An Investigation into Philadelphia’s Opioid Crisis

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Part 1: My Research

I. Introduction

The opioid epidemic continues to destroy the lives and livelihoods of drug users and their loved ones. Since 1999, the number of overdose deaths from opioids—including prescription pain medications, heroin, and synthetic opioids—increased by a factor of six.¹ It recently was announced that over 100,000 Americans died from drug overdoses between 2020 and 2021 alone, with about 75% of these deaths being caused by opioids.² Much of the increase in overdose deaths can be attributed to the pandemic as well as the rising prevalence of the potent and dangerous synthetic opioid fentanyl, which is up to 100 times more powerful than morphine.³ Furthermore, the economic cost of the opioid crisis in 2018 was about $700 billion, and from 2015 to 2018 the cost topped $2.5 trillion.⁴ Opioid addiction infamously refuses to discriminate; it traps people of all demographics and has devastated families and communities in both rural and urban parts of the country. Finally, opioid overdose deaths have contributed to the declining U.S. life expectancy along with other “deaths of despair,” like alcohol-related deaths and suicide. Obviously, this is a pressing and relevant issue for all Americans, and especially policymakers.

I center my focus on conducting a large case study in Philadelphia, a hotspot for opioid use. Of all major U.S. counties, Philadelphia County has the highest overdose rate.⁵ The city’s

Kensington neighborhood in particular attracts “drug tourists” from across the northeast and the entire country. It is commonly said to be the largest open-air heroin market on the East Coast. Kensington is known for its cheap and pure heroin and has become practically synonymous with flagrant opioid use, dealing, and drug-related violence.

Virtually all Philadelphia stakeholders at this point, including law enforcement, have shifted away from the War on Drugs mindset and accepted that instead of mass-arresting drug users, steering people into treatment should be the priority. Similarly, there is quite a bit of agreement amongst scholars and public health policymakers about the necessary steps to remedy the opioid crisis. This includes expanding harm reduction measures such as establishing safe injection sites (SIS). A major puzzle remains when considering this broad consensus: What is getting in the way of more progress? If anything, the opioid crisis in Philadelphia has only worsened in the past few years, despite the election of a progressive Democrat, Mayor Jim Kenney, who ran on addressing the city’s startling opioid epidemic and has been sympathetic to those impacted by it.

I set out to answer this question by investigating Philadelphia's opioid epidemic in an open-minded fashion—interviewing people involved in the crisis from all different angles and perspectives—to identify the major barriers stalling the alleviation of this dire public health crisis.

I begin my research by surveying the scholarly literature on the best solutions to solve the opioid crisis and tackle nimbyism (“not in my backyard”). I then present my research design, in which I hypothesize that there are two key barriers preventing more progress from being made: bureaucratic and political. Then, I provide historical background on the Kensington neighborhood over the past century and detail the city’s response to the opioid crisis from 2010
to present. Next, I present my findings from in-depth interviews with diverse actors who deal with the crisis on what obstacles are getting in the way of more progress; I categorize these obstacles in a more complex way than simply as bureaucratic and political. Finally, I analyze my findings and make catered recommendations to Mayor Kenney on the appropriate course of action.

II. Literature Review

Question 1: What is the most effective solution the city of Philadelphia can implement to remedy the opioid crisis?

Treatment

Medication-Assisted Treatment

Medication-Assisted Treatment (MAT) is the most evidence-based form of treatment for opioid use disorder (OUD). MAT consists of psychosocial counseling along with the prescription of medication to limit illicit opioid use, reduce the risk of overdose, and prolong the time one remains in treatment. MAT “… significantly augments treatment retention, reduces illicit opioid use, reduces the burden of opioid craving, and, in the case of agonist therapies, provides effective relief of the opioid withdrawal syndrome.”

The three most common medications prescribed are methadone, buprenorphine, and naltrexone. Methadone is often the most effective. However, it can usually only be accessed through opioid treatment programs (OTPs). Methadone is an opioid agonist, activating the same

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brain receptors as other opioids. Buprenorphine is a partial agonist, activating brain receptors but in a minimally potent manner. Buprenorphine can be prescribed outside of OTPs by any provider who applies for a governmental waiver.

Naltrexone can be prescribed like most medications, making it the most convenient of the three. Naltrexone is an antagonist, meaning that it binds to opioid receptors but does not activate them. Naltrexone is not an opioid and is not addictive. However, patients must go through a detox process (7-10 days) before using naltrexone and scholars have found that if individuals do relapse after taking naltrexone, they are at higher risk of an overdose because their tolerance has declined. Unlike methadone and buprenorphine, naltrexone has not been found to reduce mortality and concerns surrounding “safety following medication discontinuation or efficacy compared to agonist therapy” persist.

There are many studies that highlight various benefits of MAT. For instance, one study discovered that after nine months of taking buprenorphine, the quality of life of individuals dependent on opioids improved. The scale used to measure this—the WHO Quality of Life brief version—contains four categories: physical, psychological, social relationships, and

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13 “TIP 63: Medications for Opioid Use Disorder - Executive Summary.”
14 Connery, “Medication-Assisted Treatment of Opioid Use Disorder.”
environment. The physical domain improved the most, but buprenorphine improved all four domains of an individual’s quality of life.\textsuperscript{15}

Due to the overwhelmingly supportive evidence of MAT, many scholars advocate for a mobilization of resources focused on MAT. Winograd et al. propose a “Medication First” approach to the opioid crisis, framing their stance as a modified version of the “Housing First” policy solution to homelessness. They specifically detail the Med First platform that has been implemented in Missouri, and state that its early results are promising. The authors emphasize that medications for opioid use disorder (MOUD) are effective and strongly supported by evidence, yet many Americans struggle to access MOUD, especially for a substantial period of time. The four fundamental principles of the Med First approach are: “Clients receive pharmacotherapy as quickly as possible, prior to lengthy assessments or treatment planning sessions; Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits; Individualized psychosocial services are offered but not required as a condition of pharmacotherapy; Pharmacotherapy is discontinued only if it appears to be worsening the client’s condition.”\textsuperscript{16}

The Accessibility Problem and Potential Solutions

The largest policy issue surrounding MAT is its availability to opioid users. In fact, the 2019 National Survey on Drug Use and Health revealed that: “Among the 1.6 million people aged 12 or older with a past year opioid use disorder ... 18.1 percent (or 294,000 people) received

\textsuperscript{15} A. Dhawan and A. Chopra, “Does Buprenorphine Maintenance Improve the Quality of Life of Opioid Users?,” The Indian Journal of Medical Research 137, no. 1 (January 2013): 130–35.

\textsuperscript{16} Winograd et al., “The Case for a Medication First Approach to the Treatment of Opioid Use Disorder.”
MAT in the past year for opioid misuse.” Different reasons for this problem have been identified and various creative solutions have been proposed, which I discuss in this section.

Various scholars depict the potential benefits of loosening waiver requirements for buprenorphine to increase access. Fiscella et al. support the deregulation of buprenorphine prescribing, specifically the waiver requirement. They argue that deregulation would offer an array of benefits, including a reduction of fear and stigma surrounding the drug. They cite a case from France in which buprenorphine was deregulated and overdose mortality decreased significantly. They claim: “If such changes prove even half as effective as in France, thousands of lives could be saved.” Also, Fiscella et al. argue that deregulation (especially getting rid of the buprenorphine waiver requirement) would help primary care integrate MAT because these physicians would have the ability to conduct MAT on their patients.

Similarly, Saloner et al. advocate for the expansion of buprenorphine to be available “on demand” in emergency rooms, questioning the validity of the current tight regulations. They also allude to the successful results from France as evidence. Saloner et al. propose closer collaboration between specialty care centers and primary care providers. In terms of treatment, they suggest that communities collaborate with care providers to overcome common hurdles such as waiting lists; they specifically emphasize the importance of collaboration between specialty treatment centers and “office-based prescribers.” They cite the hub-and-spoke model in Vermont as a good example of overcoming waitlists.

Padgett acknowledges some benefits of expanding MAT to outpatient primary care providers but argues that it could lead to “the disruption of continuity of care with regard to

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17 Substance Abuse and Mental Health Services Administration, “Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health,” 2020.
18 Kevin Fiscella, Sarah E. Wakeman, and Leo Beletsky, “Buprenorphine Deregulation and Mainstreaming Treatment for Opioid Use Disorder: X the X Waiver,” JAMA Psychiatry 76, no. 3 (March 1, 2019): 229.
psychotherapy treatment," complicating the patient’s situation with the need for multiple doctors to communicate with one another about their treatment and progress. The Vermont hub-and-spoke model addresses Padgett’s concerns because it serves as a practical example of collaboration between primary care and specialty treatment centers.

Brooklyn and Sigmon review the implementation and success of the Vermont model. Before its implementation, Vermont had one of the highest rates of office-based opioid treatment (OBOT). However, waiting lists at OTPs could persist for years because OBOT providers were only treating a limited number of patients at a time. The authors share that this problem, “...prompted recognition of the need for a specialized clinic which could induct patients onto buprenorphine before transfer to OBOT, retain complex patients, and also receive returning patients who destabilize during OBOT.” The state decided to view OTPs as “hubs” or “[centers] of addiction expertise,” while OBOT providers scattered throughout the state served as “spokes.” The state of Vermont was divided into 5 sections, each with their own hub. These hubs had the ability to prescribe buprenorphine or methadone. Brooklyn and Sigmon explain: “Briefly, hub staff assess patients’ medical and psychiatric needs at intake and determine the most appropriate treatment placement…” This could mean treatment at the hub or an OBOT spoke.

Further demonstrating the comprehensive nature of this model, “entry points into the hubs also include hospitals and emergency rooms (especially after an overdose reversal or medical treatment for injection-related diseases), residential programs, Department of Corrections, and community mental health programs.” This model directly contradicts Padgett’s concerns because sending patients in spokes back to the hub “are prioritized to ensure that

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providers feel supported and patients receive continuity of care.” In sum, this model proved extremely successful in Vermont and solved the accessibility problem: “With 6604 patients on [opioid agonist treatment] and Vermont’s total population of 625,000, this represents 1.05% of all Vermonters on [opioid agonist treatment] or 10.56 people treated per 1000 people up from 2012 when it was 3.76 people per 1000.”

The Massachusetts Collaborative Care Model (MCCM) is an additional example of the successful mobilization of resources towards MAT. LaBelle et al. describe how despite the ability for physicians to get waivers to prescribe buprenorphine in OBOT settings, various barriers still exist. Hence, a group of doctors and researchers at Boston Medical Center (BMC) created the MCCM in 2003. This model has four phases: “screening and assessment of the patient’s appropriateness for office-based treatment; medication induction under a Nurse Care Manager’s [NCM] direct supervision; stabilization; and maintenance.” Community health centers (CHCs) and NCMs are crucial to the model’s success as these locations and individuals provide needed support to doctors. LaBelle et al. explain: “The NCM is usually the initial contact for patients seeking [OBOT with buprenorphine] treatment and acts as the primary liaison between the patient and the OBOT physician throughout the treatment process.” Furthermore, “With the NCM as the first point of contact, patients have access to the [OBOT with buprenorphine] team for questions, issues or support during induction and as needed throughout treatment. During treatment stabilization, patients are followed closely with weekly or more frequent visits as well as telephone communication to provide support and education, assure adherence, and address other concerns the patient may have.” If the patient follows their protocol correctly (including negative drug tests) and consistently goes to counseling meetings, they will

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begin to taper their meetings with the NCM. The authors conclude that this model is extremely effective in expanding access to MAT with buprenorphine.

Another interesting recommendation for MAT’s accessibility problem comes from Schwartz et al.\textsuperscript{23} They conduct a randomized control trial of individuals seeking methadone maintenance treatment in Baltimore. Although all participants were put on a waiting list for the requested treatment, the researchers gave some participants access to interim methadone maintenance in the meantime. They find that those given the interim treatment are much more likely to enter comprehensive methadone maintenance treatment after the 120-day period than those simply placed on the waiting list. This finding has major implications for the major barrier of long waiting lists. Based on Schwartz et al.’s research, it could be argued that a form of interim treatment is promising to help remedy this problem and maximize the total number of individuals who enter MAT.

Stigma lingers as a barrier to MAT as well. This is often a stigma held by doctors as well as abstinence advocates who believe that complete sobriety is the only way to overcome opioid addiction. Many scholars assert that stigma is all too common. According to these authors, stigma directly relates to the lack of treatment for opioid users as it is correlated with low public support for treatment funding. Saloner et al. remark: “Reducing stigmatizing attitudes among law enforcement, clinicians, emergency medical responders, and others who work closely with people who use opioids should be a priority of public health policy makers.”\textsuperscript{24}

However, one study determined that stigma is not a large factor in preventing medical professionals from adopting MAT.\textsuperscript{25} Knudsen et al. attempt to identify the main barriers

\textsuperscript{24} Saloner et al., “A Public Health Strategy for the Opioid Crisis.”
preventing publicly funded substance use disorder (SUD) organizations from adopting MAT. They randomly select programs throughout the country. They find that one of the most salient barriers cited by these programs is a shortage of trained medical personnel to administer MAT. They state: “This latter finding suggests that greater MAT-specific training for physicians and nurses currently employed in the substance abuse treatment field is needed.” Furthermore, the medical field must strengthen its ability to “attract and retain nurses and physicians with specialty training in implementing MAT. These workforce-related issues will likely require additional funding as well as incentives for medical personnel to obtain specialty training.”

Significantly, the authors find that “intra-organizational” factors such as personal views on MAT and cultural norms were not major barriers preventing programs from adopting MAT. They obtain the same result when it comes to “patient-level barriers,” apart from patient inability to pay. These findings shed light on the challenges faced by health professionals and call into question other scholar’s claims that things like clinical and patient stigma against MAT are the major barriers to access.

Criticisms of MAT

Concerns about MAT range from calls for more conclusive evidence to full-blown disapproval of MAT. While many of these concerns are legitimate, there are also a number of prevalent myths about MAT. One common misconception is that MAT simply replaces one addictive substance for another.

One area of concern pertains to the effect of these drugs when taken over the long term. This is particularly relevant when considering ideas like Winograd et al.’s Med First approach,
which explicitly argues for MAT to be “discontinued only if it appears to be worsening the client’s condition.”

Maglione et al. review the literature on “functional outcomes” of individuals on different OUD medication. They argue that there is a lack of research on this and therefore do not draw any sharp conclusions. However, they disclose: “We found that although MAT patients performed significantly better on some functional outcomes than persons with OUD who did not receive MAT, they performed worse on several cognitive measures than did matched “healthy” controls with no history of SUD or opioid use.” Although this may raise concerns about MAT, it is important to note that they did not compare cognitive outcomes of people on MAT with other persons struggling with OUD. These findings point more to the inherent hardships opioid addiction poses. Overall, Maglione et al. find that the quality of evidence in their review is low, so again, precise conclusions about MAT cannot be made.

Recent research addresses another concern pertaining to MAT: overdose and overdose deaths. The authors find that a substantial number of individuals receiving MAT have had an overdose, with 8% going to an emergency department in the last year because of this. Au et al. conclude that MAT should be viewed as “... a period of increased risk in the event of an overdose due to potential loss of tolerance to opioids.” However, they detect an inverse relationship between overdose and time on MAT, suggesting that better MAT retention decreases the risk of overdose.

Despite the promising effect of long-term MAT shown by Au et al., research conducted by the Norwegian Institute of Public Health shows that methadone treatment in the long term can

26 Winograd et al., “The Case for a Medication First Approach to the Treatment of Opioid Use Disorder.”
27 Margaret A. Maglione et al., “Effects of Medication-Assisted Treatment (MAT) for Opioid Use Disorder on Functional Outcomes: A Systematic Review,” Rand Health Quarterly 8, no. 4 (June 15, 2020): RR-2108-OSD.
impact the brain’s nerve cells. The authors conclude: “Our studies show that prolonged methadone treatment can affect the nerve cells, and thus behaviour, but the results are not always as expected. Many more pre-clinical and clinical studies are needed to understand methadone’s effect on the brain, how this can result in altered cognitive function, and, if so, how long these changes last. Knowledge of this is important—both for the individual methadone patient and the outcome of treatment.”

Abstinence and Sobriety

A belief that abstinence is the only way for an individual to conquer opioid addiction originates from the historical prominence of sobriety-focused groups for various addictions, such as alcohol. Programs like Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) are often called “Twelve-Step” groups. Advocates of MAT often conflict head-on with those who support and follow the Twelve-Step approach. The reason for this division is that the latter approach began in the 1930s, well before medication was available as a treatment form for alcohol addiction. Because of this, “The Twelve-Step approach then became embedded in the treatment community as part of the culture of recovery from alcoholism.” Galanter argues that consistent members at AA or NA meetings are extremely skeptical towards medication as a solution to addiction: “Few of them are acquainted with contemporary evidence-based medicine and, furthermore, may have had unproductive encounters with medical professionals. Because of this, they are often averse to a medically oriented approach to addictive disorders. Thus, new attendees, who may be on methadone or buprenorphine maintenance, and even ones prescribed naltrexone, may be sidelined in the fellowship’s meetings or discouraged from speaking there.”

Galanter suggests that treatment facilities or “rehabs” founded on the Twelve-Step model incorporate more physicians who can provide MAT.

Also, and perhaps more controversially, Galanter contends that physicians must incorporate aspects of the Twelve-Step approach into their treatment procedures. The Twelve-Step approach offers crucial resources and a reliable network to recovering opioid users that cannot be overlooked, according to Galanter. He suggests that medical professionals make more referrals to AA and NA to combat the harmful existence of these “two cultures.” He concludes: “Another way of looking at the utility of these combined services may be that they can overcome attitudinal issues by communicating that it is a health issue when supportive advice is offered [to] patients along with medications that are prescribed. In this way, participation in a Twelve-Step program can be likened to the advice offered by a nurse in addition to the physician’s prescribing itself. Given the demonstrated gap in our capacity to provide effective treatment for severe substance use disorders, this is an area that merits attention.”

Harm Reduction

Harm reduction solutions to the opioid crisis differ from treatment in that they aim to reduce some of the negative impacts of OUD like disease and overdose deaths, but do not try to stop individuals from using opioids. These solutions aim to increase the safety of opioid use. Given the United States’ history of policing drug use and adopting punitive measures, harm reduction measures carry controversy with them.

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31 Ibid.
Safe Injection Sites

Safe injection sites (SIS) are facilities where drug users can inject drugs safely, with employees nearby to reverse overdoses, clean needles, and an overall support network. Many synonymous terms exist for SIS, but for consistency, I use SIS throughout this literature review. Although no sites currently exist in the United States, various cities have proposed or considered implementing them. Because of this, research on the efficacy and impact of SIS comes mainly from Europe, Canada, and Australia.

Support for SIS

Empirical research overwhelmingly points to various benefits being derived from SIS in communities. One study estimates the potential impact of a SIS in Philadelphia based on models from San Francisco and Baltimore that conduct cost-benefit analyses of hypothetical SIS in these cities. The authors find that the hypothetical SIS in Philadelphia would prevent up to 18 HIV and 213 hepatitis C infections annually. They proceed to use two existing models to predict the impact on overdose deaths. The first model predicts the avoidance of between 27 and 43 deaths annually. The second model predicts the avoidance of between 24 and 76 deaths annually. The researchers also examine the costs associated with a SIS in Philadelphia: “Reduced costs related to hospitalization for skin and soft tissue infections (SSTI) are estimated to be between $1,512,356 and $1,868,205 per year.” In addition, they find that the “total value of overdose deaths averted is between $12,462,213 and $74,773,276 annually.” Furthermore, according to their estimates, ambulance costs would drop by $123,776, hospital emergency departments would save $280,683, and fewer hospitalizations would save $247,971 in health care costs. The

authors conclude that a safe injection site in Philadelphia would benefit drug users and their communities.

Aligning with the above study, another researcher finds that Vancouver’s SIS—Insite—and syringe service programs are cost effective. The operating costs of Insite are significantly lower than the medical costs of treating HIV infections that would occur without Insite. In addition, Andresen and Boyd create mathematical models which indicate that Insite is cost-effective based on two measures: HIV infection and overdose death. Specifically, they find that “...Vancouver’s [SIS], Insite, on average, prevents 35 new cases of HIV and almost 3 deaths each year. This provides a societal benefit in excess of $6 million per year after the programme costs are taken into account...”

Another promising benefit of SIS is that they could potentially connect addicts to treatment. Indeed, there is some evidence of this exact trend. A study of the connection between usage of a SIS in Vancouver and entrance into detoxification services determined that “the opening of the Vancouver [SIS] was associated with a greater than 30% increase in the rate of detoxification service use among [SIS] users in comparison to the year prior to the [SIS’s] opening.” This study disputes claims that SIS make it less likely for drug users to seek treatment; indeed, SIS can foster networks in which drug users are more easily referred to treatment.

Not Enough Conclusive Evidence

Some scholars argue that not enough conclusive evidence exists to speak to the efficacy of SIS. This critique is evident even in the above section, in which many scholars get their evidence from the same SIS in Vancouver. Caulkins et al. summarize the literature on SIS and put forth their own nuanced view on the question of whether there is enough evidence to move forward with them. They admit that the literature is overwhelmingly positive towards SIS; still, there is simply not enough evidence at this point to make any sweeping proclamations, especially causal claims, according to the authors. They argue that the answer to the evidence question is dependent on various factors. Multiple decision-makers and perspectives naturally lead to differing opinions on if there is enough evidence to move forward.36

In addition, another review of the literature on SIS concludes that although much evidence supports their implementation, many questions still need to be answered before drawing appropriate conclusions. Specifically, Lingle points to the lack of long-term longitudinal studies that “capture changes over time.” She also stresses that no studies compare different SIS.37

Moral Objections

Some scholars (mainly ethicists) object to SIS due to perceived moral flaws. In this category is Bozza and Berger, who argue that safe injection sites are “morally illicit.”38 The authors reason that addiction is a destructive force for individuals, their families and their communities. They think society’s goal should be to help those addicted to opioids end their

“enslavement” to these substances. The authors go on to argue that although the intention and circumstance of this intervention may be morally good, the fact remains that SIS promote “an intrinsically evil act.” They propose other harm reduction measures that include centers that give essential resources to drug addicts but do not allow or provide drugs.

In line with moral objections is the “rock bottom argument.” This argument aligns with the abstinence approach to addiction because it asserts that until a drug user hits rock bottom, they will not possess the motivation required to get sober. The rock bottom metaphor “…attends to the belief that SISs will further perpetuate an endless cycle of drug addiction by allowing individuals to remain addicted to drugs.” According to this narrative, a SIS makes it nearly impossible for users to hit rock bottom. Although the evidence that safe injection sites connect some users to treatment is strong and perhaps contradicts this argument, I bring it up mainly because it reflects a prevalent belief held by various drug counselors and former users and serves as a barrier to SIS.

**Legal Objections**

There is truth to the claim that SIS violate federal law, specifically the “crack house statute” within the Controlled Substances Act. The deputy attorney general under President Trump, Rod Rosenstein, argued in a 2018 op-ed that the sites proposed in many American cities are illegal as these locations violate federal law by “facilitating illicit drug use.”

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Negative Externalities

A major concern pertaining to SIS is negative externalities. However, there is mixed evidence about how accurate these concerns are, and some evidence exists in support of the exact opposite idea: SIS reduce some negative externalities. The most contentious matters are crime and public nuisance. A 2020 report from the Canadian Province Alberta found general increases in crime around their seven sites: “Except for Edmonton, crime, as measured by police calls for service, generally increased in the immediate vicinity in contrast to areas beyond the immediate vicinity of the sites.” However this report has since been disputed, and scholars have attacked it. Livingston explains that various scholars and organizations have disputed the claims made in the Alberta report. He proposes three key issues with the methodology used to study crime data: “crime was poorly operationalized and measured, change in crime was inadequately assessed, and the effect of [SIS] on crime was not ascertained.” Livingston asserts that crime was measured indirectly and inefficiently: by looking at “police service calls and public perceptions of crime.”

In addition, there are studies that show SIS do not bring more crime with them. One of these studies looks at crime reports before and after Vancouver’s SIS opened. The authors find no increase in drug-related crime around the site, and in fact, report “a decline in vehicle break-ins/vehicle theft …”

However, there seems to be a disconnect between empirical studies and on the ground news reports from credible sources. For instance, a 2020 news article from ABC Action News

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Philadelphia suggests that safe injection sites in the Toronto area have increased crime and general disorder outside. The literature overwhelmingly agrees that safe injection sites do not increase crime. However, Action News reporter Chad Pradelli tells a different story. A local bar owner in Toronto, Christine Wittick, tells Pradelli: “We started to have drug dealers and prostitutes across the street. Crime started to escalate, neighbors have had their homes broken into, my husband has been punched in the face by a man who was very, very high in front of customers.”

Syringe Exchange Programs

Syringe exchange programs (SEPs) aim to provide clean needles to drug users and facilitate proper disposal of needles. A study that systematically searches the literature finds that from the 12 studies narrowed in on, there is evidence that syringe exchange programs reduce HIV infections.

On the other hand, a different study finds that although SEPs greatly reduce HIV transmission, they also can increase opioid-related overdoses: “Taken together, these findings suggest that while SEPs are successful in reducing disease, lowering the cost of obtaining clean needles and other supplies unintentionally encourages more drug use, leading to more opioid-related overdoses. While many of these overdoses can be reversed in the ER, SEPs do little to prevent mortality rates from rising in subsequent years. These effects become more pronounced over time, indicating that any future cost-benefit analyses of SEPs should consider

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effects at least 2-4 years after the introduction of the program. Packham recommends that policymakers consider the full array of costs and benefits of SEPs or any intervention to the opioid crisis.

**Naloxone and Good Samaritan Laws**

The intention behind both naloxone (Narcan) distribution and Good Samaritan laws is to empower bystanders or witnesses of a potential opioid overdose to either reverse it themselves with naloxone or to call for help without fear of getting in trouble thanks to Good Samaritan laws.

Naloxone is an opioid antagonist that can reverse the effects of an opioid overdose. Given its ability to save lives, many public health experts advocate for getting it in the hands of various community members, drug users, and loved ones of drug users. This is also the drug that would be available at a SIS. Cerdá et al. maintain that in order to create the largest societal benefit from the expansion of naloxone availability, people must be trained to use it properly and feel confident doing so. One study finds that the passage of a Naloxone Access Law can reduce overdose deaths by between 9 and 11%. Another study credits Naloxone Access Laws with a 14% reduction in opioid overdose deaths.

The literature on Good Samaritan laws—which legally protect people who call 911 due to an overdose—is a bit hazier in terms of their impact as a harm reduction measure. One study

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saw no statistically significant relationship between these laws and overdose deaths. However, another finds that Good Samaritan laws reduce opioid overdose deaths by 15%.

**Fentanyl Test Strips**

Increasingly, fentanyl is found in the drugs of opioid users. Cerdá et al. suggest that the availability of test strips to identify the presence of fentanyl in other drugs could boost harm reduction efforts. However, they note that more research is needed to better understand the impact of testing for fentanyl.

**Multifaceted Approaches**

Many policy solutions to the opioid crisis garner a lot of empirical support for their efficacy and cost-effectiveness. Therefore, it is easy to come across proponents of an all-encompassing or multifaceted approach to the opioid crisis that incorporates the use of multiple strategies which have been outlined above.

One model for 2020-2030 illustrates the results of four different policy interventions to the opioid crisis. The researchers model each solution’s effect on overdose deaths as well as persons with opioid use disorder (PWOUD). The four interventions are: reducing the dosage of opioids prescribed by 20%, reducing user “diversion” to illicit drug markets by 30%, increasing the number of opioid users who use MAT from 45% to 65%, and increasing naloxone use from 4% to 20%. They also model the results of combining these four solutions. Homer and Wakeland find that the four solutions are complementary and thus their combination would “[reduce] PWOUD by 24%, overdoses by 4%, and deaths by 18% by 2030.” The authors are confident in

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51 Rees et al., “With a Little Help from My Friends.”
52 McClellan et al., “Opioid-Overdose Laws Association with Opioid Use and Overdose Mortality.”
their novel model which accounts for unintended consequences and “includes behavioral feedback loops.” Overall, the model emphasizes the need for multiple interventions to the current opioid crisis and underscores how the goal should not just be reducing deaths but also decreasing PWOD.

One model of U.S. adults generates the results of different policy interventions to the opioid crisis. The researchers test 11 different interventions in the model over 5 and 10 years. They conclude that policies that reduce the supply of prescription opioids have public health benefits in the long run, but they have negative effects in the first 5 years because already-addicted opioid users gravitate towards the illicit heroin market. Other solutions that support opioid users have no downside to their implementation, according to this study. However, I classify these scholars as advocates of a multifaceted approach because they argue that no single solution has a significant, positive change on opioid deaths: “our threshold analysis suggests that no single policy is likely to have a large enough impact to substantially reduce addiction-related deaths over 5 or even 10 years. Moreover, strategies that focus solely on mitigating immediate impacts of addiction will not address the root of the problem. Instead, to effectively combat the epidemic, a portfolio of interventions is likely needed to prevent iatrogenic addiction, prevent addiction from drug diversion, treat addiction, and mitigate its effects.” They do find that “Over 5 years, increasing naloxone availability, promoting needle exchange, expanding medication-assisted addiction treatment, and increasing psychosocial treatment increased life years and quality-adjusted life years and reduced deaths.” The policy that reduces overdose deaths the most (by 4%) is increasing the availability of naloxone.

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Heterogeneity

In the realm of multifaceted approaches are critiques that take issue with some aspect of the usual public health and policy approach. These critics tend to argue for more individually catered approaches that meet the distinct needs of specific populations to remedy the opioid epidemic. Two of these debates are detailed below.

Women-Centered Approaches

Becker and Mazure argue that the current understanding of the opioid epidemic and potential solutions do not account for the societal and biological differences between men and women. Women are more likely to be prescribed opioids, become addicted to opioids, experience adverse withdrawal symptoms, and relapse. Female drug users pose a greater threat to overall community wellbeing as they are more likely to be caregivers—and thus, less likely to enter treatment out of concern for leaving their children behind. Thus, “As a consequence, programs that include women-oriented services such as child care and domestic counseling tend to show better attendance and outcomes for women.”

Moreover, one study examines the supply and demand of women-centered treatment options in the United States over 7 years from 2002-2009. The authors argue that women need unique services to overcome hardships related to drug addiction: “Women with substance use disorders have unique barriers to obtaining treatment, such as intimate partner violence, need for transportation or child care, and coexisting mental health problems.” The authors also find that even centers that claim to be women-focused often fail to meet the needs of their clients; in fact,

“... fewer than 50% also reported offering child care, domestic violence counseling, transportation assistance, and residential beds for children.” The authors conclude: “Prevalence of women with unmet need ranged from 81% to 95% across states. Change in availability of women-centered drug treatment services was minimal from 2002 to 2009, even though need for treatment was high in all states.”

Employment and Economic Conditions

One study analyzes the relationship between opioid prescriptions and employment at the county level and finds no “simple causal relationship between economic conditions and the abuse of opioids.”58 In fact, they observe a slight positive correlation between employment and opioid use among women. Therefore, the authors conclude that any policy solution must respond to the reality that many opioid users work: “Treatment options that help people retain their connection to the labor market are likely to be necessary to effectively combat the epidemic.” This research calls into question a dominant belief in the literature that opioid abuse stems from dire economic conditions.

Moreover, one article argues that the opioid crisis was not caused by economic conditions.59 This is good news in the sense that it can be remedied without changing the reality of economic hardship and depression. The authors assert that “...the relationship between opioid use and contemporaneous measures of labor force activity is weak.” They view the over-prescribing and irresponsible prescribing of opioids as the main cause of the crisis. To treat

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current opioid users, the authors criticize “abstinence-only” approaches and praise the promise of MAT. They also express support for naloxone access laws.

Question 2: How can nimbyism be overcome?

Scholars agree on a variety of solutions to nimbyism, and most scholars do not mention just one solution. Therefore, I place scholars in the section I feel they fit best, but some common themes and recommendations persist throughout each section.

**Coalition Building and Community Engagement**

Many scholars stress the need to unite residents and leaders in a broad coalition of support, and to encourage participation from all community members, supportive or not. One study conducts phone interviews with various stakeholders and leaders throughout the country who are trying to establish safe injection sites. From their conversations, the authors identify multiple strategies that are essential to establishing these sites and catalyzing public support and eventual implementation. They suggest that “engaging partners with diverse perspectives” is extremely important in building a broad coalition of political support. Even if support is motivated by different reasons than the advocates themselves, it remains essential to garner and nurture this support. Another way to build a broad coalition is to support groups with similar or related policy priorities and to “show up” for them as allies. They also speak to the power of organizing and collaborating with drug users themselves. Locating and lobbying lawmakers who are friendly to the idea is most useful when done before confronting the opposition. Another significant finding, which will be brought up in more detail later, is that “Many participants felt

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that smaller meetings enabled more productive discussions about how to address community concerns and led to less fraught public meetings.”

Danley agrees that community-centered solutions need to be fully utilized. He argues that in order to overcome Philadelphia’s safe injection site controversy, community buy-in has shown to be essential. Although difficult, it is possible. He suggests that the solution lies in expanding and fully taking advantage of community participation. Specifically, he advocates for the broadening of “community” to be as inclusive and diverse as possible. Community is not only opposition. Upon broadening the conception of community, a supportive coalition “would include mothers with concerns about their children, and ask them to contribute to choosing a location. It would define community as including families facing the challenges of addiction, then ask them to tell their stories when possible. It would ensure participation is accessible and, to the extent possible, welcoming.” Danley also encourages the hands-on participation of elected officials that actively work with communities instead of “around their constituents.”

While Kennedy-Hendricks et al. and Danley argue that SIS can gain support through proper community engagement and coalition building, we get an illustrative example from Bancroft and Houborg. They study the impact of “drug consumption rooms” (DCRs) in the inner-city of Copenhagen. They recognize that these facilities were integrated into the community relatively smoothly through close, proactive, and enduring collaboration between stakeholders. The authors state: “... all apartment buildings have information sheets with direct hotlines to DCRs as well as the local police. Regular information meetings are arranged, allowing residents to obtain information on recent drug scene developments or vent frustrations.

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NGOs operate in the area, providing opioid overdose reversal training. Taken together, these important measures indicate that local authorities view the local DCRs and the drug scene as integrated parts of the area.”

**Legitimacy and Trust**

Some scholars that advocate for community involvement and coalition building place special emphasis on legitimacy and trust. To begin, McAvoy studies the controversy, nimbyism, and subsequent failure to implement a hazardous waste facility in Minnesota. He asserts that mutual trust must exist between citizens and elected officials. In these situations, trust is often lost in preliminary stages when there is a lack of information being provided to citizens. This creates “initial suspicions” which prove difficult to resolve. The more that people do not trust the organizers, the more they will oppose the given site: “In Minnesota’s siting effort, lack of trust in the state appeared to weigh heavily in people’s evaluation of the … facility.”

One study finds that trust and legitimacy are important factors to accompany simultaneous community engagement. The authors survey representatives of the few successful cases of siting hazardous waste facilities. Along with a strong foundation of trust, the authors assert that “early and continuous public involvement,” educating the public, “the incorporation of citizens’ concerns into risk mitigation plans,” and the “empowerment of host communities” led to success in these cases.64

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Education

While some scholars emphasize public trust, others highlight the need for education campaigns to set a project up for success and conquer nimbyism. For instance, one study finds that stigma is associated with lower support for syringe exchange services and SIS. The authors identify the solution in education campaigns, especially ones that combine reliable, scientific evidence with personal anecdotes.

Next, one study that looks at the views of stakeholders on implementing safe injection sites in North Carolina finds that many stakeholders—including public health officials, law enforcement, and EMTs—understand SIS as “common sense policy” and an idea that demonstrates compassion towards drug users. At the same time, stakeholders hold major concerns about public perception and fears of nimby opposition. Stakeholders shared that to overcome this opposition, there is a “... need to educate the public on the benefits that this intervention has for a community rather than to let people maintain a negative image on [injection drug users] and drug use in general. As explained, many people immediately assume that this intervention encourages and enables drug use, which is a challenge to the overall feasibility of this intervention.” Parham’s findings from stakeholders who experience the opioid crisis first-hand demonstrate the absolute necessity of educating the community on SIS and the benefits they offer to those who need them most.

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Framing the Issue

A few scholars see the framing of a given project as at the forefront of any strategy to overcome nimbyism. A study of two communities that sought to implement services for immigrants and the subsequent nimbyism that came with it generates a number of suggestions to organizations that want to provide services to immigrants.\textsuperscript{67} The suggestion can be broadly applied to overcoming nimbyism as it relates to the opioid crisis. Through their two case studies, the authors observe that advocates should plan ahead and prioritize “developing a plan designed to both prevent and respond to opposition.” Furthermore, organizers can foster support by framing the issue as a necessary policy development and one that helps a group deserving of sympathy. They find that sympathy was more present in the case study focused on helping women who were victims of violence than the service focused on helping male immigrants. They also suggest that dialog with opponents is necessary but is more successful when in the form of community advisory boards rather than community meetings; the latter often become dramatic and polarizing. Abraham and Maney stress the power of media representation and suggest the media cover supporters who community members can relate to. Overall, creating a narrative that portrays users of the service as members of the community and not outsiders proves crucial.

Perhaps even small framing changes can yield a large, destructive blow to nimbyism. A group of researchers issue two surveys in which they provide some facts about the opioid epidemic and proceed to ask participants if they support either “safe consumption sites” or “overdose prevention sites.”\textsuperscript{68} They find that using the first term, 29\% of survey participants


were supportive, compared to 45% support of “overdose prevention sites.” The results suggest that language matters a great deal and can have important implications when talking about drug addiction. Stigma around drug addicts is potent and minor changes like the one shown in this study can help combat stigma and garner public support.

**Overcoming Opposition**

In this section, I discuss scholarly approaches to overcoming particularly hostile or lasting opposition after strategies like coalition building, community engagement, and framing have been used.

*Strategic and Holistic Approaches*

Dear (1992) draws a distinction between productive nimbyism that leads to improved social projects which value community input and “… the more self-interested, turf-protectionist behavior of facility opponents…” In focusing on the latter, Dear argues that the three most common nimby opposition arguments are “the perceived threat to property values, personal security, and neighborhood amenity.” He outlines how service facilities have historically been “saturated” in inner-city neighborhoods. Therefore, Dear asserts that planners and advocates of new service facilities must pay special attention to these inner-city communities and “advance very special arguments.” Increasing community education and awareness of the issue at hand can be important in making residents more tolerant. He notes however, that education strategies require time and money, and therefore “… may be more effective and efficient when the service provider has links to a broadly based national or local advocacy group with resources,

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experience, and expertise.” In terms of community outreach, Dear cautions that early planning is essential because if poorly planned meetings occur, it delegitimizes the planner’s goals, intentions, and competency. Dear suggests the creation of community advisory boards and the inclusion of vocal opponents on these boards. He suggests doing this early on before opposition arises because it solidifies the support of individuals like politicians who may cave to the pressure later on. Dear also suggests that concessions to the community are sometimes necessary and small modifications can have a large, positive effect. Some examples of meaningful yet small concessions are operating hour changes, landscaping, and parking arrangements. Furthermore, Dear stresses that planners should detail how the service facility will benefit the host community; one such way is through employment opportunities.

Ross lays out another detailed, holistic strategy for overcoming nimbyism towards affordable housing. Many of these strategies can be applied to the debate over opioid addiction services, including safe injection sites. Ross argues that education campaigns help a great deal: “Anecdotal information about particular residents and the success of previous developments goes a long way in a public education effort.” Building a broad coalition with influential allies is important as well. Ross suggests advocates reach out to a wide array of prominent figures such as business and religious leaders. The media plays a massive role in portraying the issue, so Ross suggests that planners reach out to the media well before nimby opposition arises in order to objectively explain the issue.

Schively reviews the literature on nimbyism and locally unwanted land uses (LULUs) and details some strategies to ease nimbyism. The first is compensation, in which she suggests

that auctions or property tax credits may be beneficial. However, she notes that compensation may not be helpful at all in some contexts. Next, she discusses the need for clear communication to residents about the effects of any LULU; she calls this “risk communication.” Proper risk communication can have a positive impact on public trust; executing this successfully requires transparency. Her next suggestion is “empowering affected parties.” In this section, she recommends either community advisory boards or allowing citizens to monitor the site themselves. Her fourth suggestion is consensus building, meaning that a wide array of residents and stakeholders are involved in often lengthy dialogues and political debates. Schively notes that informal settings for community meetings and engagement are more effective than large meetings. This aligns with Kennedy-Hendricks et al.72

Understanding Legitimate Concerns

Rautenberg conducts interviews with various stakeholders regarding Canadian safe injection sites.73 She illuminates many factors that have contributed to implementation, eventual support among local residents, and the conquering of nimbyism. Rautenberg argues that nimby narratives often portray opposed residents in a stereotypical and overly simplistic manner. Instead, media and local leaders should acknowledge the nuances within the community: “The causes and reasons behind opposition must be carefully examined, and not just treated as a general NIMBY level.”

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72 Kennedy-Hendricks et al., “Establishing Sanctioned Safe Consumption Sites in the United States.”
73 Joyce Rautenberg, “Addiction in the City: Analyzing Supervised Consumption Site Development Processes” (M.C.P., Canada, University of Manitoba (Canada)), 2013.
Concessions and Compromise

A recent study interviews various stakeholders in counties that have been hit hard by the opioid epidemic and specifically evaluates stakeholder perspectives on safe injection sites. The authors find relatively high levels of support from stakeholders. The stakeholders illuminate various concerns about safe consumption sites. In terms of overcoming opposition, stakeholders in these counties stressed the importance of providing reliable, scientific evidence on the effectiveness and benefits of safe consumption sites. Thus, more rigorous evaluations are needed to persuade stakeholders. Importantly, the authors note that some communities simply may not be ready for safe consumption sites: “In the meantime, starting where a community is ready to start, with the introduction or expansion of other harm reduction services such as [Syringe Services Programs], syringe disposal boxes, or naloxone distribution, might serve to demonstrate the value of intervention options in tandem with treatment, while also opening the door for meaningful community dialogue and education.” Although less ambitious than other scholars, Taylor et al. emphasize the value of education, but still think that it is not sufficient in every context to effectively garner enough public support; compromise or gradual implementation may be necessary.

Another scholar focused on compromise and even avoiding nimbyism altogether is Kilmer, who lays out ten “creative” solutions that the federal government should take to ease the opioid crisis. One in particular relates closely to the idea of compromise to overcome nimbyism. Kilmer suggests injection sites that are mobile and not in a singular location. He feels that sidestepping stationary facilities can avoid the nimbyism issue altogether and that “… it is imperative that we not limit our thinking about supervising consumption to fixed sites.”

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75 Kilmer, “Reducing Barriers and Getting Creative.”
Furthermore, a regression analysis of the effect of affordable housing in Sacramento County, California on property values finds that more affordable housing decreases home values, which legitimizes a prominent nimby concern. The authors note that California has successfully lowered greenhouse gas emissions through the cap-and-trade method, and suggest the state does the same when it comes to affordable housing:

A cap-and-trade mechanism would offer a similar option to a jurisdiction seeking to satisfy its 30% affordable housing mandate when facing resistance from NIMBY groups saying that it imposes too high a cost to do so. Responding to this resistance, the local policymaker approaches another jurisdiction in the region and asks how much compensation they require to take on an additional amount of affordable housing. A jurisdiction expected to experience a greater drop in home value because of affordable housing would pay another jurisdiction expected to see less. Ideally, the payment could then compensate the homeowners who subsequently had the affordable housing placed in their backyard by funding additional local government expenditures intended to mitigate the actual and perceived fiscal and social costs of the new affordable housing. This could be a possible win for all involved, including the lower income residents who now have access to affordable housing units that would otherwise be planned for but not built because of NIMBYism.

Again, this line of thinking when it comes to affordable housing and concessions can easily be applied to SIS.

III. Research Design

Tentative Answer to Research Question and Rationale

From my research on effective solutions to the opioid crisis, I tentatively conclude that one of the best policies for Philadelphia to implement is some form of integrated treatment that stresses close collaboration between specialty care providers and primary care or office-based physicians. Furthermore, safe injection sites (SIS) offer promising results as a harm reduction

strategy. The presence of a SIS would allow for the adoption and expansion of other important harm reduction measures as well, such as fentanyl test strips and Narcan. The city should also expand Narcan availability throughout Philadelphia. Lastly, I believe there is a need for a more heterogeneous approach when it comes to gender and meeting the specific needs of women opioid users. All of these strategies are largely agreed upon and endorsed by scholars, although the women-centered approach lacks sufficient attention.

For my second research question, I have tentatively identified the best strategies to overcome nimbyism. Engagement appears to be the most critical strategy. It is best to engage all members of the community (likely supporters, likely opponents, and those in between) early on and frequently throughout the entire process. This engagement should mainly take place in the form of small, informal meetings and not huge “town hall” events that can quickly become dramatic and heated. Community advisory boards that include vocal opponents should be set up. The engagement stage should also involve inviting drug users to share personal stories and allowing opponents to do the same. When opponents share concerns, they should be treated as legitimate and not portrayed as self-serving. Lastly, resources should be mobilized towards educating residents about the site’s goals in a transparent manner.

Even with proper community engagement, there will likely still be opposition. To deal with persistent opposition, Philadelphia should be open to some form of compromise or concession with residents. This could take the form of community grants or perhaps even heightened law enforcement. Finally, there may be some situations where nimbyism has to be avoided altogether. This can be accomplished with solutions like mobile safe injection sites.
Next Steps and Hypothesis Formulation

The broad consensus among scholars and the scarcity of a substantial debate surrounding my first research question begs the question of why Philadelphia has not taken all of these steps. The lack of effective implementation of solutions in Philadelphia suggests that there are significant obstacles to doing so. Thus, I am more interested in investigating these obstacles and how they can be overcome. Based on some initial research I conducted about Philadelphia in local news outlets, I hypothesize that there are two main groups of obstacles preventing the city from adequately addressing the opioid crisis: bureaucratic obstacles and political obstacles. I have already investigated and researched solutions to one type of political obstacle: nimbyism.

There are numerous patterns that illuminate the bureaucratic inefficiency problem in Philadelphia. The city is slow to respond to the changing crisis and new trends, such as the rising prevalence and danger of newer substances like fentanyl. Philadelphia is also slow to identify and respond to problems, even those they have caused, such as the smoking ban that deterred opioid users from attending treatment facilities. Overall, Philadelphia prefers a reactionary strategy to a proactive one.

In terms of political obstacles apart from nimbyism, there is a certain resentment and anti-SIS view among Kensington residents which stems from the fact that their neighborhood is overloaded with services for drug users who often are not originally from Kensington and instead come to the area as “drug tourists.” Drug dealers dominate street corners in the neighborhood, and gun violence is an unignorable daily threat to residents. Some residents and journalists say that the city is consciously limiting law enforcement on the ground in Kensington to keep the crisis’s visibility limited to a single neighborhood. There is some evidence that many residents may support more police to deter drug dealers, making it harder to access cheap, illicit drugs and
thereby limiting the influx of drug users into Kensington. There is also a racial dynamic to opposition because of how Philadelphia did little to remedy the crack cocaine epidemic in the 1980s which largely impacted the black community. Today, SIS garner more support from white Philadelphians and elected officials than their black counterparts because of a feeling that the city is bending over backwards to help white drug users.

**Case Selection**

Philadelphia is a unique city for opioid crisis research. The crisis is especially severe in Philadelphia and therefore, the need for solutions is even more pressing than in other cities. I can conduct the most rigorous and thorough research here because of my proximity to the city. Philadelphia is a logical location to research implementation obstacles because Mayor Kenney has made remedying the opioid crisis a focus of his administration, and yet he has still struggled to do everything he would like, such as opening the nation’s first safe injection site. Philadelphia is also unique because of the geographic concentration of the epidemic’s visibility into a single neighborhood, Kensington. Philadelphia has a robust harm reduction nonprofit sector which serves as a suitable comparison to the city bureaucracy. Furthermore, there have been a wide array of well documented political controversies here, particularly related to nimbyism. Despite its specific intricacies, my research on bureaucratic and political obstacles in Philadelphia can certainly be applied to other major American cities plagued by the opioid crisis because it is likely they face similar bureaucratic problems (especially cities larger than Philadelphia) and because political controversies like SIS are not limited to Philadelphia. In a lot of ways, Philadelphia has been forced to get ahead of the game on considering and trying novel interventions to the opioid crisis.
Data Collection and Analysis Methods

A. General Information

Primary Sources

1. Newspapers
   - *The Philadelphia Inquirer*
     - I will systematically and chronologically look through this source. I will search the keywords “opioid” and “Kensington” and adjust as necessary. I will begin in 2010, the year that the modern opioid epidemic is thought to have started.77

2. City-produced documents
   - Task force reports and status updates (nine reports available from October 2018 through January 2019).

B. Bureaucratic Obstacles

Interviews

1. Individuals in the city bureaucracy
   a. Someone from the Department of Health and ideally its Substance Use Prevention and Harm Reduction Division

      - This interview will focus on the city’s bureaucratic obstacles. I will ask these individuals:
        1. Are there bureaucratic obstacles? What are they? How can they be overcome?
        2. Are there political obstacles? What are they? How can they be overcome?

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3. How would you describe the city's approach to the opioid crisis?
4. What did Mayor Kenney do when he first came into office? How has it changed over time?

2. Individuals from nonprofits who work closely with the city
   
a. Someone from Prevention Point Philadelphia (PPP)

   - I will ask similar questions to this individual and the city employees in order to compare the differences:
     1. Are there bureaucratic obstacles? What are they? How can they be overcome?
     2. Are there political obstacles? What are they? How can they be overcome?
     3. How would you describe the city’s approach to the opioid crisis?
     4. What did Mayor Kenney do when he first came into office? How has it changed over time?
     5. Can the city’s slowness be overcome? What would this look like? Would it look more like the nonprofit sector you are a part of?

C. Political Obstacles

Interviews

- To research political obstacles and how the city may overcome them, I will conduct interviews with three general groups of people:

  1. Activists in favor of SIS and other harm reduction measures
     - This will ideally be with someone from Prevention Point.

  2. Political Actors
     - Someone from Councilmember Maria Quiñones-Sánchez’s staff.
     - Someone from Councilmember Mark Squilla’s staff.

  3. Opposition to various aspects of Mayor Kenney’s agenda
     - Someone from an anti-crime citizen group such as Stand Up South Philadelphia.
       - Will contact them through their Facebook group.
     - Someone from an anti-SIS group such as Harrowgate Civic Association.
Someone aware of the racial dynamics at play such as New Kensington Community Development Corporation Executive Director Dr. Bill McKinney

D. Both Obstacles

Interviews

1. Someone from the Police Department
   - This interview will focus on the city’s bureaucratic obstacles as well as on political resentment, public opinion, and policy surrounding opioid-related policing in Kensington. I will ask:
     1. Are there bureaucratic obstacles? What are they? How can they be overcome?
     2. Are there political obstacles? What are they? How can they be overcome?
     3. How would you describe the city’s approach to the opioid crisis?
     4. What did Mayor Kenney do when he first came into office? How has it changed over time?
     5. How would you describe PPD’s approach to the externalities of the opioid crisis (i.e., drug dealers, gun violence, etc.)?
     6. Specifically, how does PPD deal with the Kensington neighborhood? Has your approach evolved over time?

Observation

- To understand both obstacles, it will be helpful to observe Kensington to gain insight into the forces that collide and collaborate in the neighborhood on an average day. I plan to drive through the neighborhood at least twice (once before my interviews and once after) and perhaps meet with one of my interview participants there as well.
Part 2: Background on Philadelphia’s Opioid Crisis

I. Kensington Historical Background

In the late 19th century and into the early 20th century, Kensington solidified its position as an industrial center, especially for textile manufacturing. Due to the bustling industry, Irish, English, Polish, and German immigrants poured into Kensington. In the 1920s, the Great Migration brought substantial numbers of African Americans to the neighborhood and Philadelphia more generally to work in factories as demand for labor increased. Similar pull factors resulted in the arrival of Puerto Ricans as well. The blue-collar, booming Kensington of the first half of the 20th century would become nearly unrecognizable a few decades later.

By the 1950s and into the 1960s, Kensington’s economy was declining. Deindustrialization and mass-manufactured goods produced cheaper elsewhere would soon destroy the once thriving neighborhood. White flight followed the loss of economic promise in the neighborhood, and minority groups moved into Kensington: “By the 1950s and ’60s, African Americans migrated from the South into the area, with Puerto Ricans from the island’s countryside also moving into now-cheap housing. Race riots ensued, whites fled Kensington, and a minority population without work began to multiply in a crumbling postindustrial area with 30,000 abandoned houses—the poorest neighborhood in America’s poorest big city.”

The decline of the manufacturing business, which continued until the 1970s, was the driving force behind the rise of the drug market. In fact, the lucrative drug trade directly filled the economic

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79 Ibid.
80 Ibid.
82 Ibid.
void from factory closures: “...with few investments from the city, the drug market filled the economic vacuum. Houses transformed into drug dens, factories into spaces to shoot up, rail yards into homeless encampments.” Abandoned homes and factories are one factor that made Kensington ideal for the drug trade.

In the 1960s, Kensington still had an ethnic white, working class population. Irish gangsters and other organized crime groups contributed to Kensington’s involvement in the methamphetamine market. Director of the Center for Addiction and Recovery Education at Saint Joseph’s University Stephen Forzato disclosed: “Kensington was known as the birthplace of methamphetamine on the East Coast of the United States, there was a group of Kensington residents, quasi gang members that used to cook it up and all that.” Kensington is in a convenient location for drug trafficking with its easy access to transportation like the train and nearby highway that attracts suburban customers. According to John Machen—who runs Another Day Clean Recovery Homes—from the 1960s onwards, Kensington has always been known for “having a couple of drug corners.”

The crack cocaine epidemic hit in the early 1980s and Kensington slowly lost its meth title, taking on the sale and use of a variety of different drugs. Machen stated that in the 1980s, “it just blew up.” Kensington solidified its reputation as a “place that people could buy drugs” and attracted people from across the northeast. The drug gangs and plague of addiction in the 1980s earned Kensington its notorious “badlands” nickname. At this point, Kensington was a predominately Puerto Rican neighborhood, as whites had fled the neighborhood over the past

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83 Percy, “Trapped by the ‘Walmart of Heroin.’”
84 Stephen Forzato, interview by author, virtual, February 17, 2022.
85 John and Rachel Machen, interview by author, virtual, February 24, 2022.
86 Ibid.
87 Forzato, interview.
few decades. Kensington residents saw few legal job prospects in such an economically deteriorated neighborhood that received few city resources. There is an argument that “The cocaine supply chain from Colombian smugglers to Dominican distributors on the East Coast set up Puerto Rican neighborhoods to be particularly vulnerable: a population that shares a language, has a high unemployment rate, and can’t be deported.” In addition, it is possible that Kensington’s demographics attracted white suburban customers because they blended in more easily than in a predominantly African American neighborhood.

Kensington’s drug market received a boost in the 2000s from the growing imports of Columbian heroin by Dominican gangs. This heroin was cheaper and purer than ever before. At this time, the city of Philadelphia took police-centered responses, seen best in 1998’s Operation Sunrise, where police and federal law enforcement overtook the Kensington area in a tough-on-crime “crackdown,” making arrests and targeting crime and drug dens. This was thought to be the most effective strategy: “…city officials said attacking the neighborhood problems from every angle and all at once—from boarding up vacant houses to towing abandoned cars, chasing away prostitutes and removing trash and graffiti—holds great promise.”

Kensington could not escape the drug trade as heroin attracted people from all over and relentless dealers continued to profit from this lucrative business. It remains difficult to go after the dealers because the market does not contain a few “big players,” but rather is horizontal and

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89 Ibid.
90 Ibid.
91 Percy, “Trapped by the ‘Walmart of Heroin.’”
highly competitive. A few arrests on some drug corners, no matter how major, do little to make a dent into the market. Other dealers quickly take over an abandoned corner in a matter of hours, if not minutes: “Kensington’s decentralized market kept competition high and prices low. Most corners were run by small, unaffiliated groups of dealers, making the area difficult to police; if a dealer was arrested, there was always someone there to replace him.”

These dynamics festered long enough to present the almost otherworldly Kensington you see today. Discarded syringes and litter cover the sidewalks and streets. Steady chaos flows throughout the ghostly blocks. Drug users sleeping on the sidewalk cover themselves with tin foil blankets. Whether the neighborhood is best described as looking like a zombie apocalypse or a village just hit by a bomb—I’ve heard people use both descriptions—the look of pure hopelessness in the foggy eyes of a man walking in circles on a sidewalk is the type of impression that sticks. It does not feel like an exaggeration to assert that the state of Kensington today is a humanitarian crisis.

II. The City’s Response

In this section, I lay out the city’s response to the opioid crisis and major events that occurred from 2010 to 2022. This information comes largely from my research in The Philadelphia Inquirer.

The Nutter Administration

Mayor Michael Nutter, a Democrat, took office in 2008. He supported stop-and-frisk and generally embraced a tough-on-crime platform. The opioid crisis was not at the center of

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93 Percy, “Trapped by the ‘Walmart of Heroin.’”
Mayor Nutter’s platform, likely because it was not as big an issue at the time, especially for the first few years of his tenure. The crisis around 2010 was just shifting from prescription medications to illicit heroin, and therefore advocacy efforts focused more on regulatory gaps that led to the over prescription of opioids. In 2011, there were calls for a prescription database to halt “doctor shopping” by keeping readily accessible records of patients’ prescription histories at the state level. There were also efforts at the state level to pass Good Samaritan laws. Mayor Nutter, for his part, did loosen marijuana laws and lower arrests as he decriminalized small amounts of marijuana.

The city’s impassioned harm reduction nonprofit sector was active during the Nutter administration. By 2012, addicts, spouses, and others close to drug users could undergo Narcan training through Prevention Point Philadelphia. Headquartered in Kensington, Prevention Point is the city’s most prominent, opioid-related nonprofit to this day.

In 2013, a controversy over methadone clinics occurred and a bill went through City Council banning all methadone clinics within a certain distance of pretty much all residential and business areas. Mayor Nutter vetoed this bill—proposed by then-Councilmember Kenney—but it was overridden by the Council.

In 2014, Kensington’s homeless population increased dramatically, and it was concluded that “heroin plays a part” in the spike. However, other factors like the cut to PA General

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 Assistance dollars and “gentrification in nearby Fishtown” were cited as well.\textsuperscript{100} Also, there was an understanding that the homeless population in Center City received the most attention from outreach workers whereas there was little attention on Kensington and limited homeless shelters in the neighborhood. The city, for its part, said it was trying to help but the large increase in homelessness was overwhelming.\textsuperscript{101}

In the Nutter years, the police department was aware of the common transition from prescription opioids to heroin, as people hooked on prescriptions sought out cheaper alternatives that gave a similar effect. In early 2015, police underwent Narcan training and carried it with them on patrol.\textsuperscript{102} This was true of the fire department and other first responders as well. Further complicating the picture under Nutter was fentanyl’s destructive and growing impact. In 2013, Philadelphia had 25 overdose deaths from fentanyl.\textsuperscript{103} By 2015, this number had jumped to 184.\textsuperscript{104}

\textit{The Kenney Administration}

In 2016, progressive Mayor Jim Kenney took office. In November 2016, he announced an Opioid Task Force that would bring action within 90 days.\textsuperscript{105} The 16-person task force brought together council members, law enforcement officials, addiction experts, and others impacted by the crisis.\textsuperscript{106}


\textsuperscript{101} Ibid.


\textsuperscript{105} Mike Newall, ”Courting death in a struggle to survive ‘You find out people are dying from it - you got to find it,’” \textit{Philadelphia Inquirer, The (PA)}, December 14, 2016: A01. NewsBank: Access World News Research Collection.

In Kenney’s first year in office, the “Air Bridge” program—in which the Puerto Rican government sends people addicted to drugs to cities like Philadelphia, claiming that they will get help in recovery homes—was starting to get some attention. Many of the recovery homes in question are exploitative, abusive, and steal money from their clients. Councilmembers Maria Quiñones-Sánchez, Alan Domb, and Mark Squilla tried to draw attention to this as it did not have much publicity or even the mayor’s attention. Due to Air Bridge and the growing opioid crisis, Puerto Ricans and white, suburban, young people were flooding into Kensington in search of the rumored cheap and pure heroin. Hundreds of drug users were allegedly coming to the neighborhood each day. Kensington Councilmember Quiñones-Sánchez, in an op-ed, argued that the city must adopt a proactive approach that entails collaboration between the federal, state, and local government, utilizes resources from all three levels, and overcomes the shortage of political will.

The Philadelphia Inquirer articles with my key words skyrocketed in 2016, and for good reason. Part of this is surely due to the increased attention from city and mayoral leaders. But the crisis was worsening dramatically as well. On November 17, Philadelphia had 50 overdoses in a single day. Five were fatal. They were likely caused by fentanyl-laced heroin or super-pure heroin. On December 1 through 5, 35 people died of overdoses. This included nine deaths over the weekend within 36 hours. The same month, the Philadelphia Police Department (PPD)
arrested 176 people thought to be responsible for bad batches of heroin. In total, 2016 had 25-30% more overdose deaths than 2015. Philly had over 900 deaths from drug overdose—triple the number of homicides.

The 35 deaths in December of 2016 resulted in more pressure on the city and Conrail to figure out a solution to “El Campamento,” an encampment of drug users hidden underneath the Conrail railroad tracks. In the discussion of clearing this encampment, the idea of meeting addicts where they are and providing social services seemed to gain traction. Harm reduction advocates brought up SIS as a logical replacement to the unhygienic, trash-filled encampment. The Conrail cleanup was a very gradual process. Trust needed to be built. There was a fear that cleaning up the encampment would lead to more overdose deaths because users would be injecting drugs alone in abandoned houses, and thus, less likely to be saved with Narcan. Tellingly, only 17 out of the 907 overdose deaths in 2016 occurred in the encampment. On August 1, 2017, the cleanup began; the city set up trailers and tents to help people get treatment and housing. The city also began to increase police, collect trash, and recruit residents to be “block captains.”

Soon after the Conrail cleanup, drug users increased in numbers around the Emerald Street bridge in Kensington, called “Emerald City.” Every Friday, police would clear the area but by the end of the day, everyone had returned. In response to the growing population at Emerald

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113 Stephanie Farr and Don Sapatkin, "Medical examiner: Philly overdose surge may have killed 35 over 5 days," Philadelphia Inquirer, The (PA), December 22, 2016: WEB. NewsBank: Access World News Research Collection.
City and drug users injecting in abandoned buildings like an old Kensington church, the city installed a recovery space at the ER, began sending outreach vans to crowded Kensington bridges, and bricked up the church.\textsuperscript{118}

As drug users gravitated closer to residential areas, the city handed out blue light bulbs to residents to light up the neighborhood and make it harder for injection drug users to find a vein.\textsuperscript{119} Upon growing media coverage of librarians at Kensington’s McPherson Square Library frequently reviving people with Narcan and children cautiously watching for needles and witnessing people overdosing, police cleared out the area in mid-June of 2017.\textsuperscript{120}

The city also formed the Porch Light program, a partnership with nonprofits that attempts to invest in the community and create public art. As a part of this partnership, Mural Arts, a storefront for art and social services launched in March 2017.\textsuperscript{121} At the Mural Arts opening, officials acknowledged that Kensington had been abandoned in the past but stressed that this was no longer the case. Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) Deputy Commissioner Roland Lamb proclaimed: “Treatment programs are not going to be enough. Police are not going to be enough. But if we invest in the community, that will be a real opportunity to make a change.”\textsuperscript{122}

Additionally, in May 2017, the city launched a TV and social media campaign that referred to prescription pain medications as “heroin in pill form.”\textsuperscript{123} In August 2017, Kenney

\textsuperscript{119} Ibid.
\textsuperscript{122} Ibid.
pledged that more social workers would be added to Philadelphia schools to help kids in crisis and prevent drug use.\textsuperscript{124} Philadelphia hired a harm reduction expert and began to establish a paramedic team solely for overdoses. Additionally, the Police-Assisted Diversion (PAD) program launched late this year, diverting drug users from arrest and instead connecting them with social services.\textsuperscript{125} Overall, there was some agreement that under Mayor Kenney, Philadelphia had sharpened its efforts and created a more comprehensive approach by the end of 2017.

For one thing, the city was searching for more major solutions to the opioid crisis. On May 19, 2017, the task force’s final report was released with 18 recommendations, including launching ad campaigns, expanding Narcan distribution, increasing treatment capacity, responding to “outbreaks” of overdoses rapidly, and addressing homelessness faced by drug users.\textsuperscript{126} The most contentious recommendation was to “further explore comprehensive user engagement sites,” also known as safe injection sites.\textsuperscript{127} The SIS recommendation was taken seriously by the city. District Attorney (DA) candidate Larry Krasner came out in support of SIS. Even the Republican candidate Beth Grossman expressed her openness to SIS.\textsuperscript{128} Demonstrating the earnestness with which the city was considering this recommendation, a delegation of the health, fire, and police departments toured Vancouver SIS and visited Seattle, where a SIS was in the process of being opened.\textsuperscript{129}


\textsuperscript{125} Samantha Melamed, "DA diverting drug cases for treatment - The aim is to not jail people for being addicted, but put them in touch with help to get clean.." \textit{Philadelphia Inquirer, The (PA)}, December 3, 2019: A1. \textit{NewsBank: Access World News Research Collection}.


\textsuperscript{127} Ibid.


Despite the city’s efforts, overdose deaths in Philadelphia increased by 50% during the first six months of 2017. The city saw a total of 1,217 overdose deaths. Fentanyl deaths increased by 95%, killing more people than any other opioid. However, overdose deaths in the last quarter of 2017 dropped slightly. Homicides in 2017 increased by 15% from 2016. A likely contributor was the drug trade in Kensington. Additionally, “new hotspots” besides Kensington emerged. The death toll likely would have been much worse without Narcan and the DEA seizure of 40 kilograms of fentanyl earlier in the year.

The SIS efforts progressed in 2018. On January 24, city officials including Health Commissioner Thomas Farley and Managing Director Mike DiBerardinis declared that they would sanction and encourage SIS run by private organizations. Councilmember Quiñones-Sánchez was absent from the SIS news conference, as was Mayor Kenney despite his vocal support for the site. After the announcement, Governor Tom Wolf expressed some concern, while PA Attorney General Josh Shapiro and Councilmember David Oh staunchly opposed the sites. Councilmember Cindy Bass, the leader of the Health and Human Services Committee, expressed skepticism as well. Various council members claimed that their permission was necessary for the SIS, but the Kenney administration disagreed. Police Commissioner Ross was still concerned about SIS, but more open to the idea after speaking to police officers in

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130 Aubrey Whelan, "Fentanyl blamed in most fatal ODs Of the 1,217 overdose deaths in 2017, it killed more people than all other opioids, the city says. OPIOID EPIDEMIC," Philadelphia Inquirer, The (PA), April 25, 2018: A01. NewsBank: Access World News Research Collection.
131 Chris Palmer, "Deadliest year since 2012 at 300-plus Although violent crime was down, the opioid crisis, a shortage of officers, and easy access to guns are cited as contributing factors. PHILA. HOMICIDE RATE Homicides," Philadelphia Inquirer, The (PA), January 1, 2018: A01. NewsBank: Access World News Research Collection.
132 Aubrey Whelan, "Fentanyl blamed in most fatal ODs Of the 1,217 overdose deaths in 2017, it killed more people than all other opioids, the city says. OPIOID EPIDEMIC."
Vancouver. In March and April, the Department of Public Health held informational meetings around the city about the opioid crisis, many of which became consumed by arguments and concerns over the SIS idea. In October, Safehouse became incorporated, marking the first concrete step towards a SIS. Former Pennsylvania Governor Ed Rendell sat on the board of directors. It was looking like many prominent Philadelphians who had been touched by the crisis would fund the Safehouse nonprofit considerably.

While Safehouse’s momentum grew, the crisis did too. In January 2018, a Code Blue was announced as it was freezing outside. Drug users didn’t want to go inside for too long because of withdrawal, so the city transformed a recreation center into a warming center and deployed additional outreach workers. In reflection, the city decided it wanted to replicate Prevention Point’s shelter model and expand on the Pathways to Housing model—neither of which require sobriety. Kenney’s budget requested 60 more slots in the Pathways to Housing program. The premise is that drug users need stability (permanent housing) to recover and get sober. Staffers visit at least twice a month. An additional 40 bed shelter was expected to open later in 2018, “long after the most dangerous months have passed—a delay that has angered residents who see misery all around them, advocates for those in addiction, and the people who live in the camps.”

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140 Ibid.
More problems regarding drug encampments arose. In March 2018, three more heroin encampments manifested in Kensington along Lehigh Avenue, in addition to Emerald City. The city set the deadline of May 30 to clear two of the four encampments in Kensington. A huge effort was deployed to get people into treatment or housing. Outreach workers kept a list of the names of people who had spots in shelters. This was pretty close to treatment on demand. The treatment on demand attempts continued into July, with the opening of Access Point, a 24-hour treatment center. The aim was to reduce red tape and missed chances of those who seek treatment for a narrow period of time. The third encampment was cleared in November 2018.

In October 2018, Kenney declared a disaster in Kensington and ordered the establishment of an emergency operations center where the relevant city departments would come up with solutions, dubbed the Philadelphia Resilience Project. While Kensington was finally receiving some attention, the heroin crisis in South Philly started to show. Nonprofits were the most engaged here, as Prevention Point sent vans with needles to South Philly once a week.

Overall, Philadelphia’s heroin supply was almost fully contaminated with fentanyl and other substances by 2018. Around July 23, a bad batch of “heroin” cut with other substances flooded the streets. The city warned users of the culprit, “Santa Muerte,” which was previously

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144 Ibid.
thought to be reliably not laced with fentanyl.\textsuperscript{146} Around September 25, 7 people died and 110 were revived over the weekend from a deadly mix of heroin, fentanyl and K2.\textsuperscript{147}

HIV infection rates among drug users in Kensington increased by 48\% in 2018.\textsuperscript{148} Kensington’s homeless population doubled between July 2017 and July 2018, and over half of Philadelphia’s homeless population lived in Kensington, addicted to drugs, by July 2018.\textsuperscript{149} The dynamics of homelessness underwent a notable shift in the last decade, with an increasing percentage of deaths being tied to overdoses. In fact, “Between 2009 and 2015, about 37\% of deaths among the homeless population were from overdoses. Between 2016 and 2018, overdoses accounted for 59\% of such deaths.”\textsuperscript{150} The citywide overdose death rate did decrease by about 100 in 2018, largely credited to efforts by the city to expand Narcan’s accessibility and prevalence.\textsuperscript{151} Kensington’s overdose death rate declined by 23\% from the previous year. But parts of South Philly saw increases of 20\%, largely credited to the lack of harm reduction in the neighborhood as Kensington stepped up its game.\textsuperscript{152}

In early 2019, the city cleared the final Emerald City encampment that arose in 2017.\textsuperscript{153} The encampment was the last to be cleared largely because of its deep entrenchment in the drug market. But this also increased the value of clearing it, since the past four years saw 3,000 police-involved incidents.\textsuperscript{154} While Emerald City harbored some sense of safety for drug users since there were always people close by in possession of Narcan, according to the city, it was unsafe for nearby residents.\textsuperscript{155} The city’s outreach efforts were effective to some extent, as they promised shelter beds to all those living in the encampment. However, the two shelters in Kensington that do not require sobriety were full, and thus, “about 10 people who remained in the camps refused to go anywhere else in the city.”\textsuperscript{156} Overall, 64\% of people living at Emerald City accepted either treatment or shelter spots, many at the last minute.\textsuperscript{157}

In the realm of safe injection sites, the city hit a major legal obstacle in February 2019 when U.S. Attorney William McSwain announced a lawsuit in an effort to stop the establishment of the Safehouse site. In March 2019, Safehouse was considering signing a lease for a site in Harrowgate, located directly north of Kensington. But the lease never went through because of community outcry.\textsuperscript{158} Councilman Mark Squilla announced he was uncertain about SIS after visiting Toronto, and residents remained concerned about the impact of a SIS in residential or business areas. The opposition to a SIS in Kensington stemmed largely from its residents having been neglected for decades, and a sense that the city was trying to confine the opioid crisis to

\textsuperscript{153} Whelan and Reyes, “Small drop in city OD deaths - They fell from 1,217 in 2017 to 1,116 last year. Officials link naloxone to dip, but “we’re still at crisis levels.””
\textsuperscript{154} Aubrey Whelan, “Last camp removed, but crisis remains - In bitter cold, the final few residents of Kensington’s “Emerald City” left, to shelter or some other street,” \textit{Philadelphia Inquirer, The (PA)}, February 1, 2019: A1. \textit{NewsBank: Access World News Research Collection.}
\textsuperscript{155} Ibid.
\textsuperscript{156} Ibid.
\textsuperscript{157} Ibid.
\textsuperscript{158} Lofaro and Miller, “Narrative Politics in Policy Discourse: The Debate Over Safe Injection Sites in Philadelphia, Pennsylvania.”
Kensington permanently. Still, the site’s outspoken board members like former Governor Rendell pledged they would keep trying to push this through. In the summer of 2019, Mayor Kenney and other officials toured the SIS in both Toronto and Vancouver, with the intention of learning more about their impact. In October 2019, a federal judge ruled that the crack house statute did not apply to Safehouse’s aspirations, clearing a path for the potential SIS. Still, McSwain said that he would appeal and in the meantime, arrest anyone involved in a SIS.

In March 2019, a $200,000 ad campaign launched encouraging people to seek out MAT. The motivation behind this campaign was the fact that about 25% of MAT slots in the city were unfilled. Mayor Kenney's budget included a five-year plan in which he asked for $35.9 million for the Philadelphia Resilience Project. The city also opened 100 new shelter beds for drug users in Kensington.

In 2019, overdose deaths rose again—by 3%—after the slight dip witnessed in 2018. Looking to 2020, the city and its hospital partners planned to hire more peer specialists: people

in recovery who connect with drug users and talk to them about seeking treatment. Furthermore, the city hoped to expand mobile treatment options, particularly in South Philly.\footnote{Whelan, “City sets a 2020 plan to lower opioid deaths - Efforts have failed to make a big dent after 2017’s record. The battle will be waged on many fronts.”}

In January 2020, the city launched a work to earn program where people could clean streets for four hours and earn $50. The “safe corridors” program which enlisted community volunteers to walk children to school, avoiding any confrontation with public injection and drug dealers, grew in popularity as well.\footnote{Ibid.}

In February 2020, the judge in the Safehouse case issued a final ruling that the site would not violate federal law, shutting down remaining fears of arrest. Immediately after, Safehouse announced that it would open a site in South Philadelphia within the next week, which was quickly rumored to be in a former hospital building.\footnote{Jeremy Roebuck, "INJECTION SITE RAISES IRE, HOPE - South Phila. neighbors were angry, and city officials said they were blindsided. But not all were opposed," \textit{Philadelphia Inquirer; The (PA)}, February 27, 2020: A1. NewsBank: Access World News Research Collection.} Mayor Kenney declared: “The bottom line is that overdose prevention sites— which exist in more than 100 cities around the world—offer compassion for fellow human beings.”\footnote{Aubrey Whelan and Jeremy Roebuck, "South Phila. selected for injection site - Sources say building at Broad and McKean will hold facility after judge affirms ruling. U.S. promises appeal," \textit{Philadelphia Inquirer; The (PA)}, February 26, 2020: A1. NewsBank: Access World News Research Collection.} Within a day, massive outcry from South Philly residents, surprised council members, and an unyielding federal government consolidated.\footnote{Roebuck, INJECTION SITE RAISES IRE, HOPE - South Phila. neighbors were angry, and city officials said they were blindsided. But not all were opposed."} Many were shocked by the South Philly announcement because a SIS in Kensington had been the dominant presumption. City Council quickly proposed legislation to block SIS throughout the city, and no member defended the proposed site in South Philly. Even those who may have been allies seemed disappointed by the way Safehouse handled it.\footnote{Sean Collins Walsh, "Opposition from City Council over injection site - Introduced legislation would make opening another site impossible," \textit{Philadelphia Inquirer; The (PA)}, February 28, 2020: B1. NewsBank: Access World News Research Collection.} Within 48 hours,
Safehouse’s plans were postponed, and its landlords canceled the lease because of community blowback. Safehouse Vice President Ronda Goldfein said that they were prioritizing speaking with community members, but this willingness towards open conversation came after the site was already announced. The Philadelphia Inquirer concluded that, “At a rowdy news conference, the Safehouse founders realized that while Philadelphians have a history of tolerating urban chaos and inept leadership, plopping a drug den in the middle of a commercial and residential corridor full of working-and middle-class families will not be quite such an easy sell.”

When the Covid-19 pandemic hit, the city struggled to determine how to shelter in place and house homeless people and people in addiction. They began putting people who tested positive in the Holiday Inn Express and loosened restrictions on MAT. Isolation struck the Kensington community as essential services that drug users relied on closed or changed their operational status due to social distancing rules. In 2020, “Black Philadelphians’ share of the city’s fatal overdoses nearly doubled, surpassing that of white Philadelphians.” The city and nonprofits tried to continue promoting harm reduction efforts and treatment options in neighborhoods of color, but the overdose rate of black Philadelphians increased by 29%.

Moreover, Philadelphia saw the highest percentage of fentanyl related deaths ever in 2020; it was

176 Aubrey Whelan, "Record toll for fatal ODs is feared - The rise is seen as one more effect of COVID isolation and stress. What is also different is the share of Black victims.," Philadelphia Inquirer, The (PA), December 6, 2020: A1. NewsBank: Access World News Research Collection.
involved in 81% of all drug related deaths. Philadelphia had 1,214 overdose deaths in 2020; 3 less than 2017’s all-time high. Much of this is largely attributed to the pandemic and the chronic loneliness, weakened support services, and time alone in the home it brought with it.

In February 2021, city officials—especially Kensington Councilmembers Mark Squilla and Maria Quiñones-Sánchez—along with their nonprofit partner Prevention Point announced several initiatives geared toward helping the Kensington community. For one thing, a new police station would be set up in the middle of the drug market in Kensington. Also, the two homeless shelters run by Prevention Point would move to Temple University’s Episcopal Hospital by the summer, away from residential and business areas into a less visible Kensington location. Syringes would be distributed more evenly throughout the city, and Prevention Point planned to reduce the distribution of syringes in Kensington by two million.

In March 2021, SEPTA closed its Kensington Somerset Station due to elevators trashed with litter, syringes, and public urination. SEPTA also shared its desire to improve public safety in its stations, specifically Somerset, due to alleged harassment by drug users. Protests erupted following the closure, with Councilmembers Squilla and Quiñones-Sánchez leading the charge and Mayor Kenney staying quiet. The dominant complaint was that people could not get to work without walking a long distance, further isolating the largely black and brown Kensington

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community. The closure was also seen as a display of the government’s inability to solve major crises, forcing transportation operators to confront these social ills.\footnote{181}{“It’s time for Kenney to show leadership - The mayor’s voice has been missing in the controversy over closing of Somerset Station,” \textit{Philadelphia Inquirer, The (PA)}, March 28, 2021: A15. \textit{NewsBank: Access World News Research Collection}.}


Finally, the pandemic exacerbated the opioid crisis in a variety of ways. The money Americans received from the federal government (a payment of $1,200 in 2020 and then $1,400 in 2021)\footnote{184}{“Economic Impact Payments,” U.S. Department of the Treasury, accessed March 31, 2022, \url{https://home.treasury.gov/policy-issues/coronavirus/assistance-for-american-families-and-workers/economic-impact-payments}.} caused issues for drug users and people in recovery. Multiple interviewees testified that this check tempted recently sober individuals to buy drugs or allowed current drug users to buy a surplus of drugs they didn’t have the tolerance for. Hence, John Machen called this the “death check.”\footnote{185}{John and Rachel Machen, interview.} At the same time, powerful animal sedatives like xylazine were increasingly being found in Philadelphia’s fentanyl supply, drugs thought to be more resistant to Narcan.

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**Part 3: Obstacles to Solving the Opioid Crisis**

**Interview Participants**

I divide my interviewees into four categories: (1) nonprofit leaders/employees, (2) PPD/experience with law enforcement, (3) city employees, and (4) political actors.
Structure of Obstacles Section

I identify four main groups of obstacles preventing the city from fully tackling the opioid crisis. They are in order of simplicity, with the first group being the easiest to attack and so on. I begin with administrative problems which should be rather quick for the system to address. I then discuss flawed policies, which will be more difficult but ideally could be targeted in a timely fashion. Then, I outline problematic approaches which will likely take the city longer to correct. Lastly, ongoing political challenges are the hardest obstacles to overhaul, but also the most important if the city really wants to see tangible progress and satisfy the grievances of Philadelphians.

I. Bureaucratic Problems

There is a broad consensus about the value of not simply arresting drug users but providing them with effective treatment and social services. In this section, I detail the various bureaucratic issues that have impeded the attainment of this goal and curbed the city’s ability to resolve the epidemic more broadly.

Red Tape

Most nonprofit workers I interviewed feel well supported by the city financially. The criticism revolved more around the ineffective usage of funding and harmful, seemingly arbitrary regulations and policies. Elvis Rosado—former Coordinator of Education at Prevention Point

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186 In many of my interviews, the division between city departments and bureaucrats was blurred with political actors and members of the Kenney administration. In other words, the distinction between bureaucratic and political actors was not viewed as significant or even existent by some of my interviewees. Given this and the fact that many of the barriers are complex or lead to other barriers (e.g., a political barrier leads to a bureaucratic one), I try my best to place each barrier into the most representative category, but often discuss the widespread implications of a given barrier.
who now works at the Department of Public Health—discussed a situation in Kensington where a parking lot run by Love Lot had been feeding the homeless and other community members for two years. Rosado shared that to get this approved and implemented, “You have to jump through all the hoops and cross all your T's and dot all your I's and everything else to get it put into place.” Then, the principal of the school across the street complained, arguing that the lot was making kids scared to go to school; according to Rosado, “that was enough for folks to say, you can’t feed there anymore, you have to move.” Rosado expressed anger over how a principal from outside the neighborhood could have so much leverage, and declared: “The red tape seems to be thicker and longer to implement services than it is to shut them down.” Love Lot may have been a valid concern for Kensington residents and their children, but according to Rosado, no process for airing grievances was put in place before making a final decision that harmed a lot of people with little notice.

Prevention Point Executive Director José Benitez provided another example of nonsensical red tape. Despite the burdensome process necessary for an individual to obtain MAT, “There’s no pre-authorization for opioids. So as a provider, I can write as [many] opioids if I want to. Right? Which doesn’t make sense.” To be sure, the issue is not that red tape exists, but more so that it festers in areas where it shouldn’t (e.g., to set up Love Lot) and is absent in areas where at least a slight regulatory process would be beneficial (e.g., to shut down Love Lot or prohibit the over prescribing of opioids in the first place).

Another example of red tape and reluctance to adopt solutions comes from Benitez. He gave the example of Prevention Point’s attempt to get clearance to provide mobile buprenorphine treatment:

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188 Ibid.
189 Ibid.
So we, Prevention Point, went to DEA. Right. Remember, buprenorphine is regulated by the DEA…And we went to them and said, ‘hey, we have a crisis going on…we’d like to prescribe buprenorphine mobile.’ And they were like, ‘Are you crazy? What are you talking about? Like, you honestly think that you can do it out of the van?’ And we were like, ‘Yes. And here’s why we should do it out of the van. Right. There are a lot of homeless people that live in Kensington, people that are not going to come to us for the service. So we should take the service to them where they are, where they’re hanging out. Right. And we could park a van and have people line up and they can go through the assessment. We could prescribe. And then they could go pick up the buprenorphine at a pharmacy. Right. Or we could provide the buprenorphine off the van, either way.’ They went crazy. They were like, ‘Absolutely not. It’s going to increase diversions.’ Meaning that basically people are going to sell drugs…to folks. So we were like, ‘Okay, well, let’s give us a chance.’ And we kept after them. We kept after them. And they were like, ‘Okay, we’ll try it. We’ll try it. We’ll give you guys an exemption. We’ll try it.’ Well, you know what we found? What we found was there was no more diversion than any other clinic.\(^{190}\)

While there may be a valid reason for the DEA’s slowness to permit mobile buprenorphine, another insightful and potentially cynical point from Program Manager for Police-Assisted Diversion Kurt August—that especially rings true when thinking about the opioid crisis—is that in order to be implemented “…things need to have, like, a really strong evidence base under them. Right. And evidence-based practices is something that academic institutions love. Right. But that’s like, foundation of the bureaucracy. I can use that language and that emphasis to stall on things to buy more time and say, hey, maybe we should research this further. Maybe we should look into this.”\(^{191}\) Thus, it is a trend that reluctantly stalling the implementation of policies that will likely be successful is widespread throughout the city and stems from bureaucratic rigidity. The common goal of providing treatment and social services to drug users is halted by the city bureaucracy that centers around maintaining one’s job and the status quo.

\(^{190}\) José Benitez, interview by author, virtual, February 15, 2022.

\(^{191}\) Kurt August, interview by author, virtual, March 2, 2022.
Disconnect Between City Workers and Nonprofits

A common criticism was that city officials were “creating policy in a vacuum.” This is a major problem if the city wants its policies to be relevant and useful to people in Kensington and other parts of Philadelphia. Interviewees portrayed the bureaucracy as distant from them yet more powerful. At the same time, there was a tendency for interviewees to indicate that this doesn’t apply to all city employees or all police officers. Savage Sisters Executive Director Sarah Laurel praised the “progressive harm reduction unit” within the Department of Health, but then we had the following exchange, demonstrating the unhelpful initiatives and out of touch work of some city employees:

Laurel: When you have just a city official with another contract on their desk or another policy that they’re trying to push forward, it’s not deep rooted in their soul…You know, somebody who’s just a suit, sorry bro but you don’t got it. I wouldn’t come to your office and try to write a fucking new legislation, don’t come to my city and think that your gonna connect with our people just because, you know, you have to do it to get something passed. It…it…it’s ineffective. And we’ve worked alongside the city workers that have come down and they set up tables and they hand out brochures. Nobody wants a brochure. They’re coming to our table because we’re giving out clean syringes, Narcan, clothes, mace for the survivor sex workers. They’re coming to our table cause we know what they need.

Me: Yeah, that makes a lot of sense. And I think that makes a good case for the city just funding nonprofits and not being hands-on involved.

Laurel: Yeah, but they like to have their hands in everything. And also a lot of people would say that it’s their responsibility to do this kind of work and I think that what happens is the people that are being forced to do this work, cause this is not their life’s divine purpose, grow resentful towards the cause. They don’t want to hang out with a bunch of addicts all day. [laughs]

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192 Sarah Laurel, interview by author, virtual, February 9, 2022.
Coordination and Communication Problems Among Key Actors

Many of my interviewees alluded to problems with coordination between different stakeholders. These stakeholders range from activists and nonprofit leaders to elected officials and representatives of various city departments. Philadelphia has countless departments. The particularly relevant departments concerning the opioid crisis seem to be Health, DBHIDS, Homeless Services, Police, and Prisons.

Perhaps it is difficult to imagine constant conversation and progress on the opioid crisis when considering all of these relevant departments as well as the array of sub departments within each one. Indeed, this was a theme throughout my interviews and is one of the easier barriers to understand; it simply is the very structure of the city bureaucracy. Simply perusing the city’s website can feel daunting and one can quickly become overwhelmed by the different departments and how exactly they are distinct from one another. While I am sure this is a common problem in most major cities, I get the sense that little effort is made to bridge these communication gaps in order to solve this massive crisis, at least for an extended period of time. Executive Director of the Liberty Mid Atlantic High Intensity Drug Trafficking Area Jerry Daley expressed how the “Department of Health does its thing…Behavioral Health and Intellectual Disabilities…they do their thing. The Police Department does its thing. There’s just very little coordinated effort. And I lay that at the feet of the administration, not just this one, but several administrations that have created a million offices, but very little thread running through them…Have you ever looked at the city’s web page? And have you clicked on that button for agencies and offices and see how many freaking offices there are in the city of Philadelphia that are not, by the way, listed in the city charter?” 193

The lack of effective communication between city departments that all have a role to play in conquering the opioid crisis leads to evident confusion over responsibility and who is the “top dog” when it comes to crucial decisions. Elvis Rosado argued that this situation has accelerated to a point of total bewilderment and even hopelessness for nonprofit organizations and activists:

Honestly, at this point, we don’t necessarily know who makes these decisions because there was a meeting a while ago where people were confronted who were there representing different departments of the city, including City Council, and were asked, ‘Are you the person that makes the decisions on whether this happens or not?’ ‘Oh, no.’ ‘Well, are you?’ And pretty much everybody said, ‘No, it’s not me.’ Okay, so then who is it? Because you are the faces. You’re the ones that keep coming here and saying what you can and can’t do, but you’re also saying you’re not the ones making the final decision. So let us speak to the person who actually makes the final decisions, who has that power, and you guys can just stand aside because obviously you don’t have that power, but that never happens. And no one in that meeting could also say who is the person that we would go to that makes those decisions. All these people saying no, yes and no, but when it comes down to it, when you ask them for sure, ‘Are you the one that makes this final decision?’ And they say, ‘No, that’s not me.’”

So, poor delegation of tasks and a hazy decision-making hierarchy creates an environment where no single actor or city agency will be held accountable. Even on a more simplistic level, outside actors working on the crisis do not know where to turn, who to persuade, or how to get their concerns or suggestions in the ear of the right person; they don’t even know who that person is!

From a former city employee’s perspective, there is truth to the communication problem between and within departments. Allison Herens, former Harm Reduction Manager at the Philadelphia Department of Public Health, credited the various departments with stalling developments and disclosed that when they meet, “it’s just like everyone’s just trying to be civil. No one really says anything that might come off as, it’s like very passive aggressive, and nothing ever really gets addressed. So, it’s very difficult to move anything forward when you have to cross departments, and almost everything crosses departments. Um, so it’s tough.”

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194 Rosado, interview.
An example of this type of disconnect is the city’s divided response to the rise of fentanyl in the drug supply. While the city as a whole was slow to adapt to this, Forzato said, “I could tell you law enforcement, we knew it first. We’d get our bags tested for cases that we bring to trial or prosecution.”196 The police were aware of the rising fentanyl problem fairly early on.

Another interesting claim that bears mention is that there may be a similar communication problem between and within nonprofits. Kensington has an impressive nonprofit sector. Yet, Daley argued that this could actually be inefficient, or not as productive as it would be with greater collaboration: “But then there’s a boatload of others [besides Prevention Point] that are kind of, I don’t want to say freelancing, but certainly not dialed in with a plan as such, a master plan. They’re going out and they are doing God’s work, but on their own. And that is unfortunate.”197 This is a minor part of the communication barrier, but I do find Daley’s claim compelling and even obvious because of the sheer number of nonprofits that do incredible work, but do not have as much ambition about an end game as Prevention Point.

Diverging Interests Among City Departments and Agencies

Departments within the city have different ideologies on how to deal with the drug crisis. So, while communication and collaboration are surely obstacles, this is a more deep-rooted problem. People disagree on the fundamental philosophy necessary to remedy the crisis. Zoe Soslow, Central Administrator of OD Stat at the Department of Public Health, corroborated this, sharing: “We’re thinking about everybody having to come together from a Public Health Department, which is very harm reduction focused, to a Department of Behavioral Health that is tasked with getting people access to quality treatment. And then we have a Police Department

196 Forzato, interview.
197 Daley, interview.
where we struggle much more with getting them on board with harm reduction methods. And so there’s this constant push and pull of not everybody agrees on the best way to kind of treat this issue.”

There is also evidence of a similar dynamic within departments. Corroborating Soslow, Herens revealed the rigid environment at DBHIDS: “...anyone who has worked within [DBHIDS] will kind of tell you, if you don't show a certain amount of loyalty, you're not going to last there, because that's really what it is. Everyone maintains the status quo, and, you know, everyone is happy to maintain the status quo.”

Summary of Bureaucratic Problems

While relatively minor, these obstacles prevent the city from reaching its goals because stakeholders and agencies have diverging ideas about the best way to approach the crisis. Red tape makes any sort of common goal—such as connecting drug users to services—harder to achieve as regulations exist in counterintuitive places, hindering the initiatives of nonprofits and restraining them from moving at the quick pace they prefer.

II. Flawed Policies

Under Mayor Kenney, the city has made some strides towards improving the resources available to drug users, including social services and treatment. However, there are too many policies in place that bring with them destructive flaws. Social services are still not designed to meet the specific needs of the drug using population. A myriad of problems exist pertaining to accessing treatment, especially effective MAT that creates lasting results. Finally, the hands-off

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198 Zoe Soslow, interview by author, virtual, March 1, 2022.
199 Herens, interview.
policing policy is well intentioned but deeply flawed in that it strips police of all their power to place drug users into treatment; they can only offer services and treatment, both of which have their own problems. The policing approach also brings unintended yet predictable consequences with it.

**Entry Barriers to Social Services**

Drug users are not naturally in a position that easily connects them with social services, nor are they often inclined to accept them. Under the Kenney administration, headway has been made towards improving the quantity and quality of social services offered to drug users. This is seen in initiatives like Mayor Kenney’s Community Life Improvement Program (CLIP)—simultaneously promoting clean streets and offering same day pay to drug users—and the PAD program. The city also deploys outreach workers to areas like Kensington to connect drug users with jobs, housing, and wound care. There are also increased strides towards informing drug users of benefits they may be eligible for (e.g., Medicaid, veterans’ benefits) and helping them navigate these systems. In addition, the city has done a solid job of drastically increasing the amount of Narcan on the street, a direct result of the task force.²⁰⁰

Still, barriers remain that prevent drug users from accepting services and feeling comfortable doing so. A high-ranking policeman I talked to expressed: “I think it’s hard to imagine as a rational person trying to think like somebody who’s out there because we do have all these services that we’re offering. The city services are offering people healthcare. They’re offering a roof over your head and all these various other things. You think people would want to take those on. But a lot of them just walk away from us…”²⁰¹ The refusal of services by drug users is.

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²⁰⁰ For more details on what the city has done in terms of social services, see “The City’s Response” section.
²⁰¹ Interview with a police leader, interview by author, virtual, March 2, 2022.
users is a complex phenomenon. Many nonprofits are growing more aware of the need for low barrier entrance and to “meet people where they are.” The idea here is that by garnering trust between outreach workers and drug users, they eventually will be able to ask for support when they are ready because this trust has been built up over time. While this strategy has merit and has been expanded under Mayor Kenney, there are concrete barriers on the bureaucratic end that could ease some of this hesitancy to accept services.

One barrier concerns identification documents often required to access social services. Drug users who have been living on the street for years often don’t possess the required documentation. There has been some progress in this area, with nonprofits like Prevention Point providing drug users with new IDs that use the Prevention Point address. The city has been an ally throughout this process, but the issue of entrance barriers has not been totally addressed. Laure Biron, former Director of the Porch Light Program, elaborated on the best strategy to engage drug users in social services: “...I think that the first step really is to provide more spaces for people to be able to enter and immediately get access to really basic stabilizing things that they might need with dignity, without having to fill out paperwork or hand over their things or go through security.”

Stigma against drug users comes into play here and results in unwelcoming behavior towards drug users. A variety of interviewees deemed the poor treatment of drug users when seeking social services—and treatment for that matter—a major deterrent. Even as this stigma weakens, many are skeptical of social services and distrustful of government because of past experiences; there is a lot of past harm that needs to be reconciled.

The most prevalent social service entrance barrier consistently illuminated in my interviews is that most homeless shelters require sobriety through a negative urine test. Some

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202 Laure Biron, interview with author, virtual, February 24, 2022.
shelters do not even permit people who are on MAT.\textsuperscript{203} Even shelters without this requirement do not allow drugs inside and therefore, drug users tend to prefer to live on the streets of Kensington than to enter a shelter, knowing they will soon endure the dreadful physical effects of withdrawal. There are only a few shelters—predominantly run by Prevention Point—that house people without the sobriety requirement. In times of extreme cold or extenuating circumstances, other shelters in the city become attractive from a public policy perspective to meet the sheer number of individuals in search of beds and to prevent Kensington residents from being overwhelmed with yet another service geared towards drug users. But these other shelters are not accessible or attractive to drug users. The city has not been aware of or eager to take action to address this problem. When the clearing of the Conrail tracks encampment occurred, the city claimed it would have places for everyone to go, but this barrier halted their mild efforts;\textsuperscript{204} so, the inadequate preparation for and anticipation of this obstacle falls on the city. A police sergeant chronicled the hesitancy to seek shelter outside of Kensington and the complexities of this problem:

One of the things is many of the drug users in Kensington want shelter but don’t want shelter out of the Kensington area because they want to be close to the market. The thing that the community doesn’t want is their area just to be an area full of shelters. Right. So people don’t want to leave the area because it’s close to the drug markets. So while there might be shelter and beds available elsewhere in the city, they don’t want to do that. Currently, the drugs in Kensington have a lot of tranquilizer in them. Most people on the street are nervous to detox off of [tranquilizer] because the detox is apparently a fairly bad one. So that’s stopping people also from getting off the streets because they don’t want to go through that detox as well.\textsuperscript{205}

While I classify sobriety requirements and other entrance policies that deter drug users in particular as bureaucratic barriers, a police-affiliated interviewee who requested anonymity

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\textsuperscript{203} Daley, interview.
\textsuperscript{204} Ibid.
\textsuperscript{205} Interview with a police sergeant, interview by author, virtual, March 2, 2022.
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argued that this barrier remains because there is not much political will for any change and perhaps rightfully so:

We’re talking about people who are taking drugs in the train stations, for example. I asked them, ‘why don’t you want to go to a shelter?’ ‘I don’t want to go to a shelter because people are assholes there. Or I can’t take my stuff, or I have to be clean, or I can’t take weapons, or I can’t get high and I can’t get drunk in there.’ You have to find a way to make the alternatives more attractive to doing all of those things on the street. So, I’m not sure how much political will there would be to create housing opportunities without any kind of barrier or entry into it. And then what happens, then, The Philadelphia Inquirer gets hold of it and says ‘Mayor Kenney is basically fueling drug dens. Places for people to just take drugs.’ So, I suspect behind closed doors and I don’t know this, to be sure, because I’m not part of these discussions. But I suspect that they’re probably thinking without some modest criteria that people are trying to make an effort to get clean, to manage that…I suppose that’s the question, right. Is that a reasonable barrier or is that an unreasonable barrier? I get the feeling that it was implemented as a barrier for a reason.

Not only does this interviewee highlight the potential political thinking behind not removing this common shelter requirement, but he also brings to light other reasons besides sobriety requirements that may deter drug users from entering shelters.

On the whole, the potency of the drug supply, potential for political fallout or backlash, and the complication of Kensington already being overloaded with social services geared towards drug users all contribute to the stagnant barrier of finding shelter for drug users and serve as obstacles in their own right. In addition, it takes time to build trusting relationships between outreach workers, police officers, and drug users. Therefore, depending on how one looks at it, it may seem like little advancement occurs because of the constant flow of new “drug tourists” into Kensington.

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206 Interview with PPD affiliate, interview by author, on phone, March 10, 2022.
**Treatment Barriers**

The city and nonprofit community have made strides towards opening treatment slots and getting people into treatment—especially MAT—more easily. The ID barrier to access MAT has been largely reduced and more funds have been allocated towards treatment providers in the city budget. The crux of the remaining treatment barrier stems from the reality of modern drug addiction where fentanyl, and increasingly tranquilizers like xylazine, rule the streets.207 The potency and addictive nature of these drugs make it more challenging to want treatment for an extended period of time, especially when barriers stand in the way. A major obstacle concerns the Philadelphia County insurance contractor, CBH, which appears to be deeply flawed.

**The Assessment Process**

When someone seeks treatment, their willingness to do so often appears for a narrow window of time. If all the resources are not in place, the opportunity will pass as the dreaded effects of withdrawal kick in. The laborious assessment process in Philadelphia County fails to meet this temporary demand. Notably, the two interviews that focused on this were with individuals who have lost a child to overdose. Rachel Machen, who runs Another Day Clean Recovery Homes with her husband, John, detailed the tedious process: “In order to get treatment in the city of Philadelphia, you have to go through an assessment process. Right. In Montgomery County, we make a phone call, and someone with Montgomery County insurance can go right into treatment. In Philadelphia, you have to go to one of the crisis centers. It can take 23 hours, sometimes more. And people who are using, especially with fentanyl now, they’re not going to sit there for 23 hours.”208 The Philadelphia system was often contrasted with neighboring

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207 Forzato, interview.
208 John and Rachel Machen, interview.
counties where it is much easier and faster to get a treatment bed; the CBH system is a large reason this disparity exists.

Even beyond the waiting time for treatment, the potency of today’s drugs outweighs the efficacy of long-standing treatment options like MAT. Allison Herens argued: “Like, opioid-related treatment, like methadone treatments, suboxone treatment. That’s all a joke, because none of that has adapted for, like, the fentanyl crisis that we now have. At this point, still, they will only dose you max 30 milligrams of methadone to start like, that in the age of fentanyl is insane. Like, that’s not going to hold anyone for 24 hours at this point. And so, it’s like, I don’t question why people don’t want to go to treatment...” Rachel Machen corroborated the idea that acceptance of MAT has not caught up to the strength of today's drugs. While not touching on the dosage problem specifically, there is prevalent anti-MAT stigma within the AA community and amongst medical professionals: “It's really easy to stigmatize MAT and make them feel less than. But with fentanyl, like honestly, I'm grateful every day I got clean before fentanyl. With fentanyl, I get it, like people want to go on suboxone or methadone.” The nature of addiction has totally shifted because of fentanyl; what hasn’t is society's acceptance of this reality and subsequent openness to different treatment options.

Treatment Providers

José Benitez illuminated a massive problem with treatment and resolved some of my confusion about treatment beds and their availability. Despite the enormity of this crisis, about 25% of all treatment beds are empty. Benitez clarified: “So what really is happening on the street, for example, are clinics like ours that do things low barrier, for example. Right. Have long waiting lists, and then you have other providers that no one wants to go into the program. They

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209 Herens, interview.
210 John and Rachel Machen, interview.
have empty slots. Right. And so, the bureaucrats have to take a look at systemically what’s happening here. Right. Why, on the one hand, do we have waiting lists with certain providers? On the other hand, we have empty slots with certain providers.”

I lay out Benitez’s specific suggestion in my recommendation section, but this is truly a prime example of poor allocation of funding and resources. Benitez’s point highlights the fact that cries for more funding for treatment identify the wrong solution to the lack of easy treatment access. The problem is not the total number of treatment beds. Rather, it is that the allocation of city funds to treatment providers does not account for how they vary drastically in their appeal to drug users. High demand follows certain treatment providers: the ones that are approachable and provide treatment in a low-barrier way. The city’s funding does not prioritize these treatment providers.

Herens elaborated on what exactly makes so many treatment providers in the city classify as “high barrier”; “...almost every methadone clinic I can think of, they’re open at the very most between, like, five and one p.m…that in and of itself, it’s like, how do you actually expect someone to get their life back when they have to be somewhere within those hours? It's like, it doesn't actually make sense. But then we sit here and wonder why people don't want to do these things. They’re just not very person centered at all and not really set up for people to succeed. You know, I constantly tell people, people get sober in spite of our treatment system. Right, like it's not because of it. Because more times than not, there’s, like, these very real barriers that exist at every level.”

**CBH and Insurance**

Multiple interviews demonstrated the challenge of navigating insurance and treatment coverage through Philadelphia’s CBH system. According to its website, CBH is “a nonprofit

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211 Benitez, interview.
212 Herens, interview.
501(c)(3) managed care organization contracted by the City of Philadelphia’s Department of Behavioral Health and Intellectual Disability Services (DBHIDS) to manage the delivery of behavioral health services for Medicaid recipients of Philadelphia County.”

August labeled CBH a “monstrous bureaucracy.” It seems to be a bureaucracy within the even larger city bureaucracy. Many interviewees were critical of CBH. One problem is the assessment process described above. The smoking ban on many treatment centers that likely deterred drug users from seeking and staying in treatment exemplifies CBH’s flaws. Herens shared that she has heard “Too many stories of people getting kicked out for smoking or people not wanting to go to treatment because they couldn’t smoke or whatever it was. And I could sit there and tell people until I was blue in the face and no one was willing to acknowledge how actually harmful this thing was. And like years later now we all know that it was like for research and it was never really required by the state.”

Need for a Continuum of Care

Another important aspect is that drug users who enter treatment often need consistent guidance. The failure to be attentive to this is partially responsible for frequent relapses, especially in times of stress. Kurt August is an advocate for “raising the floor” in terms of services like affordable housing and peer support so that drug users are guided back into society. To take advantage of social services and to navigate the complex bureaucratic system, drug users often need support, as Mr. August detailed to me:

... it’s discouraging for a lot of people that are just trying to kind of foundationally piece their life back together. A lot of what we do with peer support is basically just tell somebody to go with somebody to do their basic stuff. For instance, what we used to do

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214 August, interview.
215 Herens, interview.
is people need IDs. Right. So, we would say, ‘Okay, you need an ID. Here’s a money order to PennDOT for $32. Like, go get your ID.’ And we will find that a lot of people would never end up using it. And we would talk to them, and they would say, ‘Yeah, I went down there, they told me to pull a number. I was like, E 283. I had to fill out all this paperwork. I didn’t understand. And I was just like, fuck it, I left.’ So, when you send somebody to go down there and help somebody navigate the situation, some people don’t have anything. So, you got to start with their birth certificate and all these other things that you have to get, like. So you need more support around kind of navigating the bureaucratic process, somebody that can make that easy for folks.216

The need for enhanced hands-on assistance is reflected in my recommendations.

Councilman Mark Squilla, who represents part of Kensington, also stressed the need for a greater continuum of care, arguing that “...you can’t expect somebody who’s been entrenched in addiction to be healed in 30 days and then throw them right back out into the street again and expect that they’re going to be better…the reason why people relapse over and over again, because it’s hard for them to then cope back with life skills.”217 For all of the talk about making treatment accessible and connecting people with treatment—which is absolutely important—the city seems to forget about the job of maintaining relationships with those in treatment and continuing to support them throughout their recovery journey. Simply abandoning someone once they are connected with treatment, patting yourself on the back, and moving on is not enough and will backfire. I do think there would be enough political will to increase funding and programs that provide this type of peer support throughout the recovery process and encourage former drug users to become productive members of society.

**Too Many Carrots, No Sticks**

The Kenney administration has taken a public health approach to the opioid crisis. While all of my police-affiliated interviewees agreed that we cannot arrest our way out of this and that

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216 August, interview.
addiction is a disease, there was a prevalent view that the new approach, which is solely a public health one, has brought new consequences and limitations from a law enforcement and bureaucratic standpoint. I classify this as a political obstacle because elected officials such as Mayor Kenney and DA Krasner have instituted these changes since they took office; this is indisputable. It is a matter of opinion if not arresting drug users and equating the opioid crisis with a public health crisis is good or bad. Generally speaking, nonprofit interviewees supported these developments; this makes sense as they primarily focus on the wellbeing of drug users by taking a harm reduction approach. To police officers, those who work closely with the police, and less progressive council members, this is a problem. The progressive Kenney administration has “…deemphasized law enforcement…deemphasized policing, and it’s deemphasized taking a criminal justice approach.”

A high-ranking policeman told me that the police really view themselves as partners to other nonprofits and social service providers in Kensington; it is not, as he said, “law enforcement forward.”

The city’s relatively new policing strategy that doesn’t arrest drug users, which virtually everyone agrees is good, does leave a vacuum in which no other systems exist to hold people accountable. The change in prosecutorial policy is an obstacle to adequate law enforcement because nothing else has replaced this system besides asking if drug users want social services. In reality, this limits the tools that police officers have to enforce the law. A police sergeant I spoke with elaborated on this point: “So we don’t want to arrest people, but we don’t really have anything in between arresting people and then just asking people if they want services. There’s not really a middle ground of getting people to a drug treatment court or something like that.”

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218 Interview with PPD affiliate.
219 Interview with police leader.
220 Interview with a police sergeant.
Councilman Mark Squilla told me that drug court ended because people argued it was “trying to criminalize drug use.”

The high-ranking policeman discussed the impact of orders coming out of the mayor’s office on their approach to the opioid crisis: “We’re all social service led, and we’re asking people that are addicted to something to willingly take those services where there’s nothing to hold them accountable for that. And that’s where, when you ask if there’s something to do, we could do something similar to [community court]…And I don’t know. But again, as law enforcement in the area, we’re going to just continue to work within our policies and procedures until those policies and procedures change and we’ll go from there.” This quote solidifies the connection between politics and bureaucracy, the mayor’s office and the police force, and a hands-off approach to policing and a lack of accountability. Although the police leader avoided explicitly drawing this connection, it is obvious that the policy and views of Mayor Kenney and DA Krasner have a direct impact on policing the opioid crisis and what Kensington looks like today.

I heard from multiple police-affiliated interviewees that it is harder to prosecute drug dealers when drug users aren’t being processed. Daley explained this from a law enforcement perspective:

So if you’re witnessing what looks like a drug transaction and you go to stop the person who is buying it to see if they do in fact have drugs and they do, well then you’re supposed to lock them up. But if you lock them up, they’re not going to be charged. If you then use that as the basis of your probable cause to lock up the person who was selling the dope, then you’ve got a problem. Now it’s like, well, we don’t have an arrest of an individual in possession. We don’t have that evidence that you seized from him analyzed because we’re not prosecuting him. So we’re not going to waste the forensic laboratory’s time to validate that it is. Oh, and by the way, the guy that was selling, he

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221 Squilla, interview.
222 Interview with police leader.
only had a couple bundles of dope, he doesn’t even hit the radar screen as far as, so we’re not going to prosecute him either.\textsuperscript{223}

Three other police sources corroborated Daley in similar words. I think this is a good example of an unintended consequence but likely one that a police officer could have predicted; most agree it is noble and long overdue to stop arresting drug users, but that makes it much harder to incentivize the sharing of information and gather enough evidence to arrest and prosecute drug dealers who are knowingly and ruthlessly supplying the public with poison for profit.

While policing issues are bureaucratic in nature, the change comes from the mayor and thus, is rooted in politics. This barrier has widened the tension between Kensington residents and drug users and has resulted in a declining sense of safety. Laure Biron described the perspective of Kensington residents and their support for the police: “I mean, it’s another thing that I found sort of fascinating about that neighborhood. I’ve worked in Philadelphia neighborhoods for like 15 years at this point. And I would say universally, most people are against stop-and-frisk. For example, I don’t think I’ve ever been to a community meeting except in Kensington where people have said they want stop-and-frisk. [But] in Kensington, overwhelmingly, people are in huge support of stop-and-frisk.”\textsuperscript{224}

Overall, this barrier can be addressed with more sticks, innovative ways to hold individuals accountable, and to some extent, empowering police or at least equipping them with better tools, and, on a pessimistic note, what Daley described as an “almost magical alignment of police leadership and governmental assistance.”\textsuperscript{225} Otherwise, the lax policing will inevitably attract more and more drug tourists, further frustrate Kensington residents, and curtail safety with the onslaught of drug dealers increased demand undeniably brings. There’s also an argument to

\textsuperscript{223} Daley, interview
\textsuperscript{224} Biron, interview.
\textsuperscript{225} Daley, interview.
be made that more drug users would get into treatment if police had greater “coercive capacity.” My police-affiliated source who requested anonymity eloquently got to the heart of the problem surrounding the city’s approach: “It can only offer carrots, and they can’t offer much in the way of carrots. They’re not very tasty. So, what often pushes and compels people into treatment and care and shelter is some kind of coercive factor that pushes them off the streets…To some degree, the political impact has been to remove all of the push factors. And so, the only way to make the system work is to improve the attractiveness of the pull factors, pulling people into treatment and care, and they’re not doing that.”

The necessity of a coercive factor was emphasized by Councilmember Squilla, who argued that “sometimes we have to also have people make tough decisions on their own, force people to make decisions.” Squilla provided an example of the benefit derived from forcing people to make tough decisions. He related the process of clearing encampments along Lehigh Avenue throughout May 2018: “But, what we realized during that 30-day engagement, we said ‘hey, listen, we could give you shelter, we could give you short-term housing. We could connect you back to your family. We could get you rehab or MAT.’ Right? Nobody took it until the last day. And the reason why then we got 70% of those people to [take] it, they had to make a decision. Either we’re going to take all your stuff and your tents and everything away, or you go get help.” So, Squilla sees some benefit in encampment clearing with tight deadlines and, like others, sees drug court as a solid alternative to solely offering social services and treatment.

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226 Interview with PPD affiliate.
227 Ibid.
228 Squilla, interview
229 Squilla, interview.
Summary of Flawed Policies

The three sets of policies depicted in this section illuminate the oblivious nature in which policymakers approach the opioid crisis. Despite recent strides towards lowering barriers, drug users are not inclined to accept services or treatment in sufficient numbers. These policies are not catered to the peculiar needs, fears, concerns, and priorities of drug users. The policing policy remains out of touch with human nature; a superior approach would incentivize drug users into social services and treatment. The city says it wants to lower barriers and help the ravaged Kensington community, but its current policies say otherwise. Just look at the inept CBH system, the nonsensical fund allocation to treatment providers, the assessment process that results in the loss of so many, once hopeful, drug users, or the current policing policy that strips law enforcement of any tools besides connecting drug users with these flawed, rarely accepted services. The next section discusses some underlying structural and strategic issues that hamper the dismantling of these remaining, harmful policies.

III. Problematic Approaches

While Kenney has been the first mayor to try to tackle the opioid crisis and pay attention to Kensington, criticisms of the city’s approach are endless. Poor leadership is the common thread that runs rampant throughout all of the below obstacles. The city’s approach is reactive, hesitant, and scattered as opposed to proactive, bold, and holistic. Unfortunately, this results in many stakeholders feeling let down and misunderstood by the Kenney administration. These issues are fixable, but concerted reflection and major structural and strategic changes are imperative to combat the default feeble approach.
Bureaucratic Thinking: Reluctance to change and inability to pivot

It is not surprising that opioid use has been declared a crisis or even an emergency given the overdose rates throughout Philadelphia and particularly in Kensington. Despite this, various interviewees classified the city’s response as lacking a sense of urgency. From August’s insider perspective, we can see the distinction between talking points, minor actions or initiatives, and full-fledged effort, with the latter being the missing part. August articulated:

We know how to describe the solution. It’s more of an issue of acting kind of with a sense of urgency, or at least at like a scale. Right. So, we can say something needs to be done, and then what we’ll do is we’ll pilot it in a small area in a limited period of time. Right. Instead of making it a citywide robustly funded kind of program, we just kind of dip our toe in, you know, hope that the problem will go away, and then we can just kind of move on to something else. So we don’t really have the full commitment…Whose job is going to change, like, whose priorities are going to shift? What kind of resources are we putting into this to actually effectuate the change that we’re all saying needs to be made?\(^\text{230}\)

While August emphasized the timidity of the city and fear of fully committing to an initiative, Forzato stressed the city’s weakness of pivoting and mildly improving interventions. The inability to pivot and adapt quickly is not unique to Philadelphia; rather, it is the norm for large bureaucracies. Still, this criticism was so common that it bears discussion, especially given the severity of Philadelphia’s opioid crisis and the acknowledgement of this severity by city and state actors. Forzato explained how he picked up on this flaw during his time working at the attorney general’s office, stating: “It will take six, eight months, a year to think through and put a program out there. And then there’s a lot of unwillingness…to tweak it to make it better…When it comes to the crisis in Philadelphia, government has to become more nimble and more reflective. And there has to be some nimble pivoting as the crisis changes or if strategies aren’t

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\(^{230}\) August, interview.
working, you give them enough time and then you say, well, wait a minute, this doesn’t seem to be working. Let’s maybe not just cancel it, but let’s make it better.”231

An example of this, corroborated by Forzato, is the city’s slow adjustment to the arrival of more potent drugs like fentanyl: “Then fentanyl came along and you rightfully said the city didn’t pivot.”232 Councilman Squilla supported this claim of insufficient adaptation to fentanyl, arguing that the city’s strategy is “not working because the opioid crisis has changed... So fentanyl has taken a whole new line to how we are addressing this. But government, city medicine are all using the same tactics they used before. So we see overdose deaths rising. We see more and more people becoming addicted. So I think that we need to start looking at different ways to deal with this. We dealt with it a certain way in the past, and we say that doesn't work. We’re dealing with it in a certain way now. We see that our numbers are continuing to grow.233

Unfulfilled Promises

Just for Show

I heard many comments about Mayor Kenney and other political actors saying or doing things pertaining to the opioid crisis almost to signal that they care or are taking action. However, according to many interviewees, their words are not followed by substantial action and their actions are merely symbolic. At first, it was hard for me to understand this criticism based on my newspaper reading and view that Kenney is a progressive who has embraced safe injection sites and other, once radical policies to deal with the drug crisis. But some interviewees argued that it is easy to “speak the language” of harm reduction activists and learn to convey the

231 Forzato, interview.
232 Ibid.
233 Squilla, interview.
messages that people want to hear. Similarly, it is easy to conduct minor initiatives that are uncontroversial to most and at least give the appearance of effort. August argued that “our rhetoric doesn’t match our actions.” He elaborated that it is easy to utilize buzzwords to one’s own advantage and “say hey, we want to have this be a person-centered harm reduction approach to mitigating the effects that it’s having. And we want to promote racial equity and do things of that nature. That sounds lovely. Like a world that we like to live in, but our actual actions that follow up with that don’t really correspond with the ideals that get espoused.”

John Machen declared of Mayor Kenney and the city’s promises: “They give a lot of lip service to what they’d like to do, but you never see any results because it just keeps getting worse. If you go down on Kensington Avenue and stand on, let’s say Kensington and Cambridge, and throw a rock in any direction, you’ll hit a drug deal.”

Another instance of this symbolic leadership is seen in the occasional tours that elected officials take of Kensington to observe the crisis. A current police officer underscored her anger at this:

All these politicians, I get so angry every time they come into Kensington. Like it’s a freak show…they’re going to come down to Kensington, they’re going to do a walkthrough. Walk through what? This isn’t a zoo. If you live in the city and you’re a politician or even the state and you don’t know what Kensington is and what’s going on down there, then shame on you, like, for you to have to walk around to see this and then come and give, the news cameras go on and they give these interviews about how much they care and they’re going to do things that change and they do nothing. They do nothing. So it’s all talk and nobody follows up on it.

Idealistic

Another common criticism of Kenney’s leadership came largely from police, people who work closely with the police in some capacity, and generally my interviewees less keen on harm

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234 August, interview.
235 John and Rachel Machen, interview.
236 Interview with a current Philadelphia police officer, interview by author, virtual, March 21, 2022.
reduction. These individuals argued that the Kenney administration is far too idealistic, especially given the sharp tensions within the Kensington neighborhood. They are also idealistic in the sense that their public health approach almost entirely dismisses policing as a way to keep the Kensington community safe, resulting in unkept promises. A police-affiliated source who requested anonymity contended that this stems from a political philosophy that lacks pragmatism, begins in high-level offices, and spreads throughout the city. He shared: “I’m underwhelmed like, I think many other people are with the city’s leadership. I think the problem is that it’s an ideological perspective, and I get it. Why would you not want to address some of the underlying issues, which is the long-term strategic healthcare approach? It makes absolute sense. It sounds wonderful in a sound bite, and it looks great on a PowerPoint slide, but there is also a brutal reality of what it’s like in the street. I think the leadership in Philadelphia is idealistic in terms of the city leadership. The [managing director’s] office, I think they’re idealistic, but I think they lack a pragmatism.”

Jerry Daley, who was on the Opioid Task Force, portrayed the final recommendations in a rather negative manner: “Promised and all and delivered very little…They came up with some conclusions and recommendations and actions. And they were very noble, but very, what would I say? Idealistic. I found some of them to be almost impossible to achieve under the best of circumstances. But in the circumstances of Kensington, would be clearly even less likely to happen because of the nature of the neighborhood.” The most idealistic recommendation from the task force was SIS, according to many interviewees.

Another way to conceptualize this barrier is to say that the city’s thinking does not account for the realities of human nature. The city’s deficient anticipation of unintended yet

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237 Interview with PPD affiliate.
238 Daley, interview.
predictable consequences suggests that leaders do not consider human nature and how people are going to react to different policies that under Kenney’s administration, tend to remove the responsibility aspect from the individual.

**Reactive Decision-Making**

The city’s reactivity is perhaps the greatest strategic flaw that contributes to the rising overdose rates and decrepit conditions evident by taking a stroll around Kensington. I view this as a leadership issue, but it certainly does exhibit bureaucratic aspects as well and may stem from the political will problem. Put simply, the city reacts to problems stemming from the opioid crisis after they have gotten out of control. Many of these catastrophes are predictable. Reactive decision-making is best demonstrated through examples, which are not in short supply.

**Encampment Clearing**

Every so often, encampments of drug users in Kensington get so out of hand that the city decides to step in. While they have become more aware that forcing people into treatment is not the answer, the city’s handling of these cleanups does little to solve the underlying issue. John Machen illustrated:

> So, they had this encampment down on the railroad a couple of years ago. So, their decision [is] to clean it up. So, in doing that, there was no plan for all those people they were chasing out of there. They set up a couple trailers where they could go to try to get to treatment or this, that, and the other, but there was really no plan. So all they did was take that encampment on the railroad and moved it to Emerald Street. So then they decided, ‘Well, now neighbors are complaining. Let’s go clean up Emerald Street.’ So they did the same thing there. They came in, they knocked down all the fences. So now they’re all living up and down Kensington Avenue, which is the business hub of Kensington.  

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239 John and Rachel Machen, interview.
This cycle of simply shuffling drug users around proves counterproductive and occurs on a reactive basis when too many Kensington residents decide to complain, or the situation poses a greater than usual public health threat.

Syringe Services

Syringe services have historically been a politically contentious issue. Soslow reported how the arrival of the Biden administration meant there was, at last, federal and state support for syringe services, making the Department of Public Health’s job and mission easier. But she cautioned me that “...when you zoom into the local level in Philadelphia, there’s actually requests from City Council based on outcry from neighborhoods about reducing access to syringe services. And that was largely due to increasing syringe litter, people injecting openly in Kensington. So, it’s like because we have allowed certain issues to persist in Philadelphia and to affect quality of life for so many community members, we then kind of reflexively are like, ‘Well, let’s get rid of this life-saving intervention because there’s litter on the streets.’” The city operates under the norm of simply removing interventions that work because of negative externalities, as opposed to finding innovative ways to modify or adjust these policies. There is no tendency right now to adapt and correct; the city quickly gives up on promising interventions when they are not implemented flawlessly.

Public Bathrooms

With so many homeless people on the streets of Kensington, there is an obvious need for public bathrooms, especially after encampments have been cleared. The city was extremely slow to address this overt problem. Activists warned the city that action needed to be taken. Herens

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240 Soslow, interview.
exclaimed: “And then lo and behold, there’s a Hep A outbreak. But activists have been sitting here saying, we need bathrooms, and a couple of months later we have this outbreak. And it’s like the response was so slow. I mean, they ended up putting up these really expensive, really nice…But you know, again, they waited until there was actually an emergency until there was actually a problem to do something about it.”\textsuperscript{241}

\textit{Wound Care}

Another dire need originating from drug use is wound care. People run out of body parts to inject into, and thus, often have severe wounds, bruising, or gashes throughout their bodies. In this context, Herens provided another example of reactivity to this predictable need, particularly as more addictive substances that are injected more frequently gain popularity: “People’s wounds are severe. People are walking around, like my coworker and I were talking about it earlier. People are walking around like missing parts of their body, like giant gaping holes in their skin. It’s like people need a lot of help. And that’s something I had been talking about again, three or four years ago. And the Health Department is only just now trying to hire a wound care nurse. Right. Like how many years later?”\textsuperscript{242}

\textit{Failure to Address Root Causes}

There aren’t many efforts underway to address the root cause of the opioid crisis or the main societal consequences. Many of the city’s initiatives focus on what a plethora of my interviewees classified as “putting bandaids over the problem.” As discussed above, the city has some basic awareness that this is not the right strategy, hence why they speak the language of “multi-pronged approaches” and stress the need to “address root causes.” But doing so is not

\textsuperscript{241} Herens, interview.
\textsuperscript{242} Ibid.
actually prioritized. The bandaid analogy was the single most common response when I asked interviewees about the city’s approach to the crisis. A woman who contracts with the city shared: “So my observation is that they’re trying things, but it’s sort of like there’s no, there’s no overarching vision. So it’s like random things. It’s like more graffiti cleanup crews, more this more that. It’s like there’s not a, and I don’t think this is easy, but it’s like what’s our direction to create systemic change. That’s what I don’t understand.”

Everyone is sympathetic to the heavy burden placed on the Kensington community and thus, supportive of initiatives like trash cleanup. But operating as they are now with no message to promote clarity and eventual unity on the end goal, city leadership is failing to offer any hope besides band aids. This approach furthers frustrations because, as a police leader told me of Kensington residents, “They see the cleanups that we do. They see the investment that the city is making in that area every single day. And I think it gets frustrating that it could be seen as taking one step forward and two steps back. You know what I mean? Like, they see all the social services that are going in there, and they think they might be making some progress, and then there’s a setback and it’s frustrating.”

No Overarching Vision

Related to root causes, the Kenney administration’s strategy was characterized as “baffling to try to figure out,” nonexistent, or “trying to throw anything against the wall.” At its core, this is a leadership issue and a major progress blocker. The sense that the city has no strategy or a very confusing one ran constant throughout my interviews. My source who contracts with the city said that “it’s almost like a crisis of imagination, like a lack of

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243 Interview with a woman who contracts with the city, interview by author, virtual, February 12, 2022.
244 Interview with a police leader.
245 Interview with a woman who contracts with the city.
246 Interview with PPD affiliate.
There certainly isn’t a multi-pronged approach in action, despite what the city may claim. In alignment with this, Herens asserted: “It really is the job of these people in these positions of power to think more creatively about how to actually address these solutions and think about it systematically.” Frankly, it seems like the city’s approach at certain points resembles a multi-pronged one or they do acknowledge that that is what they need; but again, these efforts fall short. Getting in the way is a vacuum of both creative problem solving and a binding, long enduring strategy that doesn’t just scratch the surface, end once a given task force’s responsibilities conclude, or lose urgency when another crisis arises.

Summary of Problematic Approaches

The flawed approaches laid out in this section document why there hasn’t been more progress in the fight against Philadelphia's opioid crisis. These issues are so severe that even the efforts of the best-intentioned administration yet have fallen flat. Without proactive decision-making, a targeted, binding and realistic plan, and an eagerness to monitor policies and trends with the intention of making adjustments, the city will never tackle the crisis that is infamous for quickly evolving in the most ruinous of ways.

IV. Ongoing Political Challenges

An array of overlapping political barriers were brought to light in my interviews. This is the most unwavering group of obstacles. They present a unique challenge to the city of Philadelphia. There is no easy answer to how the city can overcome these barriers. But through my interviews, I was able to gather enough evidence to explain what the city is doing wrong and

247 Interview with a woman who contracts with the city.
248 Herens, interview.
how they might begin to foster a more politically friendly environment for progress on the opioid crisis, or at least work around some of the most rigid political tensions.

**Lack of Political Will**

The first obstacle is a lack of political will to meaningfully attack the opioid crisis. Elected officials are reluctant to fully embrace harm reduction or more radical, controversial, or labor-intensive interventions—especially safe injection sites. While Kenney did throw his verbal support behind SIS, a hands-on advocacy effort was missing. According to many nonprofit leaders and city employees, the mayor’s office and other political actors do not accept or support the allegedly agreed upon solutions that will help ease the crisis. Elvis Rosado indicated how there is a desire for a solution, but no will to do what it takes to actually impact the startling overdose statistics and visibly dismal conditions:

...most of the individuals at a City Council level, at a City Hall level, at a city level, at the mayor’s level, none of them have ever worked in this field or have the experience of working in addiction and working in harm reduction and working in mental health. And yet, they asked those individuals in those fields, ‘Hey, what’s your opinion? What do you think will work?’ And when things are put before them that they don’t agree with, they go, ‘Yeah, we’re not going to do that…’ You can’t come in with no experience and dictate the folks that you want help with a solution, but you don’t agree with any of the solutions that the experts are telling you they have that would work or possibly make a difference. They want a solution where they’ll say, hey, snap your fingers, and tomorrow morning when you come, everything’s going to be fixed. It’s not that simple.\(^{249}\)

Adding to this issue, the Kenney administration became drained and distracted by the countless other problems in Philadelphia. My source who contracts with the city said: “You know, I really felt like there was [urgency] in the beginning, it was like “red alert, red alert, red alert” and then it just, and you know, because violence is up, you know, in cities across America, but up here. And there’s so many problems.”\(^{250}\) Herens argued that the city displays “fake
urgency” and that they are only willing to do the bare minimum.\textsuperscript{251} I think it is most representative of the general responses I received to say that elected officials and administrations don’t have enough political will to maintain the necessary level of urgency. I refrain from too harshly criticizing the city here because while the situation remains at crisis levels and leaders could do a lot differently, compared to other cities, “we are miles ahead of anybody else with hard reduction, granted Kensington’s a fucking disaster. But we are miles ahead of other cities.”\textsuperscript{252}

The political will problem surrounding the opioid crisis is exacerbated by the fact that drug use is a very personal issue for everyone—not just nonprofit employees or people active on the ground in Kensington. The opioid crisis has become a widespread problem, notorious for its relentless nature and ability to strike anyone. Many people have been touched by this problem and develop their own, very personal and idiosyncratic views on drugs; data and mere platitudes do not outweigh the impression that personal experience leaves on people.

While Mayor Kenney was praised by nonprofits for his support of SIS and greater attention to the opioid crisis, most of my interviewees suggested that much of Kenney’s agenda so far has included interventions that do little in the realm of actually solving the crisis. Herens articulated her view on this: “I appreciated them continually putting money towards our program because obviously we needed it. And a lot of it, to be honest, a lot of it went to Narcan…These are kind of just like the bare minimum of what could have been being done, especially in a city where we’re talking about we have three people die every day, we have the highest overdose rate of any large city in the country.”\textsuperscript{253} While it makes sense that advocates would say that the city could always be doing more, practically all of my interviewees expressed this or argued that the

\textsuperscript{251} Herens, interview.
\textsuperscript{252} Laurel, interview.
\textsuperscript{253} Herens, interview.
city is not doing things in the right way at all; so, even if we give the city the benefit of the doubt and say that they are trying (which is fair in my opinion), it is clear that these efforts are falling short and the will to shift gears is nonexistent.

All in all, I think there is a lack of political will on the city’s part. I saw a notable divide in what my interviewees of different categories were saying. While all acknowledged problems with political will, they often cited very different instances of initiatives being halted by political fears. Upon synthesizing the different responses, I conclude that lacking here is the political will to meaningfully address the opioid crisis without trying to self-preserve or blame or stretch the truth. Political actors have shown that they cannot think in a totally apolitical fashion without consideration to how things “look.” Of course, this is true only until a given impact of the crisis gets so out of hand and visible that they must look and address it. I do think Kenney deserves credit for being the first mayor to really try to address the crisis; this is best seen through his Opioid Task Force and emergency declaration that brought about the Resilience Project. Most of my critiques center around poor management of the bureaucracy and governing mistakes that are to some extent influenced by the greater political climate. Importantly, I try to give the benefit of the doubt to all of my interviewees, keeping in mind Forzato’s belief that “honestly, you can’t judge a person’s heart. You can’t judge an agency’s heart.”

One explanation for the lack of political will to deal with the opioid crisis is that the drug users on the streets of Kensington are not politically powerful. Benitez declared: “So you have folks that come from all over. And so, you got local politicians that get to say ‘they’re not really my constituents. They are other people’s constituents who moved here and now wind up on the street. And I have to deal with that…But they don’t vote. And frankly, they’re drug users’… I’m saying it kind of crass, but the way that it gets said to me, ‘They’re not voting and they’re not

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254 Forzato, interview.
contributing to society. So therefore, you know what? I’m not going to worry about them all that much.”\textsuperscript{255} Again, I think there is truth to this, but obviously elected officials would respond like Councilman Squilla, with Kensington residents in mind; “Well, we represent those folks, too. We need to care about them. Right. We need to care about everything that we put in those communities, how that impacts that community.”\textsuperscript{256}

**Coalition Building and Representation**

Even in the scenario that many city departments are on the same page, this is only half of the picture. None of this matters without proper coalition building in which residents and other stakeholders are on board with a given intervention. Safe injection sites are the best example of this. Soslow revealed: “So we’re often trying to kind of balance and make people comfortable. And sometimes the harm reduction policies, even though, as the Health Department we know that it will reduce overdoses. If the community is not happy and doesn’t feel comfortable, then we know that it’s not going to be successful.”\textsuperscript{257}

A claim of poor representation and limited people in city government who “get it” or even care came from a current Philadelphia police officer, who concluded from her personal experience with drug court that “…adjustments could be made to make it a really good program. If you’re really going to have the right people in there handling it, substance use disorder, people are dying. And if you’re not going to run it properly, then don’t do it at all.”\textsuperscript{258} Many valuable ideas that could make a real impact fail to do so because staffing these initiatives are the wrong people or people who solely care about maintaining their jobs. So, we see that an initiative like drug courts which many think should be brought back can only get so far if coalition building is

\textsuperscript{255} Benitez, interview.
\textsuperscript{256} Squilla, interview.
\textsuperscript{257} Soslow, interview.
\textsuperscript{258} Interview with a current Philadelphia police officer.
not done and those touched by these policies are not consulted to get meaningful feedback on how to improve it. Furthermore, many interviewees urged for more representative panels and task forces; pretty much every body with decision-making power should have, as Sarah Laurel put it, “a higher percentage of stakeholders with lived experiences.”

On the nonprofit side of things, Kensington and its residents may benefit from more “big,” driven nonprofits that have an abundance of political influence and city funding because not everyone feels represented by Prevention Point. Some interviewees expressed subtle concerns over Prevention Point. While generally supporting the organization, there was a sense that they had taken on too much, largely because the city outsources so many weighty tasks to them. Herens argued that “Prevention Point has really gotten so far beyond their scope that they’ve kind of, like, lost sight of their mission a little bit. They’ve taken on so many things because they think they should or they can. And I think it’s all well intentioned. But like, they’re not necessarily actually meeting the drug use needs of the people they serve.” It seems that as it expands, Prevention Point may be getting further out of reach from Kensington residents and even drug users; this is a problem of responsive representation. I discuss this further in the sections on nimbyism.

Diverging Interests

This obstacle begins with a simple political reality: people have different interests and priorities. Kensington serves as a dramatic example of what happens when these interests are so different and go unmet for decades. Only in the past few years has the city turned its attention to the worsening, flagrant drug crisis in Kensington. A heavy load of services, nonprofits, and

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259 Laurel, interview.
260 Herens, interview.
media attention followed, but largely with a lens on the drug-using community and how to deal with that hardship. Therefore, the city’s resources and efforts followed the demands of nonprofits and people primarily focused on drug users’ wellbeing. Kensington residents, many of whom have lived there for a long time, were still not given the resources and attention they deserved.

There is an enduring and accelerating level of tension between drug users and their allies (e.g., nonprofit leaders, harm reductionists) and Kensington residents and their allies (e.g., council members). I was frequently assured that Kensington residents have big hearts and that drug users have empathy for residents and their children. Nonetheless, the problem has deteriorated further in the past few years and doesn’t seem to be slowing down. Early on, around the time that the Conrail track encampment was being cleared, the public generally supported efforts to address the crisis in Kensington. According to my source who contracts with the city, “the city felt more cohesive, like it was a cohesive effort.” This source detailed the downfall of the short-lived unity: “…the nimbyism hadn’t really started…Prevention Point was really respected…I felt we were all on the same page…that changed. As the crisis got worse, what happens and I’ve seen this over time in my job, that people start to turn on each other. So eventually people became infuriated with people who are addicted to drugs. And they were like ‘look there’s needles everywhere, I see people shooting up, there’s like feces, it’s like horrible. And our kids can’t go…’ like this was all true…And then it was like the city is only paying attention to people who are addicted, what about everybody else?”

Blame, frustration, and despair have spread throughout the community. According to Gilberto Gonzalez, a Kensington resident now running for Congress in Pennsylvania’s 2nd district, Mayor Kenney has only made things worse: “…he is completely inconsiderate of the

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261 Interview with a woman who contracts with the city.
262 Ibid.
people that have lived in Kensington. He’s inconsiderate of the children that have to walk through all this every day. It’s like I say many times, when you create policy in a vacuum that is City Hall, you serve no one.”

Balancing the needs and demands of both groups with limited resources lies at the heart of this political obstacle. Like my city contractor source alluded to, the crisis has gotten worse and turned people against each other; thus, the demands of some groups—ripe with anger—have become more extreme. The problem with this is that some demands can obviously not be met and therefore, the cycle of disappointment over results continues. August delved into the dilemma often faced by city officials:

As people that work for the city, we might think this is a good idea, but is this strategy, does it align with what the neighborhood residents really want? Is this something that they would be supportive of? And then there’s, like, that tension around, just like, do we just sort of do what they’re asking for if we think that their requests are unreasonable, or not appropriate as well? Just because 50 angry people at a community meeting want us to go around in a bus and stuff everybody on the street into there and get them out of the neighborhood, that doesn’t mean we should do it as the government. We have to take kind of a different approach to that situation and try and hear what people have to say and then come up with a solution that, again, sort of respects the dignity of the situation that we’re in, but also is something that we can plug into what the available resources that the city has.”

**Nimbyism and its Mishandling**

If there is one thing that all groups of my interviewees agreed on, it is that the city and Safehouse blew the opportunity for a safe injection site. The literature on overcoming nimbyism assures us that community engagement is key; the city simply skipped this step and seemed to (wrongly) think that doing so wouldn’t inhibit its goals. This section reveals the strategic errors made in both Kensington and South Philly and concludes with a discussion of how nimbyism contributed to the SIS failure.

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263 Interview with Gilberto Gonzalez, interview by author, virtual, March 16, 2022.
264 August, interview.
Kensington Mishandling

Some interviewees were more sympathetic than others to the grievances of Kensington residents and their quick dismal of a potential safe injection site. Others claimed that the site should have been in Kensington because the problem is already there. Regardless of where one stands on the dispute over a SIS in Kensington specifically, there was an understanding early on that a safe injection site wasn’t feasible in Kensington, but many still seem to think it should have been placed there. José Benitez disclosed the thinking that shifted the focus towards South Philly: “What they were fearful of is the fact that everything comes here first. So they were trying to sort of more from a public relations standpoint, starting someplace else outside of Kensington. The intent was to then move it, then have one open in Kensington as well.”

From my interview with Gilberto Gonzalez, I got the sense that Kensington residents felt patronized and lectured about the need for a SIS by people who do not reside in Kensington and thus do not experience the effects of different policies pertaining to the drug crisis. To Kensington residents, the heart of the issue surrounds a lack of empathy or understanding from nonprofits like Safehouse and the city:

…what they don’t see and what they don’t understand and what they refuse to understand is that the impact on the families and the children that live there. And I’ve had many conversations with this side and their responses. ‘Well, Gil, don’t you want to save lives?’ That is their condescending responses to me. ‘Don’t you want to save lives? Even one life saved is worth it.’ And I’m like, ‘yeah, I want to save lives. Well, what about the children that are being shot and killed in their mother’s arms or shot and killed on their way to and from school? Why don’t we start thinking about them and bring them into the conversation.; And I think that’s part of the systemic issue is that the people that support Safehouse and safe injection and advocate for the people in addiction. And I think it comes because most of those people are people of privilege. Right. They come from like Ronda Goldfein as a lawyer. José Benitez has how many degrees. The list goes on. All these people are people of privilege that in their mind, they know better what is for the community.

265 Benitez, interview.
266 Gonzalez, interview.
In alignment with this idea, Laure Biron, who was on the Opioid Task Force and attended early meetings about SIS, articulated: “I think people in Kensington don’t really want to be educated on the opioid crisis because they’re living it. So, I think they don’t want to have a conversation with someone like me who says, ‘well, what about intergenerational trauma and what about intergenerational poverty and what about untreated mental illness?’ I don’t think that they care. And frankly, I sort of understand why they don’t because of the crisis level that it has reached.”

The reactive mishandling of tensions in Kensington presents itself in the fact that many residents and others would have supported a safe injection site, but felt that their concerns were ignored and not treated as valid—another fallacy the literature warns against. Gonzalez, who identifies as a progressive, shared: “I actually would support a safe injection site…But you can’t just put one in Kensington and think that’s going to be okay.” Gonzalez went on to share how his concerns about safety around the site were ignored: “I’ve been in Kensington for almost 38 years, and I can support a Safehouse…I’m not going to say not in my backyard, but I want to be part of the decision-making process and not just on the surface, but really. Like, for example, we were at a meeting at a town hall in South Philly and Ronda Goldfein was there…And I asked her a question, ‘okay, so if we do say yes to a Safehouse, how are you going to protect the community?’ Her response was, ‘oh, well, we’ll cross that bridge when we get there.’ So I said, ‘screw you. No, you need to come in here with a plan, a real plan.’”

South Philly Mishandling

Early on, the city and Safehouse turned their eyes towards South Philly, a neighborhood where overdose rates were indeed rising. Yet, the secrecy in which they shifted sparked an

267 Biron, interview.
268 Gonzalez, interview.
almost instant backlash from South Philly residents. A current police officer recounted their behavior as “…very shady. They weren’t open…And they thought the neighborhood was going to be okay with it. I don’t see any neighborhood in the city of Philadelphia being okay with it, with them being as shady as they were about it.”

Furthermore, the city and Safehouse lacked an individualized, culturally aware approach that accepted the distinctions between different neighborhoods in Philadelphia, and instead failed to, as Gonzalez put it, “understand the neighborhoods of Philadelphia.” South Philly is a neighborhood with a lot of stigma around drug use. Sarah Laurel, a South Philly native, depicted the climate in South Philly and the attempt to rush the process without considering the intricacies of the neighborhood or the need to even remotely engage community members: “…they attempted to open it in South Philadelphia which is historically a very ‘us against them’ climate and neighborhood. They’re not going to be open to it if they don’t feel like they were a part of the discussion. You can’t just hit somebody with a side piece and say, ‘we’re opening this up in your community.’ Not to mention, South Philadelphia does not have hundreds of people injecting publicly. Kensington does.”

Safehouse left no room for a tailored approach when shifting from Kensington to South Philly. Elvis Rosado elaborated on the difference between opposition in Kensington and South Philly: “They don’t want it [in Kensington] because they feel like it’s just going to add to the problems. You have other parts of the city who think that they don’t have a drug problem, so don’t bring any of that here…there was this fear because people had, it’s all about misinformation. People had a lot of misinformation surrounding this. Everything from ‘they’re going to be handing out free drugs at these sites,’ to ‘our children are going to be at risk now.’ I

269 Interview with a current Philadelphia police officer.
270 Gonzalez, interview.
271 Laurel, interview.
guess, if I can use this terminology, the typical Frankenstein Syndrome. Never took the time to really get to know it, but it’s horrific, it’s a monster. Bring out the torches and let’s go burn it down type of mentality.”⁷²⁷ Again, the different perspectives and concerns of residents in Kensington and South Philly were unfairly and detrimentally lumped together as “nimbyism.” Also ignored were the distinct drug problems in each neighborhood; while both struggle with opioid use, Kensington’s is worse and much more flagrant. Safehouse failed to consider or alleviate the stigma and denial firmly embedded in the South Philly community.

The insufficient community engagement in South Philly must have been strikingly obvious because of the overwhelming consensus I received on this point. The largest theme was that Safehouse was perceived as simply planting an unapproved site into someone else’s neighborhood with no outreach or transparency, while the city did little to respond to this chaos and fear. Allison Herens argued that they “hadn’t done any of the groundwork to come to the community, have those conversations, like talk about why this is important, why something like this should go here, really give people the opportunity to learn more about this in good ways. And I mean, like, they will say they did, but I don’t think two town halls really does it.”⁷²⁷³

Similarly, Elvis Rosado summarized what happened in South Philly and the short-lived opportunity for a SIS: “The short story, it was going to get opened up. They had not reached out to the community to announce that it was coming or to inform them, and it just became a disaster because you were coming into another neighborhood to plant something and start something and the community doesn’t know you’re coming.”⁷²⁴ Likewise, Kurt August recalled, “And then what kind of ran themselves into the ground was really just like, again, sort of the community engagement around that. Like there was a lot of sort of whispers around the idea that it was

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⁷²⁷ Rosado, interview.
⁷²⁷³ Herens, interview.
⁷²⁴ Rosado, interview.
going to end up in the heart of Kensington. And then all of a sudden there was a space identified in South Philly where they were planning to stand all this up. And people were very upset that they were not consulted about that and that they did not give their approval for a facility of that nature to be in there.**

Another problem with the strategy was their communication of the main purpose of a SIS or the long-term goal. Forzato made this interesting point: “They missed an opportunity. How you market a new initiative that is somewhat controversial is so critically important. The whole purpose of a safe injection site is not just to let somebody survive that day, that hour. It is to develop a relationship with the person. And over time, when the person’s ready, develop that trusting relationship.”

Stressing the long-term goal is exceedingly crucial when many opposed actors claim that SIS enable or allow drug use to continue.

In summary, the mishandling of the SIS opportunity in Kensington and then South Philly brought with it major costs. It has been over four years since the city announced its support for a SIS and little besides chaos, widening divisions, and increasing overdose deaths has occurred. This entire story really just emphasizes the depth of tension and diverging interests surrounding opioid crisis policies. Yes, nimbyism is a political barrier. But I argue that the more potent one seems to be outside groups (the city, Safehouse, etc.) entering a space with no willingness to make the case for what they’re doing; politics is persuasion and in this respect, the city and whatever allies it had failed miserably. The city should have had a more hands-on role if they really supported this intervention; instead, they timidly watched it go up in flames. If the city and Safehouse took a more open approach, many logistical concerns would have been eased as residents simply consumed misinformation and rumors with no correction from the city.

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275 August, interview.
276 Forzato, interview.
My interviewees expressed the intuitive sentiment that no one wants outsiders coming to their neighborhood and implanting a unique social service with little information or community conversation. In this sense, Safehouse and the city likely could have garnered enough acceptance from residents who were on the fence to implement the SIS; the covert operation only exacerbated concerns and frustration. While negotiations are currently underway between Safehouse and President Biden’s Department of Justice (DOJ), many feel it still cannot be done without a massive burst of residential support. In the next section, and with this background information in mind, I look at nimbyism as a political barrier and other potential issues pertaining to the feasibility and impact of a SIS.

Disagreement Over SIS

I organize this subsection by the two dominant viewpoints over SIS. The first is championed largely by nonprofit leaders and other harm reductionists. The other is more common among police, elected officials, and Kensington residents. I then reflect on the likelihood and feasibility of a SIS going forward.

A Note on Studies

Studies from Europe, Australia, and especially Canada detail the results of safe injection sites. When I began my research, I found an overwhelming consensus from public health scholars that these studies show only positive impacts. Yet, I heard different ideas in my interviews with police officers and politicians, while the nonprofit leaders upheld my initial understanding of the studies. Much of the room for controversy lies in the small number of studies that have been conducted in places like Canada and the fact that the results of those
studies seem somewhat unbelievable to people who find the aftermath of a SIS predictable. I attempt to further clarify this dynamic in the rest of this section.

*Pro-SIS*

Nonprofit leaders, advocates, and other people in favor of harm reduction tend to view nimbyism as an enormous problem; one that emanates from poor education about addiction and the prevalent stigma against drug users. The main claim from ardent SIS supporters is that studies show they work and remaining concerns are simply rooted in stigma or a denial of valid results. José Benitez explained the tendency for people to disagree with studies or opinion polling: “...what happened locally was, ‘oh, it was a fixed study. It was a study that was predetermined. They asked the wrong people, right?’ Well, no, they stood outside, they asked people, what zip code do you live in? And they interviewed folks. And so the research methodology was sound. We just don’t want to accept the findings of it. Right…What you have is a small vocal group who is really vocal against the establishments of safer injection sites. And you have a larger group that is in support, but they live in their lives. They have other things to do.” For Benitez, there is a lot of support for SIS but a vocal minority of residents have proven themselves to be a mighty, unwavering barrier.

In corroboration with Benitez’s argument, Soslow said: “We know that supervised consumption sites save lives. There’s data to show that this is true. But Safehouse was going to be plumped down in South Philadelphia in a neighborhood that wasn’t consulted and in a neighborhood that has a lot of stigma against people who use drugs. So that’s just sort of one example of sort of the challenges that we experience in knowing that something would work to

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277 Benitez, interview.
help people. But people don’t want it in their backyard. People don’t want to be around people who use drugs, and that’s stigma.”

SIS supporters are adamant that nimbyism flows from stigma and these forces account for the absence of a life-saving intervention. So, this category of thought seems to think that more education on addiction and what a SIS would really do are most necessary to implement this intervention. They align with the public health scholars and others who feel the studies from other countries are compelling enough to set up a SIS in Philadelphia. These individuals were also likely to be hopeful looking ahead because of the Safehouse negotiations with the DOJ and the recent progress in states like New York where SIS have moved past the preliminary stage that Philadelphia got stuck in.

Skeptical of SIS

The general fear from some interviewees is that a SIS would hamper quality of life in Kensington by destroying any remaining sense of safety, especially in the areas directly around the SIS and on the outskirts. A current police officer depicted this well:

I have concerns for the neighborhoods they put them in. I have concerns for the people going in them as far as [pauses] where there are safe injections you have to remember, like it’s great they want to help people, and I’m still learning about them…But just think about and what these communities are saying. Like, you put this safe injection site here, where do you think the drug boys are going to be setting up? All around there. So now you’re bringing, because when people buy their drugs, they usually use within two to three blocks of buying that bag. So, now you’re going to this safe injection site where you have to bring your own drugs in. You’re going to have all these drug dealers flocking to that area. So wherever you’re putting this, you got to think of the neighbors. I know it’s already down there all over the place, but you still have to worry about those specific neighbors that are right there in that area. Where there’s drugs there’s guns. So now we have to deal with shootings in a congested area.279

278 Soslow, interview.
279 Interview with a current Philadelphia police officer.
Despite the results from other nations, I do think it is somewhat hard to fully counter this officer’s “where there’s drugs there’s guns” argument. It is precisely this type of common-sense cause-and-effect conclusion that results in the feeling that the studies are somehow wrong, incomplete, or biased.

I asked Councilman Mark Squilla directly about the unclear and varying interpretations of allegedly objective and factual studies. He stated: “...there are also studies done that José and Ronda and all of them rejected and said that they weren’t done properly…the statistics actually showed that by having the safe injection sites, that overdoses increased. Right. But José said they may have increased, but they didn’t inside the facility. And so you could spin that any way you want.”

So, it does seem like more rigorous studies are needed to clarify some of these confusions. Even if the studies are respectable right now, there’s not a lot and more rigorous ones would only ease fears about SIS. Another doubt about the studies and their account of crime was expressed by Jerry Daley: “If you ask the cops from Vancouver, they won’t give you a straight answer. They’ll say, ‘Well, crime hasn’t really gone up.’ ‘Okay, how about your calls for service?’ ‘Well, yeah, they’re up a bit.’ ‘So, what are your calls for service?’ ‘Well, there’s a lot more people that are unconscious on the streets. There’s more people supposedly dealing drugs and things like that.’ Okay. Anecdotal, I get it. But you can’t measure these things other than anecdotally unless you’re going out arresting people and stuff, they won’t prosecute them, so they won’t arrest them.”

It’s challenging to decipher how much of this confusion with the studies is warranted. But I do think there has got to be some truth to the fact that adverse impacts could be noted in the future; this should not be simply ignored or pushed under the rug.

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280 Squilla, interview.
281 Daley, interview.
On the other hand, SIS do save lives and have the potential to connect people to precious, lifesaving resources when they are ready. Thus, I align with a police-affiliated source who requested anonymity when he said: “I’m all for trying them as long as we evaluate them properly…and you know what? If they work then we expand them and if they don’t work then we take them away again…one of the key parts to having, claiming to have a public health approach is also evaluation, testing, and learning and that’s a piece to the public health approach that I see is missing in how we’re approaching this.”282 One way to overcome fears about SIS is for the city and its nonprofit partners to stress that this is a trial and reports on effectiveness and adverse impacts on the community will be issued in a timely fashion. But some say that once the SIS is in place and saving lives, it would be hard to garner support to shut it down.

Moving on, many of those skeptical of SIS had concerns over logistics and efficacy. Councilman Squilla shared with me that before visiting a SIS in Toronto, he thought it could truly help the crisis in Philadelphia. But upon talking to employees and policemen in Toronto, he became increasingly skeptical, much to the ridicule of nonprofit leaders. From what I gathered, it seems like his main concerns post-visit were some statistics that were shared with him and facts about the site’s operations. Namely, the fact that only 4% of users of the Canadian SIS sought treatment and how it only operated for four hours per day.283

Like Councilman Squilla, Daley feels the operating expenses and logistics were not planned out, and, like Squilla, found the hours of operation to be insufficient, especially given the potency of substances on the streets today. He articulated: “...the business model just didn’t make sense…between the rent, the staffing, the utilities, the consumable items, the security that you would need…to operate the place seven days a week for 12 hours a day, which would be the

282 Interview with PPD affiliate.
283 Squilla, interview.
minimum amount of time you would need to run an [SIS] to address the needs of most not all, but most persons with an opioid use disorder who are using two, three, four times a day.”

Interviewees I have placed in this category found the classification of the SIS backlash as nimbyism to be unfair, or at least not the dominant barrier preventing implementation. For instance, Gonzalez argued that: “That’s not fair to say that because again, it’s how they carry the conversation…At no point did Mayor Kenney sit down with all of the different community folks in Kensington. I’m talking about the grassroots because the large nonprofits…all these organizations there, they’re part of the problem. They are part of the problem because the mayor, when he wants to listen to the community, he’ll go to one of these organizations and say, well, what is the community saying, well, then they talk for us. They never asked our opinions…it’s just the way of making Kensington look bad and the people look bad.”

Overall, the question of nimbyism, how valid it is, and how rooted in stigma it is is where you start to see a massive divide between nonprofit employees and harm reductionists on the one hand, and then Kensington residents, police, and elected officials. In particular, the disagreement over adverse effects cannot be overemphasized; it is the crux of the SIS debate and until more solid evidence is available, there likely will not be enough support.

**Looking Ahead: Hospital Idea and DOJ**

Regardless of one’s view on nimbyism, there was a rather high level of agreement that it is only possible at this point to have a SIS in a hospital. The reasoning for the hospital solution being necessary ranges from extreme nimbyism and stigma that cannot be overcome, to the obvious adverse impact the SIS would have on a neighborhood’s safety and wellbeing.

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284 Daley, interview.
285 Gonzalez, interview.
While I previously referenced the promise of a mobile SIS to avoid nimbyism all-together in my literature review, some of the same logistical and operational concerns would remain. Daley said of mobile SIS: “...I don’t think again, makes all that economic sense. And it’s like, all right, where am I supposed to be? The mobile is going to meet me. Where? How many people can fit on this RV or whatever the hell?...I’m just extremely skeptical about the practicalities of it, the logistics of it, the benefits of it.”

Many interviewees raised the idea of having the SIS in a hospital, which avoids the fears of having it in a residential community and the subsequent nimbyism that would likely follow. My source who contracts with the city argued: “I think the only place they can put a safe injection site after everything over the last few years, would probably be with a hospital, in one of the hospitals in Kensington, I mean so it’s not on a business corridor or certainly not in a residential area. I mean I think that’s the only way it can possibly exist. I’m just not, I can’t see it happening without just a huge fight. Cause I think there’s not much political will for it.”

The DOJ negotiations with Safehouse will be critical to where the city goes from here. The consensus is that there is likely to be an opportunity for a SIS somewhere in Philadelphia coming from these negotiations. However, the problem of community support would remain as that is what primarily shut down previous efforts; it was not as much legal concerns. Gonzalez exclaimed: “That’s the problem. Why are you negotiating with the attorney general when you should be negotiating with the community?”

The last two sections have laid out the SIS controversy in both Kensington and South Philly. The city and Safehouse made a wide array of detrimental errors that four years later, affect the landscape we see. The stark difference of opinion between various stakeholders

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286 Daley, interview.
287 Interview with a woman who contracts with the city.
288 Gonzalez, interview.
remains a powerful political barrier. Regardless of the results of the negotiations between Safehouse and DOJ, community engagement will need to be prioritized. Whether one thinks it is nimbyism rooted in stigma, the foolishness of the SIS idea, or as most do, somewhere in between these two extremes, the inherently contentious nature of a SIS is the major barrier here. To move forward, everyone agrees that major opposition needs to be overcome, crucial questions demand answering, and logistical concerns need to be addressed in a genuine and systematic way. It is hard to ignore the need for cohesive tenacity in our leadership here to guide diverging viewpoints towards some compromise and establish and promote the common priorities and values of all Philadelphians. Everyone wants to save lives. But we must balance everyone’s concerns so that we can get there. Two ideas that would help ease these diverging viewpoints would be more rigorous studies with some sort of trial period or simply putting a SIS in a hospital.

**Covid-19 Pandemic**

A final political obstacle is the Covid-19 pandemic. Isolation, meeting and treatment session cancellations, and the “death check”\(^{289}\) exacerbated the opioid crisis. Based on interviews, the pandemic also became a political barrier. As voiced by Rachel Machen, the pandemic made the opioid crisis “easier to kind of push off to the side”\(^{290}\) from a political point of view. Bureaucratically, resources in the health department were moved towards the pandemic, as certain divisions like the Harm Reduction Unit had to focus on housing Covid-19 patients.\(^{291}\) So, urgency and focus plummeted as leaders shifted their priorities to Covid-19. I discuss the pandemic largely because it shines a light on flaws in city leadership and demonstrates that without a robust opioid crisis strategy, previous gains are extremely vulnerable. The pandemic

\(^{289}\) Discussed in Part 2: Background on Philly’s Opioid Crisis

\(^{290}\) John and Rachel Machen, interview.

\(^{291}\) Herens, interview.
shows that the city can easily ditch or pause their efforts on the opioid crisis front when something else comes up. There is no accountability, energy, or willingness to multitask. Looking ahead, this problem must be addressed; I detail ways to do this in the next section.

**Summary of Ongoing Political Challenges**

Unfortunately, the city faces a storm of political tensions that have the potential to obliterate any hope of substantially remedying the crisis. The city has made lethal mistakes in its alleged appeals to various interests. While the SIS mishandling is the most pervasive example, the lack of effective coalition building and failure to make residents and drug users feel represented and heard stood out as well in my interviews. The good news is that over time, the city can mend some of this ill will by reflecting on prior political miscalculations and viewpoints previously dismissed. I truly believe that once-implausible interventions could be introduced that heal the Kensington community and ameliorate the opioid crisis. Remember, it was only two years ago that the first American SIS was going to open in South Philly. If the city repairs its relationship with residents, adjusts to their concerns, and remains truly open to alternate routes that may not be perfect, measures like SIS are immensely possible in Philadelphia. It is still possible for Philadlephians to come together like they did momentarily in 2016 and fight back against a crisis that has had the upper hand for too long.
Part 4 - Possible Solutions

I. My Impressions from Interviews

Early on in my interviews, I came to believe that this issue is more complex than most understand. While some interviewees expressed this, I also came to believe this implicitly by listening to how different people placed importance on various, sometimes niche aspects of the crisis and at times expressed outright different answers to questions I thought would garner the same response.

To discuss the first point, some people stressed the need to address the corruption of various city-funded recovery homes that exploit recovering drug users, while others stressed the need to dramatically enhance substance abuse education in schools. While both should be addressed, I rarely heard other interviewees bring up the same issue or at least talk about it in detail. The different focus on these very specific aspects of Philadelphia’s opioid epidemic was overwhelming to me and gave me the impression that no one (even if operating in the same sector) was on the same page about steps that needed to be taken.

In terms of the lack of unity in response to seemingly objective questions, I struggled to receive a straightforward answer on the level of policing in Kensington—answers ranged from Kensington as a total police state, to it having just the right amount of policing, to Kensington as a neighborhood with absolutely too few police officers on the ground. Conflicting views like these were hard for me to look past. However, I have tried to find patterns between and across groups of interviewees, and I emphasize these themes in the remainder of this section. While I do not totally disregard the unique statements some interviewees made in my analysis section, I am
more interested in this unique perspective when followed with compelling examples rather than simply sweeping, unclear pleas.

Another impression that may sound obvious is that the opioid crisis in Philadelphia is extremely complex. This is true of all massive and related issues (e.g., homelessness, gun violence) and equally true of the opioid crisis more broadly and in other major cities. But the crisis in Philadelphia is incredibly nuanced and unique in that its visibility is largely concentrated in a single neighborhood, with its own complex history. A lot has happened in Philadelphia pertaining to the opioid crisis in the past six years or so, largely due to Kenney’s arrival in office and national media attention over safe injection sites and the alarming state of Kensington from personalities like Dr. Oz. This context makes Philadelphia a landscape with events, decisions, feelings, and tensions ripe for political analysis. At the same time, it may make my recommendations less transferable to other cities as they are tailored to Philadelphia and Kensington’s peculiar needs based on my newspaper research and intensive interviews. The geographic dynamic of Philadelphia’s opioid epidemic, where Kensington serves as a visible “containment zone,” undoubtedly makes this study special and therefore, it must be approached in as individualistic a fashion as possible.

The complexity of the crisis also disproved my initial thinking that there were two, fairly distinct groups of obstacles. The bureaucracy is infused with politics and political actors depend on the bureaucracy to carry out their goals. For instance, in my research design I assumed that nonprofit leaders would have a lot to say about bureaucratic issues, but they ended up talking a lot about political obstacles. What’s more, many interviewees used the terms “bureaucratic” and “political” in a blended fashion, leaving me to clarify if they were referencing bureaucrats or elected officials. Some of the largest issues like poor leadership and the absence of an
overarching vision may stem from the mayor, but cannot be easily categorized as political barriers. Hence, organizing the barriers as minor administrative issues, flawed policies and approaches (with both bureaucratic and political roots), and true political challenges is most representative of the situation in Philadelphia.

**Analysis of the Cycle of “Grassroots” Representation and Blame**

In my interviews, there was a tendency for nonprofit leaders and representatives to describe elected officials and city employees as “outsiders,” “suits,” and generally out of touch with the realities on the ground in Kensington. However, as mentioned above, Gonzalez argued that leaders of nonprofits were out of touch with the Kensington neighborhood. Hence, we come across a major problem in which “grassroots” is a relative term; leaders of organizations view themselves as grassroots, “in touch” leaders, but they are not perceived to represent the entire community. Elected officials jump in here, claiming to be the real grassroots representatives of their constituents and not the nonprofit leaders who are focused on the issue of the opioid crisis alone. The city bureaucracy for its part, seems to have some employees who “get it” but also many mainly focused on maintaining their jobs and thus, the status quo.

Kensington residents or even elected officials with their constituents’ worries in mind step in frequently, saying that nonprofits contribute to the problem by distributing syringes that litter the streets and “enable” drug users to live comfortably with some level of modern convenience.

And then you have the police, who, perhaps surprisingly, seem to operate somewhere in the middle, creating relationships with drug users through the PAD office while also garnering the support of most Kensington residents and elected officials.
All in all, this cycle of blame and claims of out of touch people with too much individual power and decision-making autonomy arose across all groups of interviewees. The significance of this is hard to decipher, and it is tempting to say that all of these groups need to “grow up,” learn to compromise, and unite. In fact, there was a tendency in all my interviews for people to say that we should be uniting, and that compromise is more necessary now than ever before. Yet, upon further reflection, these tensions over grassroots representation and the tendency to say that “these ‘other people’ don’t represent me” is important to sit with and eventually address because no real solution will come about with vague notions of unity; in other words, people are so ramped up about the opioid crisis in Kensington, and have so many grievances at this point over how it has been handled that simple cries for unity are unlikely to be achieved without a real, honest process of understanding everyone’s point of view and making efforts to address them. I present some ways to begin this in my recommendations below.

Where to go from here

The gravity of leadership arose in many interviews and criticisms did not come from a single category or type of interviewee. I did not hear from anyone who had great things to say about the administration’s leadership, whereas some individuals praised other aspects of the administration. Under the assumption that the city and its leaders do care, try to address the crisis, and refrain from totally static thinking—which I do believe to be the case—there are aspects of their leadership that need to change for the crisis to be solved. It is fine to have the mayor’s office and other high-level officials fully behind one strategy. But far more vital and indicative of quality leadership would be Mayor Kenney spreading his message and priorities throughout the city, its massive bureaucracy, and across the Philadelphia area.
We need leadership beyond what we get from our routine elected officials to tackle this vicious epidemic. In fact, it is this slacking, docile leadership we have generally accepted that chose to wait passively for decades while the crisis blew up and people turned on their neighbors, friends, and those struggling with a wicked disease. My interviewees seek better leadership too, as some nostalgically recounted other models employed by former Philadelphia mayors or police chiefs in other cities that effectively curbed a major challenge. For instance, the graffiti cleanup initiative under Mayor Wilson Goode was referenced by my source who contracts with the city as a novel idea that did receive some blowback, but was an innovative and successful approach nonetheless: “So Wilson Goode could have just said ‘I'm gonna put a lot of money to clean walls,’ but instead he said ‘you know what, I'm gonna work with the graffiti writers and have them help clean up the city.’”

A type of leadership that is exceptional, creative, proactive, innovative, data-driven, considerate of human nature and unintended costs, and honest about all of these things is sorely needed in Philadelphia to tackle the opioid crisis and make a massive, long-enduring, and robust dent into the crisis.

II. My Recommendations to Mayor Jim Kenney

The nine recommendations articulated below result from my intensive research and interviews with a diverse range of individuals who bring with them personal experience and often expert knowledge on Philadelphia’s opioid epidemic. I do not organize these recommendations by the barrier or barrier group they address because many target an array of obstacles. I have specifically designed these suggestions to overcome the most potent barriers

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292 Interview with a woman who contracts with the city.
identified through my research. Thus, they are likely to assist with remedying the crisis because they either work around or help to address the bureaucratic and political barriers faced by the city.

1. Bring back drug court, but reform it.

From my interviews with police officers, those who work closely with law enforcement, and individuals with law enforcement backgrounds, it is clear that the Kenney administration and DA Krasner have limited the tools police have at their disposal. There are too few sticks to incentivize people to seek help. Drug court, where drug users would be sent and assigned to treatment, was previously shut down by the city. I urge Mayor Kenney to bring it back because it would serve as a substantial middle-ground policing approach that many interviewees expressed the acute need for. Some considerable reforms must be made; namely, Mayor Kenney must ensure that the people staffing the drug courts are experts on the crisis and truly care about improving the lives of drug users. The vetting process must be elaborate.

Most importantly, Mayor Kenney must recognize that reinstating drug court is not antithetical to progressive values and does not mean the revival of a police-centric solution to drug use. Rather, this will help to push drug users to become productive citizens and contribute to society without the cruel and unnecessary locking up of people who use drugs. Additionally, it is in line with Kenney’s proclaimed values to support people in low income, largely minority communities (i.e., Kensington) by fostering safety, empowering small business, and enhancing welfare. Drug courts would do this.

The final reform necessary is to model the new drug court with an eye to the community court structure. Community court was an initiative that also ended, but the premise was that people who committed low-level crimes would be assigned to tasks like community service. This
should be incorporated as an option in the drug court as well, as it would hold people accountable but refrain from forcing them into treatment. There could be a rule, however, that upon refusing treatment multiple times, it would become required and the community service option would end.

2. **Fund research and development to help treatment catch up to the changing drug supply.**

   Mayor Kenney must direct funds and resources towards cutting-edge treatment for opioid use disorder. Doing so would address barriers around the potency of today’s drugs—an indisputable force that traps so many in the hollows of addiction. This would be a chance for the city to be proactive to some extent, acknowledging that drug strength is only increasing. Instead of solely stressing the fact that addiction is a disease, the Kenney administration must begin to exemplify this through prioritizing top notch treatment. This also includes loosening any remaining red tape on current MAT that remains at too low a dosage to be very effective.

   Even apart from spending funds on research and development, there are a surplus of ways the Kenney administration could indirectly lay the groundwork for more up-to-date treatment modalities in Philadelphia. For one thing, they could only contract with treatment providers who use the most advanced treatment. Overall, this is an opportunity for Mayor Kenney and his administration to be creative and resist the urge to put forward slightly different variations of exhausted solutions. I urge Mayor Kenney to acknowledge that human nature is deeply tied to incentives, and thus, the right people must be incentivized to do what is necessary to attack the opioid crisis. Recommendation 4 also utilizes incentives.
3. Cut down on relations with CBH. Make the assessment process like nearby counties and as simple as making a phone call.

This is one of the most complex recommendations I make to the mayor. I include this recommendation because the CBH system must be addressed and modified in a major way. Moreover, we know that this system can change given the fact that nearby counties have much simpler assessment procedures. Changing the process one must endure to access treatment accounts for the increasing numbers of extremely addictive substances in Philadelphia's drug supply. The moment when someone seeks out treatment must be seized upon, and the appropriate forces must be fully operational when this time comes. It seems like other counties have this down to a science.

So, Mayor Kenney ought to keep in mind that CBH is a private company whose contract with the city need not be renewed. He should confide in and hear from multiple people well versed in the CBH system and decide if it is best to cut off this relationship with CBH. The mayor is best equipped to make this determination as he has many sources and much information at his disposal. It may not be necessary to cut off ties with CBH. Nonetheless, the assessment process must be shifted to a phone call. The mayor should talk to nearby counties and closely mimic their systems, while still adjusting for the intricacies and size of Philadelphia County.

4. Incentivize treatment providers to fill slots.

This solution is geared at remedying the treatment barrier; it comes largely from José Benitez. There are open treatment slots available, but not all are in use because of the policies employed by certain providers. Thus, Benitez recommended “[adding] incentives to fill in your slots…If you fill a particular slot to a certain percent, you get a bonus in your reimbursement rate. Problem solved. And if you don’t…The stick part of this is you say to folks, you don’t get
to have that many slots next year on the contract.”

Mayor Kenney must realize that refusing to change this system will harm him more politically than standing up to these treatment providers, who, according to Benitez, have “some political muscle.” Not only would this help drug users easily access treatment, but the impact in the long run would alleviate tensions in Kensington, save lives, and ensure a positive, lasting legacy for Mayor Kenney. The mayor needs to step up and make the right call on this; the call that the type of leader we so desperately need would make.

5. Open a safe injection site in a hospital and hire independent evaluators. Or, heavily invest in community engagement and potential concessions if a SIS is to be put in a residential area.

The most politically feasible location for a safe injection site is on hospital grounds. A hospital is also likely the most economical and logistically sound option as well. Thus, this should be Mayor Kenney’s first choice if he is to continue his effort to establish a SIS. The establishment of a SIS in a hospital would save lives and solve many of the other concerns surrounding SIS: nimbyism, logistical issues, and negative externalities in a residential area. Certainly, it would take time for these arrangements to be settled, especially in terms of decisions like policing, staffing of the SIS, the location within the hospital campus, etc. But it is hard to imagine a residential SIS being nearly as straightforward.

To address the concern that would remain from various parties, the city should hire independent evaluators to publish transparent and far-reaching data on the site’s effectiveness in an array of categories. The hospital idea is particularly compelling in this regard because it offers a more feasible location for a pilot opportunity. If the evidence on overdoses, externalities, and other relevant data is less than pleasing to the hospital, they can discontinue their relationship.

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293 Benitez, interview.
with the city. This varies from the alternative because a nonprofit staunchly in favor of a SIS would not want to shut down.

If for whatever reason the hospital is not feasible or desired, and depending on the results of the current Safehouse DOJ negotiations, it is imperative that the city heavily invest in whichever neighborhood they choose to put the site in. There is simply no possibility of skipping this step; engaging the community, hearing valid concerns, and keeping an open mind towards community concessions have proven essential if the city and other actors want the dream of a SIS to turn into a reality. One relevant concession to Kensington residents would be to enhance the speed at which residents have their public nuisance or low-level crime calls responded to.

6. **Expand peer support services for people in recovery.**

The expansion of support services for people in recovery serves as another no-brainer solution that most if not all stakeholders would gladly welcome and encourage. Kurt August eloquently illuminated the necessity of this, and other interviewees touched on the importance of helping people in recovery stay in recovery; it is very daunting to enter a totally new stage of one’s life—financially, emotionally, logistically, and socially. Therefore, even a small amount of properly targeted resources put towards connecting former drug users with someone to assist them in navigating the bureaucratic system, searching for a job, or answering questions would pay off for the city in terms of having fewer individuals relapse.

This solution would ease the red tape and bureaucracy barrier. While bureaucratic thinking and other closely related problems should be addressed directly, funding supportive services for people in recovery to best approach the relevant systems will make this barrier less limiting and constraining for so many people.
7. Create a drug czar position.

Mayor Kenney should appoint a moderate, relatable, and experienced drug czar who is a proven leader with ambitious yet realistic goals. The idea here is that the drug czar’s full-time job will be the management and remedying of the opioid crisis. Hence, they cannot shift their focus when another crisis comes along. The creation of this position would ease bureaucratic barriers like communication and collaboration. The drug czar would report to the mayor, allowing him to make final decisions and focus on other, unrelenting problems the city faces. This would reduce mayoral fatigue and the appointee would hopefully be less of a political actor, but not someone solely focused on harm reduction either.

8. Update the public and relevant departments monthly on the opioid crisis and what your priorities are for the upcoming month.

This proposal would hold the city accountable for what they say they are going to do. Too frequently, the city says they are trying to do something, only for the public to never hear about the given initiative again. Instead, with monthly press conferences and briefs to departments, Mayor Kenney would be forced to follow up on how the previous month’s goals have progressed and what adjustments, if any, need to be made to actually achieve the said goal. This would also foster good will between city departments and Philadelphia residents, highlighting that Mayor Kenney cares about keeping his promises and being transparent with all stakeholders.


This suggestion is largely inspired by Forzato’s claim that “You have to have a dynamic, exceptional program in the Philadelphia school district,” but also feedback from a variety of

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294 Forzato, interview.
interviewees that in such a large city which tops the charts in having a magnitude of societal problems, children often have large amounts of trauma and thus, a propensity to abuse substances in the future. We know they are exposed to drugs fairly easily and early on.

This would also demonstrate to Kensington parents that their children are valued by the city and would instill hope in the next generation of leaders throughout the city. This is one of my recommendations I see as being quite smooth to implement. However, I caution Mayor Kenney that this program must encapsulate more than the funding of any subpar drug education program would. The curriculum and structure of this program need to be carefully thought out, and various designs (e.g., what grade levels to target, program length) must be considered rigorously by experts and school leaders.

While this program recommendation does not respond directly to any single barrier I have identified, Philadelphia has such a massive drug problem that prevention must be taken more seriously, especially by a mayor that has adopted a public health approach. Additionally, I do think investing heavily and thoughtfully in drug education in schools would ease tensions between the city and Kensington residents. It would be a show of good faith that is not merely symbolic but beneficial to what they care most about—their kids.

III. Concluding Thoughts

I began my research curious about the best solutions that Philadelphia could take to solve the opioid crisis. Upon quickly learning that there is a general consensus among public health experts about the necessary steps, I shifted my focus to examining the barriers getting in the way. From interviewing a distinct group of individuals each with unique backgrounds and in keeping an open mind, I was able to identify several concrete obstacles that range from minor
bureaucratic problems, to flawed policies and approaches, all the way to major political challenges. I then proposed solutions based on my deep dive into Philadelphia's opioid crisis, with a focus on the epicenter—Kensington.

My research and subsequent recommendations are significant given the pressing nature of the crisis in Kensington. The humanitarian need in Kensington and the burden placed on its residents is an extremely unique situation and one that will continue to fester unless a different course of action is taken by the city. My research points to a variety of barriers that must be addressed for the city to maximize its effectiveness. I am confident that the greatest strength of my research is the broad range of stakeholders I interviewed that enabled me to give an accurate representation of the realities on the ground in Kensington. My analysis of the issues and subsequent recommendations are balanced and give a voice to many different groups of people all impacted by the crisis.

I hope that policymakers can consider all of the viewpoints included here and begin work on my recommendations, keeping in mind that they are intended to attack the most potent and long-standing barriers in the city. I have given the city an abundance to work on but have organized these necessary steps in a logical, coherent, and tangible way that takes into account the different timelines of the barriers. I have gone far beyond simply criticizing the city, but really have tried to describe administrative issues, policies, and approaches that can be changed and benefit the city in the short or medium run. I have laid out the major political challenges in a way that accounts for the nimbyism narrative but also explains smaller, related issues like coalition building and diverging interests.

Beyond Philadelphia, considerations such as a SIS in a hospital and the reality of barriers to social services and treatment for drug users can be utilized in other cities. Certainly, other
cities and the entire country for that matter could benefit tremendously from increased, cutting-edge research and development on opioid use disorder treatment, so the federal government should consider prioritizing this.

Upon reading my research, citizens will better understand the perspectives of local residents in Kensington and elected officials, as well as the viewpoint of nonprofit leaders and harm reductionists. I give fair praise and criticism to all of these different groups, and while I share my own thought process on these matters, I do not mislead my reader about the “right” viewpoint or morally superior one. Ordinary citizens can decide for themselves who makes the most compelling argument and how they want elected officials and their fellow citizens to best address the opioid crisis.

It is paramount for Philadlephians to know what their city officials have done well and what they have failed at as it pertains to the crisis. A shared understanding of the history of tensions embedded in Kensington is vital to bring the community and the city together to remedy the crisis. As the next mayoral race approaches, it is up to Philadlephians to decide what type of approach to the opioid crisis they want in a mayor; ideally, they will agree with the conclusion from my research that much more robust leadership and vote accordingly.

My research contributes to and deepens the scholarly understanding of SIS. While the existing literature finds plenty of evidence supporting the establishment of SIS as a public health measure, it has thus far ignored the unwavering intuitive sense from residents that SIS will bring increased crime and other negative externalities to the community. This is not just “misinformation,” but rather a problematic gap in the SIS literature that makes it seem irrelevant and distant to communities under consideration for a SIS. Also of interest to scholars is my new categorization of these obstacles, going beyond simply saying there are “barriers” or even
“bureaucratic and political barriers”. This categorization is useful because it helps to conceptualize the major problems in Philadelphia and provides a tool to easily group together obstacles that could be targeted simultaneously.

My research does have some limitations. First, I only had about four months to complete my interviews. With more time, I would have expanded on the number of interviewees and tried to interview more Kensington residents. Also, I was not able to secure an interview with a nonprofit leader focused on the entire Kensington community, such as the New Kensington Community Development Corporation. My research also lacks an interview with someone close to Mayor Kenney who would likely be eager to rebuttal some of my criticisms. Finally, I only observed Kensington once, limiting my ability to fully understand the neighborhood’s dynamics.

Despite these limitations, my investigation into Philadelphia's opioid crisis has laid solid groundwork for future research. I believe I have charted a path for future researchers to investigate each of these barriers in greater detail. The CBH system and other treatment barriers can be investigated, with a focus on why the system in other nearby counties is so much more accessible. Solutions to the city’s problematic approaches should be investigated in a more hands-on way, perhaps by looking at other cities and how they have overcome some of this slowness and promoted creative thinking and novel ideas.

In all honesty, I fear that my research and recommendations will fail to galvanize the city and Mayor Kenney. While my suggestions address many barriers, it is clear that the city lacks urgency and struggles from fatigue: two issues that no one besides the mayor himself can fix. Nonetheless, I am confident in these solutions; they vary from the Mayor’s Task Force because, again, they are derived from a deep investigation into the specific obstacles in Philadelphia. Mayor Kenney ought to consider these recommendations because they are bound to help. The
classic political will excuse cannot even be applied here, as most of these are certain to be extremely agreeable. For the few that require more political maneuvering, I am ardent in my belief that this is an issue that touches many Americans very personally. Hence, the political and historical payoff of truly having an impact on a horrific crisis that he promised to fix will be much more pleasing for the mayor to glimpse back at in his retirement than sitting idly while overdose deaths and many other gruesome measures rise endlessly.
Works Cited


https://trumpwhitehouse.archives.gov/articles/full-cost-opioid-crisis-2-5-trillion-four-years/


