drug offense may be declared ineligible for federal benefits for up to 5 years. (Exemption for federal benefits related to SUD treatment).

21 U.S.C. § 846 - Attempt and conspiracy. Conspiracy to commit any drug offense carries the same penalty as those assigned to the offense.

RICO. Federal RICO offenses include controlled substance offenses. 18 USC § 1961(1). RICO Conspiracy charges, can include almost anyone/any entity supporting the illegal activity. RICO Conspiracy: The federal RICO statute expressly states that it is unlawful for any person to conspire to violate any of the subsections of 18 U.S.C.A. § 1962. The DOJ would not need not prove that a defendant agreed with every other conspirator, or knew all of the other conspirators, or had full knowledge of all the details of the conspiracy. *United States v. Delano*, 825 F. Supp. 534, 542 (W.D.N.Y. 1993), *aff'd in part, rev'd in part*, 55 F. 3d 720 (2d Cir. 1995) All the DOJ needs to show is that: (1) that the defendant agreed to commit the substantive racketeering offense through agreeing to participate in two racketeering acts; (2) that the defendant knew the general status of the conspiracy; and (3) that the defendant knew the conspiracy extended beyond his individual role. *United States v. Rastelli*, 870 F. 2d 822, 828 (2d Cir.), *cert. denied*, 493 U.S. 982, 110 S. Ct. 515, 107 L. Ed. 2d 516 (1989).