A SITE TO SEE: LESSONS FROM CANADA AND AUSTRALIA FOR IMPLEMENTING GOVERNMENT-SANCTIONED OVERDOSE PREVENTION SITES IN THE UNITED STATES

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In 2019, Safehouse, a Philadelphia nonprofit, was poised to open the first government-sanctioned overdose prevention site (OPS) in the United States. Its plans were thwarted when U.S. Attorney William McSwain filed a civil lawsuit seeking a declaration that OPSs violate federal law. Though the district court held for Safehouse, the Third Circuit reversed in January 2021, delivering a devastating blow to the future of OPSs in the United States.

Since the Third Circuit's decision, however, the United States has exceeded 100,000 drug overdose fatalities in a single year for the first time. Synthetic opioids, particularly those containing fentanyl, have become the main drivers of the current overdose crisis, and drug overdose fatality rates have increased most drastically for Black and Indigenous people. This Comment argues that, amidst a worsening opioid overdose crisis, advocates and policymakers in the United States must look *internationally* to countries where OPSs have already been legalized, namely Canada and Australia, to refine their own strategies for OPS implementation.

In Canada, a Supreme Court ruling has given advocates strong legal standing to open OPSs across the country. In Australia, absent both federal legislation and a ruling from its High Court, legalization of OPSs has been left to the states. By analyzing these mechanisms of OPS legalization—both in countries with federal constitutional systems of government like that in the United States—this Comment recommends potential pathways for implementing government-sanctioned OPSs despite the Third Circuit's ruling against Safehouse.

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I. INTRODUCTION

On Tuesday, October 3, 2018, board members of Safehouse in Philadelphia, Pennsylvania announced the nonprofit's official incorporation.[1] Its mission was clear: to open the first government-sanctioned overdose prevention site (OPS) in the United States.[2] The opioid epidemic in Philadelphia saw 1,217 unintentional overdose deaths in 2017, the highest death rate of any major U.S. city at the time.[3] The Mayor's Task Force to Combat the Opioid Epidemic issued its final report that year recommending that the city further explore implementing overdose prevention services.[4] Subsequently, "Philadelphia health officials announced their plan to allow—but not fund—the opening" of an OPS in the city.[5]

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1. Aubrey Whelan, *Former Gov. Ed Rendell Is Leading Nonprofit to Open a Safe-Injection Site in Philadelphia*, PHILA. INQUIRER (Oct. 3, 2018), https://www.inquirer.com/philly/health/addiction/safe-injection-site-philadelphia-ed-rendell-prevention-point-20181002.html [hereinafter Whelan, *Gov. Ed. Rendell*].

2. *Frequently Asked Questions*, SAFEHOUSE, https://www.safehousephilly.org/frequently-asked-questions (last visited Oct. 15, 2022).

3. Thomas Farley, *Fatal Drug Overdoses in Philadelphia*, 2017, PHILA. DEP'T PUB. HEALTH: CHART, Apr. 2018, at 1, 1, https://www.phila.gov/media/20180912140436/chart-v3e1.pdf.

4. THE MAYOR'S TASK FORCE TO COMBAT THE OPIOID EPIDEMIC IN PHILA., FINAL REPORT & RECOMMENDATIONS 15–17 (2017).

5. Aubrey Whelan, *Here's How Safehouse, Philly's Proposed Safe-Injection Site, Will*

OPSs are facilities where injection drug users (IDUs) can use previously purchased drugs under trained supervision.[6] At these sites, trained supervisors are able to respond quickly and effectively with oxygen and/or naloxone to prevent fatal overdoses.[7] Other names for OPSs include safe injection sites, safe consumption sites, and drug consumption rooms.[8] However, a study published in the American Journal of Public Health suggested that public support for these sites is 16% higher when using the term "overdose prevention site" rather than "safe consumption site," noting the importance of messaging in public health campaigns.[9] For this reason, OPS is the term used in this Comment. Furthermore, the term "government-sanctioned" is used throughout this Comment to underscore that these sites exist "underground" in the United States, without any government approval.[10]

After the announcement from Philadelphia health officials to allow an OPS in the city, board members of Safehouse rallied support from city leaders; among them were Mayor Jim Kenney, District Attorney Larry Krasner, and former Mayor and Pennsylvania Governor Ed Rendell.[11] Safehouse also created an advisory board of community leaders and health experts to provide guidance on the opening of the site.[12] To help with community buy-in, board members spoke with Sister Mary Scullion, the president and executive director of Project HOME, Philadelphia's "preeminent housing, poverty, and homelessness services organization."[13] Scullion endorsed Safehouse's mission immediately, noting that

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Operate, PHILA. INQUIRER (Oct. 8, 2018), https://www.inquirer.com/philly/health/addiction/safe-injection-site-philadelphia-safehouse-faq-20181008.html [hereinafter Whelan, *How Safehouse Will Operate*].

6. *Overdose Prevention Centers*, THE DRUG POL'Y ALL., https://drugpolicy.org/issues/supervised-consumption-services (last visited Oct. 15, 2022).

7. SAFEHOUSE, *supra* note 2.

8. *E.g.*, *Public Policy Statements on Overdose Prevention Sites*, AM. SOC'Y OF ADDICTION MED. (July 22, 2021), https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2021/08/09/overdose-prevention-sites; HARM REDUCTION INT'L, THE GLOBAL STATE OF HARM REDUCTION 22 (8th ed. 2022).

9. Colleen L. Barry et al., *Language Matters in Combatting the Opioid Epidemic: Safe Consumption Sites Versus Overdose Prevention Sites*, 108 AM. J. PUB. HEALTH 1157, 1158 (2018).

10. Katharine Swindells, *A New Era of Harm Reduction: Will the US Finally Embrace Safe Drug Consumption Sites?*, CITY MONITOR (Sept. 27, 2022), https://citymonitor.ai/community/public-health/america-safe-drug-consumption-sites.

11. Jeremy Roebuck & Aubrey Whelan, *A Federal Appeals Court Rejects Plans for a Supervised Injection Site in Philly*, PHILA. INQUIRER (Jan. 12, 2021), https://www.inquirer.com/news/safehouse-third-circuit-decision-safe-injection-site-philadelphia-mcswain-20210112.html; *see also* Whelan, *Gov. Ed Rendell*, *supra* note 1 (describing former Governor Rendell's involvement in Safehouse); History of Prevention Point Philadelphia, PREVENTION POINT, https://ppponline.org/about-us/history-ppp (last visited Oct. 16, 2022) (explaining Mayor Rendell's support for Prevention Point, the first and only needle exchange in Philadelphia, as a response to the AIDS epidemic in the early 1990s).

12. SAFEHOUSE, *supra* note 2.

13. Whelan, *Gov. Ed Rendell*, *supra* note 1; Aubrey Whelan, *Government Shutdown Delays Construction on Addiction Recovery Housing in Kensington*, PHILA. INQUIRER (Jan. 15, 2019), https://www.inquirer.com/health/government-shutdown-project-home-kensington-opioid-crisis-

she would "go to jail with you guys" if Safehouse ever encountered legal ramifications.[14]

Before Safehouse had a chance to open its OPS, U.S. Attorney for the Eastern District of Pennsylvania William McSwain filed a civil lawsuit in February 2019 asking the court to issue a declaration that OPSs violate federal law.[15] On October 2, 2019, U.S. District Judge Gerald McHugh ruled in favor of Safehouse yet granted the federal government's request for an Emergency Motion for Stay in June 2020;[16] it prevented any OPS from opening until the U.S. Court of Appeals for the Third Circuit (Third Circuit) issued its judgement on appeal.[17] On January 12, 2021, in a 2-1 split, the Third Circuit reversed and ruled against Safehouse, delivering a devastating blow to the organization and its mission to open the first government-sanctioned OPS in the United States.[18]

Since the Third Circuit's decision in 2021, the United States has exceeded *one hundred thousand* drug overdose fatalities in a single year.[19] Though the dispensing rate for prescription opioids has declined nationally every year since 2012,[20] the opioid overdose crisis has continued to worsen.[21] Notably, overdose death rates have increased most drastically for Black and Indigenous people since 2020, a clear sign that the opioid overdose crisis is an issue of racial justice.[22] Also,

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20190115.html.

14. Aubrey Whelan, *How the Philadelphia Nonprofit that Could Launch the Nation's First Safe-Injection Site Got Started,* PHILA. INQUIRER (Oct. 8, 2018), https://www.inquirer.com/philly/health/addiction/how-the-philadelphia-nonprofit-that-could-launch-the-nations-first-safe-injection-site-got-started-20181007.html.

15. *See United States v. Safehouse,* SAFEHOUSE, https://www.safehousephilly.org/us-v-safehouse (last visited Oct. 16, 2022) (detailing Safehouse's litigation regarding its plan to open an OPS in Philadelphia); *see also* Jeremy Roebuck & Aubrey Whelan, *U.S. Attorney Sues to Stop Supervised Injection Sites in Philadelphia*, PHILA. INQUIRER (Feb. 6, 2019), https://www.inquirer.com/news/supervised-injection-sites-philadelphia-stop-safehouse-us-attorney-opioid-crisis-20190206.html (discussing U.S. Attorney's complaint).

16. United States v. Safehouse, No. 19-0519, slip op. at 2 (E. D. Pa. Feb. 25, 2020); *see also* United States v. Safehouse, 468 F. Supp. 3d 687, 690 (E.D. Pa. 2020) ("[T]he combination of the pandemic and the momentous protests following the killing of Mr. George Floyd make this the wrong moment for another change in the status quo.").

17. United States v. Safehouse, 985 F.3d 225, 225 (3d Cir. 2021), *cert. denied*, 142 S.Ct. 345 (2021).

18. *Id.*

19. *Drug Overdose Deaths in the U.S. Top 100,000 Annually*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 17, 2021), https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

20. *See US Opioid Dispensing Rate Map*, CTRS. FOR DISEASE CONTROL & PREVENTION (2021), https://www.cdc.gov/drugoverdose/rxrate-maps/index.html (describing how opioid dispensing rate in 2020 was lowest it had been in fifteen years).

21. *See Understanding the Epidemic*, CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 17, 2021), https://www.cdc.gov/opioids/basics/epidemic.html (overviewing evolution of the opioid epidemic).

22. *Overdose Death Rates Increased Significantly for Black, American Indian/Alaska Native People in 2020*, CTRS. FOR DISEASE CONTROL & PREVENTION (July 19, 2022, 1:00 PM), https://www.cdc.gov/media/releases/2022/s0719-overdose-rates-vs.html [hereinafter *Overdose Death Rates Increased*]; s*ee also* Joseph Friedman & Helena Hansen, Opinion, *Surging Overdose*

since 2021, synthetic opioids—particularly those containing fentanyl, a highly potent opioid increasingly found in heroin, counterfeit pills, and cocaine—have become the main drivers of the current overdose crisis.[23]

Perhaps the most significant OPS-related event in the United States since the Third Circuit's *Safehouse* ruling has been the opening of two government-sanctioned OPSs in New York City in November 2021.[24] The sites opened amidst an agreement from New York City's mayor and district attorneys "not to take enforcement action" against the OPSs' operators.[25] Furthermore, Rhode Island became the first state to legalize a pilot program for OPSs in July 2021, but because its authorizing law requires approval from the local city or town council, a government-sanctioned OPS has yet to open in the state.[26] California almost became the second state to legalize a pilot program for OPSs, but in August 2022, Governor Gavin Newsom vetoed the legislation that would have authorized their opening.[27]

Advocates for government-sanctioned OPSs in the United States continue to exhaust a range of paths for their implementation across the country, whether at the federal level, as was the case with Safehouse's litigation, at the state level, as was the case in Rhode Island and California, or at the local level, as was the case in New York City. Given the complex and ever-changing legal landscape of OPSs, this Comment argues that advocates and policymakers in the United States must look *internationally* to countries where OPSs *have already been legalized* to refine their own implementation strategies.

Canada and Australia—both with federal constitutional systems of

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Deaths Are a Tragic Racial Justice Issue, L.A. TIMES (Nov. 23, 2021, 3:15 AM), https://www.latimes.com/opinion/story/2021-11-23/overdoses-u-s-black-white-native-americans (analyzing why, for first time in approximately thirty years, more Black than white Americans died from overdoses).

23. *See Understanding the Epidemic*, *supra* note 21 (detailing three waves of the opioid overdose crisis); *see also* RAND CORP., UNDERSTANDING AMERICA'S SURGE IN FENTANYL AND OTHER SYNTHETIC OPIOIDS (2019) (describing role of synthetic opioids in current stage of the epidemic).

24. *See* Kyle Jaeger, *US's First Safe Drug Consumption Sites Are Already Saving Lives by Stopping Dozens of Overdoses in Less Than a Month, NYC Officials Say*, MARIJUANA MOMENT (Dec. 22, 2021), https://www.marijuanamoment.net/uss-first-safe-drug-consumption-sites-are-already-saving-lives-by-stopping-dozens-of-overdoses-in-less-than-a-month-nyc-officials-say/ (describing lives saved by OPSs in New York City).

25. Jeffrey C. Mays & Andy Newman, *Nation's First Supervised Drug-Injection Sites Open in New York*, N.Y. TIMES (Nov. 30, 2021), https://www.nytimes.com/2021/11/30/nyregion/supervised-injection-sites-nyc.html.

26. Aubrey Whelan, *As U.S. Overdose Deaths Soar, Rhode Island Legalizes Supervised Injection Sites. Philly's Effort Remains in Limbo*, PHILA. INQUIRER (July 19, 2021), https://www.inquirer.com/health/opioid-addiction/supervised-injection-site-rhode-island-philadelphia-20210719.html.

27. *E.g.*, Victoria Colliver, *Newsom Vetoes Bill to Allow Supervised Drug Use in 3 California Cities*, POLITICO (Aug. 22, 2022, 7:14 PM), https://www.politico.com/news/2022/08/22/newsom-signs-vetoes-californias-supervised-injection-sites-00052815.

government like that in the United States[28]—are prime examples; OPSs operate legally within their borders.[29] In Canada, OPSs were legalized nationwide in a landmark 2011 Supreme Court case[30] after the first government-sanctioned OPS in Canada, Insite, was granted an exemption under § 56 of the federal Controlled Drugs and Substances Act (CDSA).[31] In Australia, legalization of OPSs has proceeded state-by-state, first with legislation passed by the government of New South Wales (NSW) granting exemptions to its state drug laws in 1999[32] and more recently with the Victorian government similarly amending its drug laws in 2017.[33] Implementing government-sanctioned OPSs in the United States could follow either of these routes: through federal action, like in Canada, or through state action, like in Australia. Alternatively, with the opening of two government-sanctioned OPSs in New York City, implementation could strictly follow local action.

This Comment will detail how OPSs were legalized in Canada and Australia, drawing comparisons to the United States to better inform U.S. policymakers and advocates about the most effective and efficient ways OPSs can be implemented nationwide. In Canada, a Supreme Court ruling has given OPS advocates strong legal standing to open OPSs across the country, yet in the absence of any affirmative federal legislation, some provincial governments have created a legal landscape hostile to their implementation.[34] In Australia, absent both federal legislation and a ruling from the High Court, legalization of OPSs has been left to the states, allowing OPSs to open in states that have taken affirmative legal action but disallowing them in states that have not.[35] In both cases, resilient activism in

28. *See* Ronald L. Watts, *Federalism, Federal Political Systems, and Federations*, 1 ANN. REV. POL. SCI. 117, 132 (1998) (citing United States, Canada, and Australia as maintaining long-standing federations).

29. *E.g., Overdose Prevention Centers*, *supra* note 6.

30. *See* Rahool P. Agarwal, *Case Comment:* Canada (Attorney General) v. PHS Community Services Society, 20 CONST. F. 41, 42 (2011) (citing Canada (Attorney General) v. PHS Community Services Society, 2011 SCC 44, [2011] 3 S.C.R. 134) (explaining that by ordering continued operation of Insite, Supreme Court set precedent for legality of future supervised injection sites).

31. *See* Thomas Kerr et al., *Supervised Injection Facilities in Canada: Past, Present, and Future*, HARM REDUCTION J., 2017, at 1, 2 (describing process of Insite's opening) [hereinafter Kerr et al., *SIFs in Canada*].

32. Cate Kelly & Katherine M. Conigrave, *The Sydney Medically Supervised Injecting Centre: A Controversial Public Health Measure*, 26 AUSTL. & N.Z. J. PUB. HEALTH 552, 553 (2002).

33. Donna Lu, '*I'm Living Proof': How Melbourne's Drug-Injecting Room Has Changed – And Saved – Lives,* THE GUARDIAN (June 18, 2021), https://www.theguardian.com/australia-news/2021/jun/19/im-living-proof-how-melbournes-drug-injecting-room-has-changed-and-saved-lives; *Drugs, Poisons and Controlled Substances Act 1981 and Regulations 2017*, VICTORIA STATE DEP'T (Dec. 8, 2021), https://www.health.vic.gov.au/drugs-and-poisons/drugs-poisons-and-controlled-substances-act-1981-and-regulations-2017.

34. See *infra* Part IV.B for an analysis of the fact-specific determination to open OPSs in Canada.

35. See *infra* Part V.B for an analysis of Australia's system of federalism and its effect on the enforcement of criminal drug laws by state governments.

the form of civil disobedience—where advocates illegally operated and protested for supervised consumption rooms—facilitated legalization efforts.[36] These paths to authorization hold several lessons for American policymakers and advocates, each of which this Comment will explore.

Part II of this Comment will further describe the public health theories behind OPSs and the various benefits that OPSs can bring communities. Part III will detail the history of the U.S. opioid overdose crisis, the federal "crack house" statute as the main federal legal barrier to OPS implementation, and the role of the Safehouse litigation in the U.S. policy response to OPSs. Part IV will describe how OPSs were legalized in Canada and what the current legal landscape of OPSs is within the country. Part V will do the same vis-à-vis Australia, and Part VI will ultimately make notable comparisons to the Canadian and Australian modes of implementation for U.S. advocates of OPSs.

II. OVERDOSE PREVENTION SITES

Among the available public health tools to address the opioid overdose crisis, OPSs are one of the most effective at directly stopping overdoses.[37] Section A of this Part will explain exactly what an OPS is, describe how OPSs fit into the push for expanding harm reduction services in the United States, and explore who OPSs are meant to help. Section B will detail the various benefits of OPSs, including their ability to prevent fatal overdoses, link clients to other social and medical services, and improve the financial toll that the opioid overdose crisis takes on communities.

A. What is an Overdose Prevention Site?

To best envision what an OPS is and how it operates, advocates have used the "lifeguard" model:[38] When you go to the beach, a lifeguard is there in case someone drowns. That lifeguard watches over everyone at the beach and intervenes to save someone when they cannot breathe. Similarly, at an OPS, a trained supervisor watches over users at the facility and intervenes when someone shows signs of an overdose, administering oxygen and/or naloxone to prevent their death.[39]

OPSs are part of a broad range of health interventions under the umbrella term "harm reduction."[40] The National Harm Reduction Coalition defines harm

36. See *infra* Part VI.C for a discussion of how OPSs illegally operated in Canada before Insite opened with government approval.

37. *E.g.*, *Overdose Prevention Centers*, *supra* note 6.

38. *See* Russell Maynard (@rusmaynard), TWITTER (Feb. 29, 2020, 11:44 AM), https://twitter.com/rusmaynard/status/1233795107943403520 (likening an OPS to a lifeguard).

39. *E.g.*, Elana Gordon, *What's the Evidence That Supervised Drug Injection Sites Save Lives?*, NPR, https://www.npr.org/sections/health-shots/2018/09/07/645609248/whats-the-evidence-that-supervised-drug-injection-sites-save-lives (Feb. 21, 2019) (explaining how OPSs work).

40. *See Principles of Harm Reduction*, NAT'L HARM REDUCTION COAL., https://harmreduction.org/about-us/principles-of-harm-reduction/ (last visited Jan. 11, 2022) (describing different harm reduction strategies).

reduction as "a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use."[41] Harm reduction strategies must be tailored to the needs of both individuals and communities and, as such, have no standard form.[42] Examples of harm reduction include distributing sterile needles, training community members to administer naloxone, providing nonabstinence housing, and offering medication-assisted treatment (MAT) with methadone and buprenorphine.[43]

Harm reduction recognizes that many people do not want to stop using drugs, or will be unable to abstain, so rather than insist users stop all use immediately or face criminal charges, they should be offered services that protect both their health and dignity.[44] In the case of OPSs, harm reduction involves giving IDUs a space to use safely and without stigma.[45] It recognizes that substance use disorder is a medical condition that must be treated with science and compassion.[46] Regardless of whether OPS users have a substance use disorder, harm reduction dictates that all IDUs deserve a space to use without fear of fatal overdose.[47]

Several studies have provided evidence demonstrating drug users' support for OPSs.[48] A study in Philadelphia interviewed both IDUs and healthcare providers at Prevention Point;[49] it found that participants overwhelmingly supported opening an OPS in Philadelphia and that they wanted to be part of the solution for reducing the burden of public injecting on the community.[50] However, only those participants who lacked stable housing suggested that they would use such a facility.[51] This reflects the belief that OPSs can be targeted interventions for the most vulnerable people who inject drugs.[52]

Furthermore, a study by the Johns Hopkins Bloomberg School of Public

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41. *Id.*

42. *Id.*

43. *What Is Harm Reduction?*, OPEN SOC'Y FOUNDS. (June 2021), https://www.opensocietyfoundations.org/explainers/what-harm-reduction.

44. *Id.*

45. *See Overdose Prevention Centers*, *supra* note 6 (discussing OPS's role in preventing drug overdoses).

46. *See id.* (citing empirical studies while discussing importance of providing safe space for people who use drugs to find connections and care without stigma).

47. *Id.*

48. *See, e.g.*, Robert E. Harris et al., *Perceptions About Supervised Injection Facilities Among People Who Inject Drugs in Philadelphia*, 52 INT'L J. DRUG POL'Y 56, 56 (2018) (concluding many people without stable housing who inject drugs in seclusion benefit from OPSs); *see also, e.g.*, Mary Clare Kennedy, *Overdose Prevention Sites Provide Wide Range of Health Benefits: New Research*, B.C. CTR. ON SUBSTANCE ABUSE (Dec. 2, 2021), https://www.bccsu.ca/blog/news-release/overdose-prevention-sites-provide-wide-range-of-health-benefits-new-research (finding OPSs meet unaddressed needs among those who use drugs).

49. Prevention Point offers HIV and HCV testing and treatment, a drop-in center to connect individuals with local resources, and a syringe service program. *What We Do*, PREVENTION POINT, https://ppponline.org/ (last visited Jan. 15, 2023).

50. Harris, *supra* note 48, at 60.

51. *Id.*

52. *Id.*

Health found that 77% of surveyed people who use drugs would be willing to use an OPS.[53] Participants included IDUs that were predominantly "male (59%), older than 35 years (76%), non-white (64%), relied on public/semi-public settings to inject (60%), had a history of overdose[s] (64%), and recently suspected fentanyl contamination of their drugs (73%)."[54] They were surveyed in Baltimore, Providence, and Boston.[55]

As of 2020, about 165 OPSs operate worldwide,[56] yet only two operate with government approval in the United States.[57] Several state governments have attempted to legalize OPSs, including those of Rhode Island, California, and Maryland;[58] again, Rhode Island passed a bill in July 2021 permitting the establishment of an OPS pilot program.[59] Cities including Washington D.C.; Seattle, Washington; Burlington, Vermont; and Baltimore, Maryland have taken similar steps, though none have been successful.[60] In addition, several prominent organizations, such as the American Medical Association, the American Civil Liberties Union (ACLU), AIDS United, the American Foundation for AIDS

53. Ju Nyeong Park et al., *Willingness to Use Safe Consumption Spaces Among Opioid Users at High Risk of Fentanyl Overdose in Baltimore, Providence, and Boston*, 96 J. URB. HEALTH 353, 353 (2019).

54. *Id.*

55. *Id.*

56. Emily Land, *Have Questions About Bringing Safe Injection Sites to San Francisco? Here's Some Key Info.*, S.F. AIDS FOUND. (Aug. 27, 2020), https://www.sfaf.org/collections/beta/have-questions-about-bringing-safe-injection-sites-to-san-francisco-heres-some-key-info.

57. These two OPSs are located in East Harlem and Washington Heights, New York. Phil McCausland, *New York City Opens Nation's First Overdose Prevention Centers*, NBC NEWS (Nov. 30, 2021, 4:01 PM), https://www.nbcnews.com/health/nations-first-overdose-prevention-centers-opens-opioid-death-spike-rcna7058.

58. *See Harm Reduction Centers*, PREVENT OVERDOSE R.I., https://preventoverdoseri.org/harm-reduction-centers/ (last visited Oct. 19, 2022), (outlining potential for harm reduction centers in Rhode Island); *see also* Ana B. Ibarra, *California Governor Vetoes Supervised Drug Injection Sites*, CALMATTERS (Aug. 23, 2022), https://calmatters.org/addiction/2022/08/supervised-injection-sites/ (describing Governor Newsom's veto of bill that would have legalized overdose prevention pilot programs); *see also* H.B. 396, 2021 Reg. Sess. (Md. 2021) (proposing permission to create OPSs).

59. H.B. 5245, 2021 Reg. Sess. (R.I. 2021).

60. *See* Martin Austermuhle, *Groups Launch Campaign to Decriminalize All Drugs in D.C. and Create Safe-Use Sites*, DCIST (Oct. 22, 2021, 2:53 PM), https://dcist.com/story/21/10/22/groups-launch-campaign-to-decriminalize-all-drugs-in-d-c-and-create-safe-use-sites (discussing push to bring OPSs to D.C.); *see also* Matt Markovich, *Court Ruling Blocks Seattle's Efforts to Create Supervised Heroin Injection Sites*, KOMO NEWS (Jan. 13, 2021), https://komonews.com/news/local/court-rules-against-seattles-efforts-for-supervised-injection-sites-for-heroin-users (discussing pushback to bringing OPSs to Seattle); *see also* The Associated Press, *Vermont City Takes Step Toward Supervised Injection Site*, ABC NEWS (Sept. 15, 2020, 2:34 PM), https://abcnews.go.com/Health/wireStory/vermont-city-takes-step-supervised-injection-site-73020083 (discussing push to bring OPSs to Burlington); *see also Baltimore City's Response to the Opioid Epidemic*, BALT. CITY HEALTH DEP'T, https://health.baltimorecity.gov/opioid-overdose/baltimore-city-overdose-prevention-and-response-information (last visited Oct. 19, 2022); *see also* Colliver, *supra* note 27 (detailing California efforts to institute OPSs).

Research, the Drug Policy Alliance, Scientific American, and the National Harm Reduction Coalition, strongly support the implementation of OPSs.[61]

B. Benefits of OPSs

The benefits of OPSs are expansive: reducing fatal overdoses, linking clients to other social and medical services, decreasing drug paraphernalia discarded in communities that house OPSs, and improving the financial burden of the opioid overdose crisis on health systems, to name a few.[62] As their name suggests, OPSs allow operators to successfully manage on-site overdoses and reduce drug-related death rates, thus directly combating the opioid overdose crisis.[63] In fact, a study by the Institute for Clinical and Economic Review (ICER) found that OPSs help prevent more deaths from overdoses than needle exchange programs.[64] The presence of an OPS in a community has also been shown to decrease the number of fatal overdoses in its vicinity.[65]

OPS supervisors are trained to respond to an overdose by administering oxygen and/or naloxone, which can be dispensed either nasally or by injection.[66] Some studies have shown more benefits when using injectable naloxone rather than nasally administered naloxone,[67] so trained supervisors at OPSs may be better positioned than untrained individuals to administer injectable naloxone given the training required to safely use a vial and syringe. Naloxone can be distributed at OPSs when visitors leave the consumption rooms.[68] Given that fentanyl and other synthetic opioids are driving the current overdose epidemic,[69] OPSs are also

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61. *See USA v. Safehouse, et al., Civil Action No. 19-0519 (E.D. Pa)*, SAFEHOUSE PHILA. (July 10, 2020), https://www.safehousephilly.org/sites/default/files/attachments/2020-06/7-10-19_Amici%20Resource%20Final_0.pdf (listing organizations that filed amici briefs in support of Safehouse); *see also* Bobby Mukkamala, *New Guidance on Naloxone to Strengthen Work of Harm Reduction Groups*, AM. MED. ASSOC. (Sept. 22, 2022), https://www.ama-assn.org/press-center/press-releases/new-guidance-naloxone-strengthen-work-harm-reduction-groups (noting AMA supports harm reduction services and providers).

62. *Harm Reduction*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Aug. 16, 2022), https://www.samhsa.gov/find-help/harm-reduction.

63. *Overdose Prevention Centers*, *supra* note 6.

64. *ICER Publishes Final Evidence Report and Policy Recommendations for Supervised Injection Facilities*, INST. FOR CLINICAL & ECON. REV. (Jan. 8, 2021), https://icer.org/news-insights/press-releases/icer-publishes-final-evidence-report-and-policy-recommendations-for-supervised-injection-facilities/.

65. *See* M.-J. S. Milloy et al., *Non-Fatal Overdose Among a Cohort of Active Injection Drug Users Recruited from a Supervised Injection Facility*, 34 AM. J. DRUG & ALCOHOL ABUSE 499, 500 (2008) (distinguishing effect of supervised injection facilities on fatal overdoses versus non-fatal overdoses, with latter showing a significant decrease when supervised injection facilities are introduced).

66. SAFEHOUSE, *supra* note 2; Mahmoud Yousefifard et al., *Intranasal Versus Intramuscular/Intravenous Naloxone for Pre-Hospital Opioid Overdose: A Systematic Review and Meta-Analysis*, 4 ADV. J. EMERG. MED. 499, 499 (2020).

67. *E.g.*, Paul Dietze et al., *Effect of Intranasal vs. Intramuscular Naloxone on Opioid Overdose*, 2 JAMA NETWORK OPEN e1914977, e1914977 (2019).

68. SAFEHOUSE, *supra* note 2.

69. *E.g.*, Farley, *supra* note 3.

frequently sites for fentanyl drug checking;[70] Safehouse itself was prepared to provide fentanyl test strips to its visitors upon their arrival.[71] This service can prevent an overdose before consumption if users are unaware that their supplies contain the potent opioid; however, it should be noted that fentanyl test strips are unable to detect the amount of fentanyl a sample contains, making the service moot to many users who have become accustomed to some fentanyl in their drug supply.[72]

In addition to fentanyl testing, Safehouse planned to offer a range of other health services, including rehabilitation options, initiation of MAT, wound care, referrals to primary care, and HIV/Hepatitis C (HCV) testing and counselling.[73] Upon arrival, a physical and behavioral health assessment would have been conducted to determine if a visitor might need any treatment services.[74] Staff members or volunteers at OPSs would then be able to establish relationships with visitors, which can be "incredibly valuable in helping to get these individuals into a treatment program or detox center" if deemed necessary.[75] For example, at Insite, 57% of participants in a study entered drug treatment after twenty-four months of using the facility.[76] OPSs additionally give IDUs a space to continue using safely while beginning treatment, as successful treatment for substance use disorder cannot involve an immediate cessation of drug use.[77]

Due to their HIV and HCV testing and counseling services, OPSs reduce behaviors that could lead to transmission of HIV or HCV, such as syringe sharing and condomless sex.[78] Insite has estimated that it prevents an average of thirty-five

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70. *See, e.g.*, Mohammad Karamouzian et al., *Evaluation of a Fentanyl Drug Checking Service for Clients of a Supervised Injection Facility, Vancouver, Canada*, 15 HARM REDUCTION J. 46, 46 (2018) (describing findings of Insite's drug checks). The study found that of the 1% of visits to Insite that resulted in a drug check, 79.8% were positive for fentanyl. *Id.*

71. Whelan, *How Safehouse Will Operate*, *supra* note 5.

72. Nat'l Harm Reduction Coal., *Fentanyl*, HARM REDUCTION ISSUES, https://harmreduction.org/issues/fentanyl/ (last visited Oct. 19, 2022). For additional discussion of the benefits of access to fentanyl test strips, see Alfonso Serrano, *$1 Fentanyl Test Strip Could Be a Major Weapon Against Opioid ODs*, SCI. AM. (Mar. 8, 2018), https://www.scientificamerican.com/article/1-fentanyl-test-strip-could-be-a-major-weapon-against-opioid-ods/.

73. SAFEHOUSE, *supra* note 2.

74. *Id.*

75. *Safe Injection Sites: What Are They & How Do They Work?*, INTEGRATIVE LIFE CTR., https://integrativelifecenter.com/wellness-blog/safe-injection-sites-what-are-they-how-do-they-work (last visited Oct. 17, 2022).

76. Kora DeBeck et al., *Injection Drug Use Cessation and Use of North America's First Medically Supervised Safer Injecting Facility,* 113 DRUG & ALCOHOL DEPENDENCE 172, 174 (2011).

77. *See* SAFEHOUSE, *supra* note 2 ("If you want to keep these people alive long enough to get them into treatment, you have to give them a space to use.").

78. *See* Salaam Semaan et al., *Potential Role of Safer Injection Facilities in Reducing HIV and Hepatitis C Infections and Overdose Mortality in the United States*, 118 DRUG & ALCOHOL DEPENDENCE 100, 100 (2011) (discussing how OPSs reduce syringe sharing); *see also* B D L Marshall et al., *Condom Use Among Injection Drug Users Accessing a Supervised Injecting Facility,* 85 SEXUALLY TRANSMITTED INFECTIONS 121, 121 (2009) (discussing how OPSs reduce

new cases of HIV annually.[79] One study found that among OPS users, consistent condom use increased among casual partners and among those living with HIV.[80] Another found that OPSs can increase access to and engagement with care for people living with HIV,[81] linking visitors to antiretroviral therapy (ART) and increasing the likelihood that their viral load becomes undetectable and untransmittable.[82] OPSs are frequently used for syringe services programs (SSPs), where IDUs can access sterile needles and syringes and safely dispose of used ones, thus reducing the need for IDUs to share needles.[83] One study found that IDUs who accessed Insite to inject drugs were 70% less likely to share syringes than IDUs who did not use the facility.[84] Given that HIV and HCV transmission can occur via needle sharing, the SSP component of OPSs can also reduce new HIV and HCV infections.[85]

OPSs are also able to provide referrals for a number of social services, including housing services, childcare, job training, legal services, mental health care, aging services, and food subsidies.[86] Individuals accessing OPSs have described them as a "safe sanctuary . . . [bringing] a sense of belonging to a community that often experiences discrimination."[87]

In addition to the various health and social benefits of OPSs, evidence shows

condomless sex practices).

79. Martin A. Andresen & Neil Boyd, *A Cost-Benefit and Cost-Effectiveness Analysis of Vancouver's Supervised Injection Facility,* 21 INT'L J. DRUG POL'Y 70, 70 (2010).

80. B D L Marshall et al., *supra* note 78, at 121.

81. *See* Ryan McNeil et al., *Impact of Supervised Drug Consumption Services on Access to and Engagement with Care at a Palliative and Supportive Care Facility for People Living with HIV/AIDS: A Qualitative Study*, 17 J. INT'L AIDS SOC'Y 18855 (2014) (concluding harm reduction services such as OPSs can greatly improve supportive care for people who use drugs).

82. *See HIV Undetectable=Untransmittable (U=U), or Treatment as Prevention*, NAT'L INST. OF ALLERGY & INFECTIOUS DISEASES (May 21, 2019), https://www.niaid.nih.gov/diseases-conditions/treatment-prevention ("[A]n overwhelming body of clinical evidence has firmly established the HIV Undetectable=Untransmittable, or U=U, concept as scientifically sound. [This] means that people with HIV who achieve and maintain an undetectable viral load—the amount of HIV in the blood—by taking antiretroviral therapy (ART) daily as prescribed *cannot* sexually transmit the virus to others.") (emphasis added).

83. *See Syringe Services Programs (SSPs) FAQs,* CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/ssp/syringe-services-programs-faq.html (last visited Jan. 12, 2022) (describing what SSPs are); *see also Syringe Service Program Laws,* TEMPLE UNIV. CTR. FOR PUBLIC HEALTH L. RSCH. (Mar. 10, 2022) http://publichealthlawresearch.org/product/syringe-service-programs-laws (explaining many states have specific syringe service program laws, which may limit their operation by requiring other services, mandating approval by local officials, or failing to carve out exemption for possession of drug paraphernalia).

84. Thomas Kerr et al., *Safer Injection Facility Use and Syringe Sharing in Injection Drug Users,* 366 LANCET 316, 316 (2005) [hereinafter Kerr et al., *Safer Injection Facility Use*].

85. *Syringe Services Programs (SSPs) Fact Sheet*, CTRS. FOR DISEASE CONTROL & PREVENTION (May 23, 2019), https://www.cdc.gov/ssp/syringe-services-programs-factsheet.html.

86. SAFEHOUSE, *supra* note 2.

87. Annie Foreman-Mackey et al., *'It's Our Safe Sanctuary': Experiences of Using an Unsanctioned Overdose Prevention Site in Toronto, Ontario*, 73 INT'L J. DRUG POL'Y 135, 135 (2019).

that the presence of OPSs in communities can lead to less drug paraphernalia on streets[88] and less public drug consumption.[89] No evidence suggests that OPSs lead to greater community drug use, initiation of injection drug use, or drug-related crime.[90] A systematic literature review in 2017 concluded that OPSs "mitigate overdose-related harms . . . as well as facilitate uptake of addiction treatment and other health services among people who use drugs (PWUD)."[91] Further, OPSs have been associated with improvements in public order without increasing drug-related crime.[92]

OPSs provide a substantial financial benefit to communities. The Centers for Disease Control and Prevention (CDC) estimates that the total "economic burden" of prescription opioid misuse alone in the United States is $78.5 billion a year, including the costs of healthcare, lost productivity, substance use disorder treatment, and criminal justice involvement.[93] Safehouse's OPS was expected to save Philadelphia at least $2 million annually,[94] and an Insite study found that it saves Vancouver more than $6 million per year.[95] Given the funds that many cities may soon see from the $26 billion settlement deal releasing pharmaceutical companies from all civil liability in the opioid epidemic,[96] OPSs funded by the settlement can serve as cost-effective public health interventions to combat the opioid overdose crisis.

As further evidence in support of implementing OPSs in the United States, sites abroad have reported significant success with preventing overdoses and improving public health. Insite in Vancouver, Canada, is the most often cited example of a successful OPS in North America.[97] Opened in 2003, Insite has

88. *See id.* ("[B]y providing a supervised place to consume drugs, fewer people will use drugs on the streets. Less drug paraphernalia will be publicly discarded.").

89. Leo Beletsky et al., *The Law (and Politics) of Safe Injection Facilities in the United States,* 98 AM. J. PUB. HEALTH 231, 231 (2008) ("[OPSs] are intended to reduce the externalities of public drug use in the communities they serve. They generally target high-risk, socially marginalized IDUs who would otherwise inject in public spaces or shooting galleries.").

90. *See, e.g.*, *Overdose Prevention Centers*, *supra* note 6 (arguing OPSs may actually reduce drug use); *see also* Chloé Potier et al., *Supervised Injection Services: What Has Been Demonstrated? A Systematic Literature Review*, 145 DRUG & ALCOHOL DEPENDENCE 48, 48 (2014) (concluding after a systematic review of seventy-five studies that OPSs were associated with less public drug use and did not appear to have any negative impacts on drug use overall).

91. Mary Clare Kennedy et al., *Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: A Systematic Review*, 14 CURRENT HIV/AIDS REP. 161, 161 (2017).

92. Potier et al., *supra* note 90, at 48.

93. Curtis S. Florence et al., *The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013,* 54 MED. CARE 901, 901 (2016).

94. SAFEHOUSE, *supra* note 2.

95. Andresen & Boyd, *supra* note 79.

96. Brian Mann, *4 U.S. Companies Will Pay $26 Billion to Settle Claims They Fueled the Opioid Crisis*, NPR (Feb. 25, 2022, 7:39 AM), https://www.npr.org/2022/02/25/1082901958/opioid-settlement-johnson-26-billion.

97. *See Insite,* PHS CMTY. SERVS. SOC'Y, https://www.phs.ca/program/insite (last visited Jan. 12, 2022) ("Since its inception, Insite has been at the forefront of health emergencies experienced by the most marginalized and under-served members of our community.").

logged 3.6 million visits to its supervised consumption room, 48,798 clinical treatment visits to take advantage of other health services, such as wound care and pregnancy tests, and 6,440 successful overdose interventions.[98] Studies have shown that Insite effectively prevented overdose deaths, educated visitors about safer behaviors that would prevent HIV/HCV transmission, and directed users to substance use disorder treatment who needed it.[99]

In Sydney, Australia, Uniting Medically Supervised Injecting Center (MSIC) opened in 2001. It has since managed 10,860 overdoses and referred 20,420 clients to ongoing care and support.[100] Syringe counts on streets in Kings Cross, the neighborhood where Uniting MSIC is located, were generally lower after the facility opened.[101]

Studies have already provided evidence supporting the effectiveness of New York City's two government-sanctioned OPSs since their opening in November 2021.[102] In their first two months of operation, 613 individuals used the sites' overdose prevention services for a total of 5,975 visits.[103] Trained staff at the centers responded 125 times to mitigate overdose risk, and 52.5% of the individuals using the overdose prevention services received additional support services while at the sites, including naloxone distribution, counseling, HCV testing, medical care, and holistic services like auricular acupuncture.[104] As of August 21, 2022, the sites have seen 1,633 unique participants, 32,428 total utilizations of overdose prevention services, and 434 overdose interventions.[105]

These examples in Vancouver, Sydney, and New York City, as well as the

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98. *Insite User Statistics*, VANCOUVER COASTAL HEALTH, http://www.vch.ca/public-health/harm-reduction/supervised-consumption-sites/insite-user-statistics (July 2019).

99. *See* M-J. S. Milloy et al., *Estimated Drug Overdose Deaths Averted by North America's First Medically-Supervised Safer Injection Facility,* 3 PLOS ONE e3351, e3351 (2008) (estimating Insite averted between eight to fifty-one deaths in first three to four years of operation); *see also* Kerr et al., *Safer Injection Facility Use*, *supra* note 84, at 316 (finding IDUs who used Insite to inject drugs were 70% less likely to share syringes than IDUs not using the facility); *see also* Evan Wood et al., *Rate of Detoxification Service Use and Its Impacts Among Cohort of Supervised Injecting Facility Users,* 102 ADDICTION 916, 916 (2007) (concluding Insite users were more likely to initiate substance use disorder treatment and access methadone compared to those not using the site).

100. *Uniting Medically Supervised Injecting Centre*, UNITING, https://www.uniting.org/community-impact/uniting-medically-supervised-injecting-centre--msic (last visited Jan. 12, 2022).

101. MSIC EVALUATION COMM., FINAL REPORT OF THE EVALUATION OF THE SYDNEY MEDICALLY SUPERVISED INJECTING CENTRE 117 (2003), https://www.uniting.org/content/dam/uniting/documents/community-impact/uniting-msic/MSIC-final-evaluation-report-2003.pdf.

102. *See* Alex Harocopos et al., *First 2 Months of Operation at First Publicly Recognized Overdose Prevention Centers in US*, 5 JAMA NETWORK OPEN e2222149, e2222151 (2022) https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2794323___(reporting various metrics about success of New York City's two government-sanctioned OPSs).

103. *Id.* at e2222149.

104. *Id.* at e2222150–e2222151.

105. Sam Rivera (@samrivera1111), TWITTER (Aug. 26, 2022, 8:47 AM), https://twitter.com/samrivera1111/status/1563146138227597313.

significant evidence amassed by public health professionals, provide strong support for pursuing legal pathways to the implementation of OPSs in the United States. To do so effectively, U.S. advocates and policymakers must look to Canada and Australia, analyzing their implementation strategies to improve outcomes in the United States.

III. UNITED STATES

Before making comparisons to Canada and Australia, the history of the opioid overdose crisis and the legal landscape of OPSs in the United States must first be examined. Section A of this Part will trace the history of the opioid overdose crisis, paying particular attention to recent changes in the dynamics of the crisis: how fentanyl and its analogs drive the current crisis and how fatal opioid overdoses among Black, Indigenous, and People of Color (BIPOC) have continued to worsen.[106] Section B will detail the legislative history of the federal "crack house" statute, the main federal obstacle to the implementation of OPSs, and how the statute fits into the racist "War on Drugs" in the United States.[107] Section C will provide a more in-depth analysis of the Safehouse litigation, which mainly concerned whether OPSs fall within the purview of the federal "crack house" statute.[108]

A. History of the Opioid Overdose Crisis

Since 1999, the number of drug overdose deaths in the United States has quintupled.[109] In 2020 alone, 91,799 people in the United States died from an overdose.[110] From March 2021 to March 2022, a reported 107,177 people died from an overdose, an increase of 9% from the previous twelve-month period and the highest number of overdose deaths ever recorded in a twelve-month period.[111] The National Institute on Drug Abuse describes the current epidemic as "a serious national crisis that affects public health as well as social and economic welfare."[112] One study estimates that the total "economic burden" of prescription opioid misuse alone in the United States is $78.5 billion a year, including the costs of healthcare, lost productivity, substance use disorder treatment, and criminal justice involvement.[113]

Opioids are a class of drugs designed to relieve pain; they include heroin, synthetic opioids like fentanyl, and prescription pain relievers like oxycodone,

106. See *infra* Part III.A for an analysis of the history of the opioid crisis.

107. See *infra* Part III.B for an analysis of the "crack house" statute and its effects.

108. See *infra* Part III.C for an analysis of the Safehouse litigation.

109. *Understanding the Epidemic*, *supra* note 21.

110. *Id.*

111. FB Ahmad et al*., NVSS Vital Statistics Rapid Release, Provisional Drug Overdose Death Counts,* CTRS. FOR DISEASE CONTROL & PREVENTION (2022), https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

112. *Opioid Overdose Crisis*, NAT'L INST. ON DRUG ABUSE (Feb. 25, 2021), https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates.

113. Florence et al., *supra* note 93, at 901–02.

hydrocodone, codeine, and morphine.[114] The current opioid overdose crisis began in the late 1990s with U.S. pharmaceutical companies' misleading claims about the chances of patients developing substance use disorder.[115] As a result of this duplicity, the first wave of the opioid crisis was dominated by prescription opioids, particularly oxycodone, until 2010.[116] During this phase, patient-privacy laws and a lack of coordination between states resulted in users amassing prescriptions and selling their excess pills.[117] Ultimately, state and federal agencies realized the scope of the epidemic and tightened regulations around opioid prescriptions.[118]

At the same time, the supply of heroin in the United States increased, and so the second phase of the opioid epidemic began with many people who used prescription drugs switching to heroin.[119] One study estimated that people with a history of using prescription opioids were thirteen times more likely to start using heroin than those with no history of prescription opioid misuse.[120] Overdose deaths involving heroin increased almost fivefold between 2010 and 2016.[121]

In 2013, the third and current phase of the opioid epidemic began with a significant increase in overdose deaths involving synthetic opioids, specifically those involving fentanyl and its analogs.[122] Heroin dealers sought to increase their profits by mixing their products with fentanyl, which is both more potent and more deadly than heroin alone.[123] Some studies estimate that fentanyl can be up to thirty times stronger than heroin.[124]

Unlike other drug epidemics, the current epidemic is not one with a rapid spread of initiation.[125] Instead, synthetic opioids like fentanyl are frequently found "in combination with heroin, counterfeit pills, and cocaine."[126] People who use drugs might not know they are using fentanyl, be aware how much fentanyl is in their drug supply, or understand that the tolerance they have built up to other

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114. *Opioids*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/drug-topics/opioids, [https://web.archive.org/web/20220122095544/https://www.drugabuse.gov/drug-topics/opioids] (last visited Jan. 11, 2022).

115. *See* Art Van Zee, *The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy*, 99 AM. J. PUB. HEALTH 221, 221–22 (2009) (discussing promotion of OxyContin by Purdue and its effect on opioid crisis).

116. *Understanding the Epidemic*, *supra* note 21.

117. *See* Sarah DeWeerdt, *Tracing the US Opioid Crisis to Its Roots*, NATURE (Sept. 11, 2019), https://www.nature.com/articles/d41586-019-02686-2 (detailing rise of three successive waves of opioid epidemic: prescription opioids, heroin, and synthetic opioids).

118. *Id.*

119. *Id.*

120. Magdalena Cerdá et al., *Nonmedical Prescription Opioid Use in Childhood and Early Adolescence Predicts Transitions to Heroin Use in Young Adulthood: A National Study,* 167 J. PEDIATRICS 605, 605 (2015).

121. *Understanding the Epidemic*, *supra* note 21.

122. *Id.*

123. DeWeerdt, *supra* note 117.

124. RAND CORP., *supra* note 23.

125. *See id.* (explaining rapid spread of initiation as rapid rise in new people who use opioids).

126. *Understanding the Epidemic*, *supra* note 21.

opioids will not protect them from the potency of fentanyl.[127] Jonathan Caulkins, a drug-policy researcher at Carnegie Mellon University, noted that "[e]very past [drug] epidemic has been about an increase in the number of [people who use drugs] . . . This is a massive increase in death."[128] In 2020, 56,000 deaths involving synthetic opioids other than methadone occurred in the United States, accounting for 82% of all opioid-involved deaths in 2020.[129]

While the rate of overdose deaths involving heroin and prescription opioids has remained steady since 2013, the rate involving synthetic opioids was more than eleven times higher in 2019 than in 2013.[130] Research also suggests that during this time period, Black communities suffered the heaviest toll.[131] In particular, the COVID-19 pandemic has exposed existing racial disparities that contributed to the increase in overdose deaths among Black people.[132] Since 2020, overdose death rates have increased most drastically for Black and Indigenous people in the United States.[133]

Researchers at the University of Pennsylvania found that during the pandemic, overdose deaths surged more than 50% among Philadelphia's Black residents.[134] At the same time, the rate of drug overdose fatalities remained flat among white residents, even declining in some months.[135] In February 2021, the American Society of Addiction Medicine released a policy statement condemning "systemic racism in drug policy and addiction medicine."[136] Dr. Stephen Taylor, a co-author of the statement, said that Black people with opioid use disorder are viewed as "the prototype of a criminal," a lasting result of the War on Drugs.[137] A

127. *Id.*

128. DeWeerdt, *supra* note 117.

129. *Synthetic Opioid Overdose Data*, CTRS. FOR DISEASE CONTROL & PREVENTION (Jun. 6, 2022), https://www.cdc.gov/drugoverdose/deaths/synthetic/index.html.

130. Christine L. Mattson et al., *Trends and Geographic Patterns in Drug and Synthetic Opioid Overdose Deaths — United States, 2013–2019*, 70 MORBIDITY & MORTALITY WKLY. REP. 202, 202 (2021).

131. *See, e.g.*, Jasmine Drake et al., *Exploring the Impact of the Opioid Epidemic in Black and Hispanic Communities in the United States,* 6 DRUG SCI., POL'Y & L. (2020) (examining CDC Multiple Cause of Death database from 1999 to 2017 for deaths where opioid-related substances were reported as leading cause of death by race and ethnicity).

132. *See* Brian Mann, *Drug Overdose Deaths Surge Among Black Americans During Pandemic*, NPR (Mar. 3, 2021), https://www.npr.org/2021/03/03/970964576/drug-overdose-deaths-surge-among-black-americans-during-pandemic (discussing toll that concurrence of COVID-19 pandemic and opioid overdose crisis has had on Black communities)

133. *Overdose Death Rates Increased*, *supra* note 22.

134. Utsha G. Khatri et al., *Racial/Ethnic Disparities in Unintentional Fatal and Nonfatal Emergency Medical Services–Attended Opioid Overdoses During the COVID-19 Pandemic in Philadelphia*, 4 JAMA NETWORK OPEN e2034878, e2034879 (2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2775360.

135. *Id.* at e2034880.

136. Mann, *supra* note 132 (citing *Public Policy Statement on Advancing Racial Justice in Addiction Medicine*, AM. SOC'Y OF ADDICTION MEDICINE (Feb. 25, 2021), https://www.asam.org/docs/default-source/public-policy-statements/asam-policy-statement-on-racial-justiced7a33a9472bc604ca5b7ff000030b21a.pdf?sfvrsn=5a1f5ac2_2).

137. *Id.*

2019 study found that Black patients with opioid use disorders were 35% less likely than white patients to be prescribed buprenorphine, a medication used to prevent relapses and overdoses for those in substance use disorder treatment programs.[138] Inequalities like these highlight that the opioid overdose crisis continues to impact BIPOC more severely than white Americans.

On July 21, 2021, a group of state attorneys general announced that Johnson & Johnson, along with drug distributers Cardinal Health, AmerisourceBergen, and McKesson, had reached a $26 billion settlement deal releasing the companies from all civil liability in the opioid epidemic.[139] In exchange for dropping their lawsuits, thousands of state and local governments will receive funding for substance use disorder treatment, prevention services, and other steep expenses from the epidemic over the next eighteen years.[140] Nevertheless, the White House Council of Economic Advisers has estimated that the opioid crisis has cost the United States $2.5 trillion from 2015 to 2018, which represents 3.4% of the 2018 GDP alone.[141] In an opinion piece in *The Philadelphia Inquirer*, Scott Burris, director of the Center for Public Health Law Research at Temple University Beasley School of Law, stated that "Band-Aids like this settlement are fine for little cuts, but for the opioid epidemic, this country needs major surgery."[142]

The major surgery alluded to, in part, refers to a fundamental shift in the U.S. approach to drug policy.[143] While much of the blame has been placed on large, multinational pharmaceutical companies as the culprits for the immense harm caused by the opioid overdose crisis, "greater damage [has been] done by policies intended to solve the problem."[144] For example, Physicians for Responsible Opioid Prescribing, a physician advocacy organization, called for a reduction in the amount of opioids prescribed to combat the crisis;[145] their efforts have, in part, led to a significant decrease in the medical supply of opioids,[146] cutting opioid

138. Pooja A. Lagisetty et al., *Buprenorphine Treatment Divide by Race/Ethnicity and Payment,* 76 JAMA PSYCHIATRY 979, 979 (2019).

139. Jan Hoffman, *Drug Distributors and J.&J. Reach $26 Billion Deal to End Opioid Lawsuit*, N.Y. TIMES (July 21, 2021), https://www.nytimes.com/2021/07/21/health/opioids-distributors-settlement.html.

140. *Id.*

141. Council of Econ. Advisers, *The Full Cost of the Opioid Crisis: $2.5 Trillion Over Four Years,* TRUMP WHITE HOUSE (Oct. 28, 2019), https://trumpwhitehouse.archives.gov/articles/full-cost-opioid-crisis-2-5-trillion-four-years/.

142. Scott Burris, Opinion, *Opioid Settlement Announced by Attorneys General is a Band-Aid for an Epidemic*, PHILA. INQUIRER (Jul. 27, 2021), https://www.inquirer.com/opinion/commentary/opioid-settlement-pennsylvania-josh-shapiro-larry-krasner-20210727.html.

143. *See id.* (noting legislative ways United States can stop overdoses, including drug decriminalization, Food and Drug Administration reform to target predatory pharmaceutical marketing, and defunding the Drug Enforcement Agency, among others).

144. Maia Szalavitz, *We're Overlooking a Major Culprit in the Opioid Crisis*, SCI. AM. (May 28, 2021), https://www.scientificamerican.com/article/were-overlooking-a-major-culprit-in-the-opioid-crisis/.

145. *Advocacy Efforts,* PHYSICIANS FOR RESPONSIBLE OPIOID PRESCRIBING, https://www.supportprop.org/advocacy/ (last visited Jan. 11, 2022).

146. Theodore J. Cicero, *Is a Reduction in Access to Prescription Opioids the Cure for the*

prescriptions by more than 60% since 2011.[147] Many physicians have "simply stopped dealing with opioid therapy for pain," causing patients with pain to suffer as a result of efforts to combat illegal opioid use.[148] Amidst this decline in opioid prescribing, overdose death rates involving opioids in the United States nearly tripled from 2011 to 2020.[149]

This trend of reducing prescriptions while failing to safely manage opioid demand has unmistakably had dangerous and distressing consequences. With opioid overdoses at the highest they have ever been in the United States,[150] significant shifts in drug policy must ensue to combat the worsening crisis. Legalizing OPSs nationwide is one of many steps that can and should be taken to save the lives of those who overdose.

B. The Federal "Crack House" Statute

In the United States, 21 U.S.C. § 856(a), known colloquially as the federal "crack house" statute, has been identified as the main legal hindrance to implementing OPSs.[151] It makes it illegal to

> manage or control any place, whether permanently or temporarily, either as an owner, lessee, agent, employee, occupant, or mortgagee, and knowingly and intentionally rent, lease, profit from, or make available for use, with or without compensation, the place for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance.[152]

Any offender "shall be sentenced to a term of imprisonment of not more than 20 years or a fine of not more than $500,000, or both" as a criminal penalty.[153] In addition, as a civil penalty, any person who violates subsection (a) is subject to a fine "of not more than the greater of (A) $250,000; or (B) 2 times the gross receipts, either known or estimated, that were derived from each violation that is attributable to the person."[154]

1. History of the Federal "Crack House" Statute

The "crack house" statute is currently part of the Comprehensive Drug Abuse Prevention and Control Act of 1970, more commonly known as the Controlled

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Current Opioid Crisis? 108 AM. J. PUB. HEALTH 1322, 1322 (2018).

147. THE IQVIA INST. FOR HUM. DATA SCI., PRESCRIPTION OPIOID TRENDS IN THE UNITED STATES: MEASURING AND UNDERSTANDING PROGRESS IN THE OPIOID CRISIS 3 (2020), https://www.iqvia.com/insights/the-iqvia-institute/reports/prescription-opioid-trends-in-the-united-states.

148. Cicero, *supra* note 146, at 1322.

149. *Overdose Death Rates Involving Opioids, by Type*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/data/OD-death-data.html (May 20, 2022).

150. *See* Ahmad, *supra* note 111 (discussing preliminary data on overdose deaths in 2021).

151. *See* SAFEHOUSE, *supra* note 15.

152. 21 U.S.C. § 856(a)(2).

153. 21 U.S.C. § 856(b).

154. 21 U.S.C. § 856(d).

Substances Act (CSA).[155] However, the original CSA legislation did not include the "crack house" statute. As a partial response to the rise of "crack houses" in the 1980s, Congress passed the Anti-Drug Abuse Act of 1986 (the Act), including the statute for the first time.[156] The Act most notably introduced mandatory minimum sentences for cocaine distribution, with "far more severe punishment for distribution of crack—associated with [B]lacks—than powder cocaine, associated with whites."[157] For example, it made the distribution of five grams of crack cocaine carry a minimum five-year prison sentence but made the distribution of 500 grams of powder cocaine, 100 times the amount of crack cocaine, carry the same sentence.[158]

The United States Sentencing Commission concluded in 1984 that crack is not appreciably different from powder cocaine in either its chemical composition or the physical reactions of its consumers.[159] Despite this finding, the stark difference between sentencing Black offenders and white offenders continued.[160] Former advisor to President Nixon and convicted Watergate conspirator John Ehrlichman, in a previously unreleased interview with *Harper's Magazine* in 1994, said,

> The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and Black people . . . . We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did.[161]

President Nixon first declared a "War on Drugs" in 1971, and his policy of criminalizing drugs, with a racist focus on Black communities, was renewed by President Reagan in the 1980s.[162] Members of Congress rushed to pass the Anti-Drug Abuse Act of 1986 based on the belief that the nation was "under siege from crack."[163] Part of their urgency in passing the legislation was to give prosecutors a stronger legal basis to shut down crack houses.[164]

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155. 21 U.S.C. § 811.

156. United States v. Safehouse, 985 F.3d 225, 230 (3d Cir. 2021), *cert. denied*, 142 S.Ct. 345 (2021).

157. MICHELLE ALEXANDER, THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS 52 (New Press 1st ed. 2010).

158. DEBORAH J. VAGINS & JESSELYN MCCURDY, CRACKS IN THE SYSTEM: TWENTY YEARS OF THE UNJUST FEDERAL CRACK COCAINE LAW i (2006), https://www.aclu.org/other/cracks-system-20-years-unjust-federal-crack-cocaine-law.

159. *Id.* at 6.

160. ALEXANDER, *supra* note 157, at 109–10.

161. Dan Baum, *Legalize It All: How to Win the War on Drugs*, HARPER'S MAG., Apr. 2016, at 22, 22.

162. *A Brief History of the Drug War,* DRUG POL'Y ALL., https://drugpolicy.org/issues/brief-history-drug-war (last visited Jan. 12, 2022).

163. William Spade Jr., *Beyond the 100:1 Ratio: Towards a Rational Cocaine Sentencing Policy*, 38 ARIZ. L. REV. 1233, 1249–52 (1996).

164. *See* 132 CONG. REC. 26447 (statement of Sen. Lawton Chiles) (explaining how the Act would help law enforcement by strengthening criminal penalties for controlled substances like crack).

During the Senate floor debate on the Act on September 26, 1986, Senator Bob Dole (R-KS) defined crack houses as "houses or buildings where 'crack' cocaine and other drugs are manufactured and used."[165] Before the Act became law, the only way for police and prosecutors to shut down the houses was with conspiracy and distribution charges.[166] Crack houses were, at the time, perceived to be central to community problems with "drug smuggling, drug abuse, and violence".[167] For example, *The New York Times* in 1989 stated in a front-page exposé of the drug crisis in Columbus, Ohio, that "little of the prosperity of this city of predominantly white-collar jobs has reached the inner-city neighborhoods; here, as in other urban areas, a far more insidious kind of consumer culture is spreading: the culture of the crack house."[168] The inclusion of § 416 of the Anti-Drug Abuse Act gave federal law enforcement officers a legal basis to crack down on the houses without hesitation.[169]

2. The Federal "Crack House" Statute Today

Congress passed the Act with twenty-nine co-sponsors in the Senate, but it did not include the exact language that now appears in federal law.[170] The version of 21 U.S.C. § 856(a)(2) included in the 1986 bill stated that it shall be unlawful to:

> Manage or control any building, room, or enclosure, either as an owner, lessee, agent, employee, or mortgagee, and knowingly and intentionally rent, lease, or make available for use, with or without compensation, the building, room, or enclosure for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance.[171]

The current version of the "crack house" statute, however, is the product of the Illicit Drug Anti-Proliferation Act of 2003, a further amendment to the CSA.[172] By changing the language from "any building, room, or enclosure," to "any place, whether permanently or temporarily," the "crack house" statute could reach indoor and outdoor venues and one-off events.[173] The purpose of this expansion was based

165. *Id.* at 26474 (statement of Sen. Bob Dole).

166. United States v. Safehouse, 985 F.3d 225, 230 (3d Cir. 2021), *cert. denied*, 142 S.Ct. 345 (2021); *see, e.g.*, United States v. Jefferson, 714 F.2d 689, 691–92 (7th Cir. 1983), *vacated on other grounds*, 474 U.S. 806 (1985).

167. *See* John Kifner, *As Crack Moves Inland, Ohio City Fights Back*, N.Y. TIMES (Aug. 29, 1989), https://www.nytimes.com/1989/08/29/us/as-crack-moves-inland-ohio-city-fights-back.html (reporting communities in Iowa, Colorado, and other states noted serious problems with drug smuggling, drug abuse, and violence linked to rise in crack and crack houses).

168. *Id.*

169. *Compare Safehouse*, 985 F.3d at 230, *with* Anti-Drug Abuse Act, H.R. 5484, 99th Cong. § 416 (1986).

170. *Compare* 21 U.S.C. § 856(a)(2), *with* Anti-Drug Abuse Act, H.R. 5484, 99th Cong. § 416(a)(2) (1986).

171. Anti-Drug Abuse Act, H.R. 5484, 99th Cong. § 416(a)(2) (1986).

172. Illicit Drug Anti-Proliferation Act of 2003, S. 226, 108th Cong. §2(a)(2) (2003).

173. Prosecutorial Remedies and Tools Against the Exploitation of Children Today (PROTECT) Act of 2003, Pub. L. No. 108-21, § 608, 117 Stat. 650, 691 (2003) (codified as amended at 21 U.S.C. § 856(a)); *see also* Jacob A. Epstein, Note, *Molly and the Crack House*

on fear about teenage ecstasy use at raves; the original amendment was aptly named the RAVE Act (Reducing Americans' Vulnerability to Ecstasy Act).[174] Nevertheless, the RAVE Act never came to a vote after many co-sponsors withdrew their support in 2002.[175]

The Illicit Drug Anti-Proliferation Act of 2003 also added the civil penalty section to the "crack house" statute.[176] A civil penalty is meant to be remedial in nature, reimbursing the government for the actual costs arising from a defendant's conduct.[177] In *United States v. Halper*, the U.S. Supreme Court held that civil penalties that far exceed criminal penalties without any remedial benefit are impermissible, reasoning that such penalties would violate the Double Jeopardy Clause of the Fifth Amendment in the U.S. Constitution.[178]

However, in *Hudson v. United States*, the Supreme Court abrogated its holding in *Halper*, instead stating that the Double Jeopardy Clause only protects against the imposition of multiple criminal punishments for the same offense.[179] As a result, defendants can face subsequent legal actions for the same violation, so long as Congress labels one set of punishments "civil."[180] Thus, by adding a civil penalty to the "crack house" statute, the Illicit Drug Anti-Proliferation Act of 2003 established greater consequences for any violation of subsection (a).[181]

C. Safehouse Litigation

The Safehouse litigation initiated by U.S. Attorney William McSwain, the former federal prosecutor for the Eastern District of Pennsylvania, details the legal arguments around the "crack house" statute and whether it prohibits the opening of OPSs in the United States.[182]

1. Statutory Interpretation of the Federal "Crack House" Statute

Before Safehouse had a chance to open its OPS, McSwain filed a civil lawsuit in February 2019 asking the court to issue a declaration that OPSs violated the federal "crack house" statute.[183] The litigation focused specifically on the last

Statute: Vulnerabilities of a Recuperating Music Industry, 23 U. MIAMI BUS. L. REV. 95, 103–04 (2014) (discussing changes made by amendment).

174. Alex Kreit, *Safe Injection Sites and the Federal "Crack House" Statute*, 60 B.C. L. REV. 414, 430 (2019).

175. Epstein, *supra* note 173, at 104.

176. Illicit Drug Anti-Proliferation Act, S. 226, 108th Cong. §3 (2003).

177. 22A C.J.S. *Criminal Procedure and Rights of Accused* § 610 (2022).

178. United States v. Halper, 490 U.S. 435 (1989), *abrogated by* Hudson v. United States, 522 U.S. 93 (1997).

179. Hudson v. United States, 522 U.S. 93 (1997).

180. Cory C. Kirchert & Adriaen M. Morse Jr., *Double Enforcers, Double Penalties, Double Jeopardy, and Double Talk,* ARNALL GOLDEN GREGORY LLP (July 27, 2020), https://www.agg.com/news-insights/publications/double-enforcers-double-penalties-double-jeopardy-and-double-talk/.

181. Illicit Drug Anti-Proliferation Act, S. 226, 108th Cong. §3 (2003).

182. United States v. Safehouse, No. 19-0519, slip op. at 1–2 (E. D. Pa. Feb. 25, 2020).

183. *Id.*

phrase of § 856(a)(2), "for the purpose of . . . using a controlled substance."[184] Safehouse asserted that to violate this phrase, the organization itself would need to have the specific purpose that its visitors use drugs.[185] On the other hand, the federal government asserted that the plain text of § 856(a)(2) demands "only the visitors need that purpose; Safehouse just needs to intentionally open its facility to visitors it knows will use drugs there."[186]

At the district level, Judge Gerald McHugh held that Safehouse's interpretation of § 856(a)(2) was proper; Safehouse would not manage or control its OPS for the purpose of using a controlled substance.[187] Judge McHugh rejected the federal government's position as "an overly simplistic formulation of 'purpose,' one that it struggled to defend at oral argument."[188] For example, the government admitted during oral argument that Safehouse could avoid violating § 856(a)(2) under its definition of "purpose" if it maintained an OPS out of a mobile van rather than a fixed piece of real property, so long as no one using drugs "c[a]me into the mobile unit."[189] Moreover, when Judge McHugh asked the government whether parents instructing their child to use unlawful drugs in their home so that they could respond in the event of an overdose would violate § 856(a)(2), the government responded that parents would not violate the statute in that situation.[190] Judge McHugh noted that this was "contrary to its previously avowed core reading of the statute . . . ."[191]

Upon appeal, the Third Circuit rejected Judge McHugh's and Safehouse's interpretation of § 856(a)(2), favoring the federal government's plain text reading instead.[192] To violate the statute, "Safehouse need only 'knowingly and intentionally' open its site to visitors who come 'for the purpose of . . . using' drugs."[193] Thus, only visitors must have the purpose to use drugs, not Safehouse itself, so long as Safehouse has opened a facility where it knows its visitors will use them.[194] The court stated that "this conclusion follows from the law's language and grammar" [195] because it avoids redundancy between (a)(2) and (a)(1), which makes it unlawful to "knowingly open, lease, rent, use, or maintain any place, whether permanently or temporarily, for the purpose of manufacturing,

184. United States v. Safehouse, 985 F.3d 225, 232 (3d Cir. 2021), *cert. denied*, 142 S.Ct. 345 (2021).

185. *Id.*

186. *Id.*

187. *Safehouse*, slip op. at 3.

188. *Id.* at 3.

189. Transcript of Oral Argument at 38–39, United States v. Safehouse, No. 19-0519 (E. D. Pa. Feb. 25, 2020).

190. *See id.* at 35–36 (" . . . would not be a violation of the 856 because it's only incidental and the parents are trying to stop the drug use.").

191. *Safehouse*, slip op. at 3.

192. United States v. Safehouse, 985 F.3d 225, 232 (3d Cir. 2021), *cert. denied*, 142 S.Ct. 345 (2021).

193. *Id.*

194. *Id.*

195. *Id.* at 233.

distributing, or using any controlled substance."[196]

Here, the court noted that § 856 (a)(1) bars a defendant from operating a place for his *own* purpose of using a controlled substance; (a)(2) would not have been included in § 856 if it did not have a distinct purpose from (a)(1).[197] The language of (a)(2), the court added, requires "at least two actors: a defendant and a third party."[198] The defendant must "manage or control any place" and "knowingly and intentionally rent, lease, profit from, or make [it] available for use" whereas the third party must have "the purpose of unlawfully . . . using a controlled substance."[199] The court likened tying a defendant's liability to a third party's state of mind to *Pinkerton* liability, where co-conspirators can still be liable for murder by a third party without sharing the third party's specific intent to kill when the co-conspirators could reasonably foresee that the third party would kill in furtherance of the conspiracy.[200]

The court in *Safehouse* also decided not to consider Congress's intent when it passed § 856(a)(2) in 1986 and amended it in 2003, excluding the statute's history from its analysis.[201] It stated that "if the text of a criminal statute 'is plain . . . the sole function of the courts is to enforce it according to its terms.'"[202] Safehouse argued that Congress intended to target crack houses with the statute, never expecting it to apply to OPSs.[203] The court admitted this was true but did not concern itself with Congress's intent because "the text is clear."[204]

Additionally, Safehouse proposed that Congress's recent efforts to combat substance use disorder, such as passing the Comprehensive Addiction and Recovery Act in 2016 and lifting the ban on federal funding of syringe-exchange programs through the Consolidated Appropriations Act of 2016, elicit a reading of § 856(a)(2) that "harmonize[s]" it with these federal efforts.[205] The court rejected this argument, for if the statute "undermines Congress's current efforts to fight opioids, Congress must fix it; we cannot."[206]

196. *Id.*

197. *See id.* at 235 (explaining paragraph (a)(1) relates to defendant's purpose and court should read paragraph (a)(2) as to not render paragraph (a)(1) surplusage).

198. *Id.* at 234.

199. 21 U.S.C. § 856(a)(2).

200. Pinkerton v. United States, 328 U.S. 640, 646–48 (1946); *e.g.*, United States v. Gonzales, 841 F.3d 339, 351–52 (5th Cir. 2016); *e.g.*, United States v. Alvarez, 755 F.2d 830, 848–49 (11th Cir. 1985).

201. *See Safehouse*, 985 F.3d at 238–39.

202. *Id.* (citing Caminetti v. United States, 242 U.S. 470, 485 (1917)).

203. *Id.* at 238.

204. *Id.* at 239.

205. *Id.*; Comprehensive Addiction and Recovery Act, S. 524, 114th Cong. (2016); Consolidated Appropriations Act, 2016, H.R. 2029, 114th Cong. (2015).

206. *Safehouse*, 985 F.3d at 239.

2. Third Circuit's Rejection of Commerce Clause Argument

The Third Circuit also rejected Safehouse's argument about the constitutionality of § 856(a)(2)[207]—that Congress's passage of the statute was an improper extension of its ability to regulate interstate commerce under the Commerce Clause.[208] The constitutional basis for the CSA lies within the Commerce Clause,[209] which gives Congress the power "to regulate commerce . . . among the several states."[210] Safehouse contended that Congress did not use this power appropriately when it passed § 856(a)(2) because Congress was regulating local, noncommercial behavior by prohibiting the operation of an OPS.[211] Safehouse would not have charged visitors for using its consumption room, so it argued that Congress could not regulate an activity that was not "commerce."[212] Moreover, it asserted that the prohibited activity, "managing or controlling any place . . . for the purpose of . . . using a controlled substance," would not have been interstate.[213]

Though Judge McHugh declined to comment on this argument in district court, the Third Circuit unanimously held that applying § 856(a)(2) to Safehouse is a valid exercise of Congress's power over interstate commerce.[214] Relying on the Supreme Court's influential holding in *Gonzalez v. Raich*, where the Court stated that Congress "can regulate local, noncommercial activity when that activity will affect a national market,"[215] the Third Circuit proclaimed that "[e]ven though Safehouse's consumption room will be local and free, the Act bans it as part of shutting down the national market for drugs."[216]

The court first articulated that Congress can regulate "activities that substantially affect interstate commerce" in *United States v. Lopez*, so long as Congress has a rational basis for deciding that an activity has substantial economic effects.[217] That activity need not substantially affect interstate commerce alone, for in *Wickard v. Filburn*, the Supreme Court held that a noncommercial activity, like growing excess wheat for home consumption, can substantially affect interstate commerce in aggregate.[218] In addition, the Third Circuit explained Congress can regulate a local noneconomic activity under its Commerce Clause power as part of

207. *Id.* at 253.

208. *Id.* at 239.

209. *See* 21 U.S.C.A. § 801(3) (expressing Congress's finding that a major portion of controlled substances flows through interstate commerce and such a flow has a substantial effect on interstate commerce).

210. U.S. CONST. art. I, § 8, cl. 3.

211. *Safehouse*, 985 F.3d at 239.

212. *Id.*

213. *Id.* at 230.

214. *Id.* at 239; *see also* United States v. Safehouse, No. 19-0519, slip op. at 1 (E. D. Pa. Feb. 25, 2020) (explaining how Judge McHugh believed statutory interpretation was sufficient to hold for Safehouse in district court).

215. *Safehouse*, 985 F.3d at 239 (citing Gonzalez v. Raich, 545 U.S. 1, 9 (2005)).

216. *Id.*

217. *Id.* at 240 (citing United States v. Lopez, 514 U.S. 549, 558–59 (1995)).

218. *Id.* at 240 (citing Wickard v. Filburn, 317 U.S. 111, 114 (1942)).

a larger regulatory scheme.[219] When it does so, Congress need only choose means that are "'reasonably adapted' to the attainment of a legitimate end under the commerce power."[220]

The majority in *Safehouse* asserted that § 856(a)(2) was a proper extension of Congress's commerce power under both the comprehensive regulatory scheme and aggregate economic effect rationales.[221] In passing the CSA, the court reasoned that Congress aimed to suppress a national and international drug market that posed a national threat.[222] Thus, § 856(a)(2) must be "reasonably adapted" to the regulatory scheme created by the CSA as per *Raich*.[223]

The Third Circuit underscored the Supreme Court's decision in *Raich*, which upheld the CSA's ban on local production and possession of marijuana for personal medical use because the ban was "part of a comprehensive regulatory scheme to shut down the interstate market in marijuana."[224] In the same way, § 856(a)(2) is part of such a scheme because it regulates where drug activities are "likely to flourish."[225] Furthermore, the Third Circuit held that making properties available for drug use is economic activity because "making consumption easier and safer will lower its risk and so could increase consumption."[226] Increased consumption would lead to greater market demand, substantially impacting interstate commerce.[227]

3. Current Status of Safehouse Litigation

With both Safehouse's Commerce Clause and statutory interpretation arguments denied by the Third Circuit, § 856(a)(2) remains the most substantial barrier to the implementation of OPSs in the United States. Safehouse petitioned for a writ of certiorari to appeal the case to the Supreme Court of the United States.[228] A group of eleven attorneys general, led by District of Columbia Attorney General Karl Racine, filed an amicus curiae brief in support of Safehouse,[229] yet the Supreme Court denied its petition on October 12, 2021.[230]

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219. *See, e.g.*, Rybar v. United States, 522 U.S. 807 (1997) (upholding federal ban on possessing certain machine guns because statute sought to halt interstate gun trafficking; to shut down interstate market, had to reach intrastate possession); *see also* United States v. Rodia, 194 F.3d 465 (3d Cir. 1999) (discussing intrastate possession of child pornography). *Cf.* United States v. Lopez, 514 U.S. 549 (1995) (upholding federal ban on possessing guns near a school struck down because connection to interstate commerce was too tenuous); United States v. Morrison 529 U.S. 598 (2000) (discussing violence against women).

220. Gonzalez v. Raich, 545 U.S. 1, 9 (2005) (Scalia, J., concurring) (quoting United States v. Darby, 312 U.S. 100, 121 (1941)).

221. *Safehouse*, 985 F.3d at 240.

222. *Id.* at 241.

223. *Id.*

224. *Id.* (citing *Gonzales*, 545 U.S. at 19, 23–24).

225. *Id*.

226. *Id.* at 242.

227. *See id.* at 243 ("Drugs typically flow through interstate markets before someone possesses them . . . . And intrastate possession helps swell the interstate market.").

228. Brief for the Petitioner, Safehouse v. United States, 595 U.S. 1 (2021) (No. 21-276).

229. Brief for the District of Columbia and the State of Delaware et al. as Amici Curiae

Notably, the Office of the Solicitor General, acting under the new Biden administration, waived its right to respond to the petition.[231]

The case is now on remand in the U.S. District Court for the Eastern District of Pennsylvania, where Safehouse plans to assert an argument that Judge McHugh had not weighed in on when originally ruling for Safehouse.[232] Safehouse argues its founders' sincerely held religious beliefs motivate them to save lives, and therefore they have a right to open an OPS under the Religious Freedom Restoration Act (RFRA).[233] As of August 8, 2022, Safehouse and the Department of Justice have agreed to continue discussions about the legal status of OPSs until the extended deadline for the Department of Justice to file its response to Safehouse in district court on September 22, 2022.[234]

IV. CANADA

Canada became the first country in North America to house a government-sanctioned OPS when activists in Vancouver opened Insite in September 2003.[235] Section A of this Part describes the events that led to the opening of Insite in 2003, including the acts of civil disobedience that were critical to its implementation and the subsequent expansion of OPSs across Canada after Insite had opened.[236] Section B pays specific attention to the litigation around Insite which led to the Supreme Court's decision that the possession and trafficking provisions of Canada's Controlled Drugs and Substances Act (CDSA), in denying meaningful access to Insite without an exemption, violated section 7 of the *Charter of Rights and Freedoms*.[237] Sections B and C further detail the current legal landscape of OPSs in Canada and how that landscape has made the opening and operation of OPSs in some provinces challenging.[238]

A. Historical Context

Insite received government approval after years of advocating to open a government-sanctioned OPS in Vancouver in response to both the AIDS epidemic

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Supporting Petitioner, Safehouse v. United States, 595 U.S. 1 (2021) (No. 21-276), 2021 WL 4462996.

230. Order Denying Certiorari, 595 U.S. 1, 5 (2021).

231. Waiver of Response by Acting Solicitor General Brian H. Fletcher, Safehouse v. United States, No. 21-0276 (Sept. 7, 2021).

232. Safehouse's Amended Counterclaims for Declaratory and Injunctive Relief, Safehouse v. United States, No. 2:19-cv-00519, E.D. Pa. (Sept. 17, 2021).

233. *Id.*

234. @SafehousePhilly, TWITTER (Aug. 8, 2022, 9:44 PM), https://twitter.com/SafehousePhilly/status/1556818651151536129.

235. Dan Small et al., *The Establishment of North America's First State Sanctioned Supervised Injection Facility: A Case Study in Culture Change*, 17 INT'L J. DRUG POL'Y 73, 73 (2006).

236. See *infra* Part IV.A for a discussion of the historical context Insite's opening.

237. See *infra* Part IV.B for an analysis of litigation surrounding Insite.

238. See *infra* Parts IV.B and IV.C for an analysis of the current legal landscape of OPSs in Canada.

and increasing overdoses in the city.[239] In 1994, the Provincial Chief Coroner of British Columbia formed a task group that produced the "Cain Report," and one of its recommendations was that Vancouver explore OPSs to combat the city's growing reputation as "Canada's overdose capital."[240] Though no immediate government action was taken to open an OPS after the report,[241] a more nuanced view of drug use and substance use disorder began to emerge in the city where then-Mayor Philip Owen once said, "We feel fundamentally that users are sick and pushers are evil."[242]

In 1995, IV Feed, a community- and peer-led group, opened an unsanctioned OPS under the leadership of activist Ann Livingston;[243] it was known as the "Back Alley."[244] Various nonprofit agencies and foundations funded the OPS—often without their knowledge of what the funds were being used for.[245] Police closed the site after about one year of its operation,[246] and no OPS operated in Vancouver until 2000, when the Harm Reduction Action Society (HRAS, pronounced "harass") established a second unsanctioned site at 217 Dunlevy Street.[247] The organization co-organized a demonstration at Oppenheimer Park in Downtown Eastside Vancouver where activists planted two thousand crosses in the ground, announcing that they would open an OPS "legal or not."[248] The OPS remained open until early 2001, when it closed amidst pressure from local police and policymakers.[249]

Around the same time, the city released its Four Pillar Drug Strategy,[250] answering the important question of how OPSs would fit into the existing framework of community responses to the growing overdose crisis .[251] The strategy called for two government-sanctioned OPSs to open in Vancouver, and though the city council endorsed the strategy, the city itself did not have the

239. *See* Kerr et al., *SIFs in Canada*, *supra* note 31, at 1–2 (describing early background and history of safe injection facilities in Vancouver).

240. Miro Cernetig, *Death Likes Canada's Overdose Capital. Vancouver Health Officials Fighting to Prevent Crisis*, GLOBE & MAIL (B.C.), May 4, 1996, at A1; *see also* Thomas B. Lawrence, *High-Stakes Institutional Translation: Establishing North America's First Government-Sanctioned Supervised Injection Site*, 60 ACAD. MGMT. J. 1771, 1779 (2017) (stating substantial rise in British Columbia's overdose rate prompted convening of the task force);.

241. Lawrence, *supra* note 240, at 1779.

242. Suzanne Fournier, *Drug Strategy Unveiled: Frontline Workers Say They Don't Need More Talk. They Need Action*, THE PROVINCE (B.C.), November 22, 2000, at A10.

243. Kerr et al., *SIFs in Canada*, *supra* note 31, at 1–2.

244. Lawrence, *supra* note 240, at 1782.

245. *Id.* at 1783.

246. Kerr et al., *SIFs in Canada*, *supra* note 31, at 2.

247. Lawrence, *supra* note 240, at 1783.

248. *Id.*

249. *Id.*

250. *See* Donald MacPherson et al., *The Evolution of Drug Policy in Vancouver, Canada: Strategies for Preventing Harm from Psychoactive Substance Use,* 17 INT'L J. DRUG POL'Y 127, 128 (2006) (summarizing prevention priorities, areas of action, and recommendations from Four Pillars Drug Strategy).

251. Lawrence, *supra* note 240, at 1784.

authority to open the sites because provinces are responsible for the administration of healthcare in Canada.[252] It was not until the Portland Hotel Society (PHS) covertly built an OPS in a seemingly vacant building in Vancouver that the first government-sanctioned OPS became operational in Canada.[253]

PHS constructed its OPS in secret, announcing publicly that it had built the site to pressure the regional health authority into working with the organization to establish an OPS legally.[254] Shortly before PHS's announcement, Health Canada, the department within Canada's national government which oversees aspects of health policy,[255] released its guidance on how individual municipalities could open OPSs in the country.[256] With this guidance, PHS opened Insite, an OPS which included thirteen spaces for injecting, open eighteen hours a day from 10:00 AM to 4:00 AM.[257] Insite was permitted to open "under the condition that it operate as a scientific pilot and be rigorously evaluated."[258] Since its opening, Insite has continued to meet its initial objectives around preventing overdoses,[259] limiting the spread of infectious diseases,[260] reducing public disorder,[261] and referring people who use drugs to external programs like substance use treatment programs.[262]

Soon thereafter, various other municipalities established government-sanctioned OPSs, including Toronto,[263] Ottawa,[264] Victoria,[265] and Montreal.[266] As

252. Kerr et al., *SIFs in Canada*, *supra* note 31, at 2.

253. *Id.*

254. *See* Small et al., *supra* note 235, at 78 (analyzing different legal and political factors considered by PHS while discretely opening OPS).

255. *Health Canada*, GOV'T OF CAN., https://www.canada.ca/en/health-canada.html (Dec. 15, 2022).

256. Kerr et al., *SIFs in Canada*, *supra* note 31, at 2.

257. *Id.* There was some experimentation with a 24-hour model as well. *Id.*

258. *Id.*

259. *Id.*; *see also* Brandon D. L. Marshall et al., *Reduction in Overdose Mortality After the Opening of North America's First Medically Supervised Safer Injecting Facility: A Retrospective Population-Based Study*, 377 LANCET 1429, 1429 (2011) (finding fatal overdose rate within 500 meters of the SIF decreased by 35% after opening of the SIF).

260. *See* Kerr et al., *Safer Injection Facility Use*, *supra* note 84, at 316 (finding infectious disease transmission, particularly transmission of HIV, had decreased as a result of Insite).

261. *See* Evan Wood et al., *Changes in Public Order After the Opening of a Medically Supervised Safer Injecting Facility for Illicit Injection Drug Users*, 171 CAN. MED. ASS'N J. 731, 733 (2004) (determining opening of Insite was independently associated with reduced public injection drug use and public syringe disposal).

262. *See* Evan Wood et al., *Rate of Detoxification Service Use and Its Impact Among a Cohort of Supervised Injecting Facility Users*, 102 ADDICTION 916, 916 (2007) (finding Insite's opening was associated independently with increased rates of long-term substance use disorder treatment initiation).

263. *Supervised Consumption Services*, CITY OF TORONTO, https://www.toronto.ca/community-people/health-wellness-care/health-programs-advice/supervised-injection-services/ (last visited Jan. 12, 2022).

264. *Harm Reduction Services in Ottawa*, OTTAWA PUB. HEALTH, https://www.ottawapublichealth.ca/en/public-health-topics/harm-reduction-services-in-ottawa.aspx (last visited Jan. 12, 2022).

265. *Overdose Prevention & Supervised Consumption Locations*, ISLAND HEALTH, https://www.islandhealth.ca/our-locations/overdose-prevention-supervised-consumption-locations

of early 2020, Canada had thirty-nine OPSs operating legally, with an estimated three thousand visits to an OPS happening in Canada daily.[267] These OPSs attended to fifteen thousand overdoses and drug-related emergencies between 2017 and 2019.[268] Furthermore, in the same time period, legal OPSs in Canada made about seventy thousand referrals to such services as substance use treatment, medical care, mental health support, and housing services.[269] Canada has even established the first "women-only, community-accessible" OPS in the world.[270] The site, named SisterSpace, is located in Vancouver's Downtown Eastside near Insite.[271]

B. Legalization and Current Legal Landscape of OPSs

Insite was granted approval from the federal Health Minister to operate in 2003.[272] Specifically, the Health Minister granted an exemption to Insite under section 56 of the Controlled Drugs and Substances Act (CDSA).[273] This section explicitly gives the Health Minister the discretion to grant exemptions to any provision in the CDSA, including those which prohibit the possession (section 4(1)) and trafficking (section 5(1)) of controlled substances.[274] Therefore, visitors would not be charged for possessing the opioids they used at Insite, and supervisors would not be charged for aiding or abetting such drug use because the use itself was not prohibited.[275]

(last visited Jan. 12, 2022).

266. René Bruemmer, *'They Save Lives': Montreal's Safe-Injection Sites Report on Year One*, MONTREAL GAZETTE (June 18, 2018), https://montrealgazette.com/news/local-news/they-save-lives-montreals-safe-injection-sites-report-on-year-one.

267. *Canadian Supervised Consumption Sites Statistics—2017 to 2019*, GOV'T OF CAN. DATA BLOG, https://health-infobase.canada.ca/datalab/supervised-consumption-sites-blog.html (last visited Jan. 12, 2022).

268. *Id.*

269. *Id.*

270. *SisterSpace*, ATIRA WOMEN'S RES. SOC'Y, https://atira.bc.ca/what-we-do/program/sisterspace/ (last visited Jan. 16, 2022).

271. Melanie Nagy, *SisterSpace: Canada's First and Only Overdose Prevention Site for Women Is Saving Lives*, CTV NEWS (May 27, 2021, 10:00 PM), https://www.ctvnews.ca/health/sisterspace-canada-s-first-and-only-overdose-prevention-site-for-women-is-saving-lives-1.5446190.

272. Kerr et al., *SIFs in Canada*, *supra* note 31, at 2.

273. Agarwal, *supra* note 30, at 42.

274. Controlled Drugs and Substance Act, S.C. 1996, c 19, s 56 [CDSA]. Section 56 of the CDSA reads: "The Minister may, on such terms and conditions as the Minister deems necessary, exempt any person or class of persons or any controlled substance or precursor or any class thereof from the application of all or any of the provisions of this Act or the regulations if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest." *Id.*

275. *See* Agarwal, *supra* note 30, at 42 (detailing how an exemption granted under section 56 permits simple possession by Insite users); *see also* Liz Evans, *What UN Really Said About Safe Injection Site*, TIMES COLONIST (Vict.), Mar. 12, 2007, at A7 (describing how decision prepared by UN Office of Drug and Crime recognized it is not the intent of places like Insite to aid, abet, or facilitate possession of drugs).

The Health Minister granted the exemption to the Vancouver Coastal Health Authority, the division of Canada's health authority responsible for health administration in Vancouver itself.[276] As a result, PHS and the Vancouver Coastal Health Authority operated Insite in partnership.[277] The guidelines provided by Health Canada with the exemption permitted Insite to operate for a three-year pilot period.[278] However, in 2006 (the final year of the pilot study), Canada elected a new Conservative government that had been "publicly vocal in its opposition to harm reduction and Insite in particular."[279] The exemption expired on June 30, 2008, and the new government did not renew it.[280] Consequently, PHS and two users of Insite, Dean Wilson and Shelley Tomic, commenced an action in the Supreme Court of British Columbia seeking injunctive relief to keep Insite operational.[281]

PHS brought forward two constitutional arguments: (1) that Insite was protected from the application of the CDSA—a federal statute—as a provincial health undertaking per Canada's division-of-powers doctrine of interjurisdictional immunity; and (2) the possession and trafficking provisions of the CDSA, in denying meaningful access to Insite without an exemption, violate section 7 of the *Charter of Rights and Freedoms*.[282] This section of the *Charter*, titled "Life, Liberty, and Security of Person," states, "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."[283]

The trial court rejected the first argument but accepted the second, declaring that the possession and trafficking provisions of the CDSA violated section 7 of the *Charter*.[284] The Canadian government then appealed to the British Columbia Court of Appeal, where the claimants cross-appealed the dismissal of their division of powers claim.[285] The appeals court held for the claimants on both of their constitutional arguments—the division of powers argument and the *Charter* issue—so the federal government then appealed to the Supreme Court of Canada.[286]

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276. Kathleen Dooling & Michael Rachlis, *Vancouver's Supervised Injection Facility Challenges Canada's Drug Laws*, 182 CAN. MED. ASS'N J. 1440, 1441 (2010).

277. *Insite - Supervised Consumption Site*, VANCOUVER COASTAL HEALTH, http://www.vch.ca/locations-services/result?res_id=964 (last visited Jan. 16, 2022).

278. Kerr et al., *SIFs in Canada*, *supra* note 31, at 2.

279. *Id.*

280. Agarwal, *supra* note 30, at 42.

281. Kerr et al., *SIFs in Canada*, *supra* note 31, at 3.

282. Agarwal, *supra* note 30, at 42.

283. Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, *being* Schedule B to the Canada Act, 1982, c 11, § 7 (U.K.).

284. PHS Community Services Society v. Attorney General of Canada, 2008 BCSC 661, paras. 117–121, 140–153, *aff'd in part, rev'd in part*, 2010 BCCA 15, *aff'd in part, rev'd in part*, 2011 SCC 44, [2011] 3 S.C.R. 134.

285. PHS Community Services Society v. Canada (Attorney General), 2010 BCCA 15, paras. 77, 193, *aff'd in part, rev'd in part*, 2011 SCC 44, [2011] 3 S.C.R. 134.

286. *Id.*

In a unanimous decision, the Supreme Court of Canada ruled in favor of the claimants, concurring with the two lower courts that the possession and trafficking provisions of the CDSA infringed section 7 of the *Charter*.[287] The Court did not find that interjurisdictional immunity applied to immunize Insite from the application of the CDSA but paid more attention to the *Charter* analysis.[288] While it did not hold that the possession and trafficking provisions themselves infringed any of the interests defined in section 7 of the *Charter*, it did state that "the Minister's refusal to renew/approve the exemption that expired on June 30, 2008 was contrary to [§] 7. The resulting application of [§] 4(1) of the CDSA to Insite's staff and users was arbitrary and grossly disproportionate, and therefore contravened the principles of fundamental justice."[289]

The Court then made an order of mandamus requiring the Minister to grant an exemption to Insite under section 56 of the CDSA, declaring that such an order was the remedy best suited to enforce the claimants' *Charter* rights "in a responsive and effective manner."[290] Nevertheless, *PHS* did not establish *explicit* precedent for the legal opening of OPSs in Canada other than Insite, for the holding relied heavily on evidence specific to Insite.[291] The Supreme Court of Canada instead granted the federal government one year to amend its guidance allowing OPSs to operate legally.[292] In response, the majority government passed Bill C-2, listing twenty-six conditions that must be met before an OPS could operate.[293] The Bill was more restrictive than Insite's initial guidance, with such conditions as local community and police support added to make it more difficult for OPSs to open.[294]

The landscape of OPSs in Canada subsequently involved several municipalities undertaking OPS feasibility research and developing plans for establishing OPSs, yet no sustained efforts were made to create government-sanctioned OPSs due to Canada's conversative political climate.[295] It was not until October 2015, when a Liberal government led by Prime Minister Justin Trudeau was elected, that municipalities began to operate new OPSs with legal exemptions.[296]

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287. Canada (Attorney General) v. PHS Community Services Society, 2011 SCC 44, [2011] 3 S.C.R. 134, paras. 156–157.

288. *Id.* at paras. 81–83.

289. *Id.*

290. *Id.* at paras. 142, 150.

291. *See* Agarwal, *supra* note 30, at 46 (articulating Supreme Court had stated explicitly its conclusion is not an invitation for other sites to open, for results of this case relied on judges' determination that Insite itself is effective at preventing death by overdose and transmission of communicable diseases).

292. Kerr et al., *SIFs in Canada*, *supra* note 31, at 3; PHS Community Services Society, 2011 SCC 44, paras. 152–153.

293. Kerr et al., *SIFs in Canada*, *supra* note 31, at 3.

294. Maria Zlotorzynska et al., *Supervised Injection Sites: Prejudice Should Not Trump Evidence of Benefit*, 185 CAN. MED. ASS'N. J. 1303, 1303 (2013).

295. *See* Kerr et al., *SIFs in Canada*, *supra* note 31, at 3 (highlighting subsequent efforts in Montreal, Toronto, Ottawa, and Victoria to open OPSs).

296. *Id.* at 4.

Bill C-37 soon replaced Bill C-2 and required eight conditions (rather than twenty-six) for an exemption to be granted, including "demonstration of the need for such a site to exist, demonstration of appropriate consultation of the community, presentation of evidence on whether the site will impact crime in the community, demonstration that regulatory systems are in place, and provision of evidence that appropriate resources are in place."[297] These conditions remain the guidelines for OPSs to open legally in Canada.[298] OPSs must abide by these conditions and receive a specific exemption under section 56 of the CDSA to open legally.[299]

C. Issues with Canada's Current Legal Landscape

This obligation to petition Health Canada for an exemption and show that that each of the conditions in Bill C-37 is satisfied before an OPS can open legally in Canada has created several issues for local advocates and policymakers.[300] The application process can be "long, complex and take several years," and once the one-year exemption is granted, Health Canada must review a facility before extending the exemption for another year (or more).[301]

As a result, some public health experts have continued to push the Liberal government to eliminate the more bureaucratic requirements of Bill C-37, such as community consultations and a demonstration of a lack of impact on crime.[302] Some provincial governments have passed legislation that interferes with the successful operation of OPSs, such as when the government of Alberta required that all new clients must provide their personal health number to access a supervised consumption site.[303] The Alberta Court of Appeal denied the emergency request of harm reduction advocates challenging the constitutionality of this new law, allowing the law to go into effect on February 1, 2022.[304]

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297. *Id.*

298. *See Royal Assent of Bill C-37 – An Act to Amend the Controlled Drugs and Substances Act and to Make Related Amendments to Other Acts,* GOV'T OF CAN., https://www.canada.ca/en/health-canada/news/2017/05/royal_assent_of_billc-37anacttoamendthecontrolleddrugsandsubstan.html (May 18, 2017) (discussing amendments to Controlled Drug Substances Act introduced by Bill C-37).

299. *Id.*

300. *See* Carmen Groleau, *What's the Difference Between a Supervised Consumption Site and an Overdose Prevention Site?*, CBC NEWS (Mar. 21, 2018, 2:49 PM), https://www.cbc.ca/news/canada/kitchener-waterloo/difference-supervised-injection-site-overdose-prevention-site-1.4584069_(describing procedure and application process to set up OPSs).

301. *Id.*

302. Zlotorzynska et al., *supra* note 294, at 1303.

303. *See* Jennifer Jackson & Katrina Milaney, Opinion, *Alberta's New Rules Requiring Health-Care Number at Supervised Injection Sites Will Only Exacerbate Barriers To Supports*, THE GLOBE & MAIL (Dec. 21, 2021), https://www.theglobeandmail.com/opinion/article-albertas-new-rules-requiring-id-at-supervised-injection-sites-will/ (explaining this requirement will only exacerbate barriers for people who already face structural and health inequalities, for many people with low income or who are experiencing homelessness do not have these health cards).

304. Daniela Germano, *Alberta's Top Court Dismisses Challenge of ID Requirement at Supervised Drug-Use Sites*, CBC NEWS (Jan. 31, 2022, 1:00 PM),

To add to the complexity of Canada's legal landscape around supervised consumption services, Health Canada announced in December 2017 that it would grant Ontario an exemption allowing the province to establish temporary urgent public health need sites.[305] Health Canada called these temporary sites "overdose prevention sites" and now refers to the "long-term, comprehensive" sites like Insite as "supervised consumption sites."[306] In 2020, the exemption was extended to all provinces and territories.[307] Under this framework, provincial or territorial governments antagonistic to safe consumption services can weigh the future of these impermanent overdose prevention sites without any federal oversight, as was the case in Ontario with the new Progressive Conservative government in 2018.[308] Many communities have used these temporary facilities as steppingstones to open a more permanent safe consumption site while their applications are pending with Health Canada, but in the interim, provincial and territorial governments have full authority to shut them down.[309]

The dynamic between the lengthy and onerous application process for federally exempted safe consumption sites and the more transient approval process for Canadian provinces and territories to establish temporary overdose prevention sites has created a convoluted web of policies that advocates of OPSs must navigate to open these facilities in Canada.

V. AUSTRALIA

The first OPS to operate legally in Australia, the Uniting Medically Supervised Injecting Centre (MSIC), opened in Sydney, NSW, in May 2001.[310] Section A of this Part will examine the events—and acts of civil disobedience—that led to the opening of Uniting MSIC.[311] Section B will then detail the state-by-state approach that Australia has taken to legalize OPSs, first in NSW and most recently in Victoria.[312] The merits of this approach will be assessed in Section C.[313]

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https://www.cbc.ca/news/canada/edmonton/alta-drug-sites-1.6334007.

305. Groleau, *supra* note 300.

306. *Id.*

307. *See Provincial/Territorial Class Exemptions for Supervised Consumption Site Operators*, CAN. DRUG POL'Y COAL. (Apr. 25, 2020), https://www.drugpolicy.ca/faq-provincial-territorial-class-exemptions-for-supervised-consumption-site-operators/ (emphasizing these temporary sites are the exclusive responsibility of provincial or territorial government which established the site).

308. The Canadian Press, *Ontario to Review Safe Injection, Overdose Prevention Sites, Health Minister Says*, CBC NEWS (July 24, 2018, 4:26 PM), https://www.cbc.ca/news/canada/toronto/ontario-safe-injection-sites-limbo-1.4760002.

309. Groleau, *supra* note 300.

310. *History of the Uniting Medically Supervised Injecting Centre: A Story of Harm Minimisation*, UNITING, https://www.uniting.org/community-impact/uniting-medically-supervised-injecting-centre--msic/history-of-uniting-msic (last visited Jan. 16, 2022) [hereinafter UNITING MSIC].

311. See *infra* Part V.A for a discussion of the historical context of OPSs in Australia.

312. See *infra* Part V.B for an analysis of the legalization of OPSs in Australia.

313. See *infra* Part V.C for an analysis of the limitations of the current legal landscape around OPSs in Australia.

A. Historical Context

Uniting MSIC was Australia's only government-sanctioned OPS until a second one opened in North Richmond, Victoria, in June 2018.[314] The recommendation to open an OPS in Sydney first came from the Royal Commission in the NSW Police Service in 1997.[315] For much of the 1990s, IDUs used "shooting galleries"—businesses where IDUs could illegally rent cubicles to inject illicit drugs rather than use in nearby back streets, lanes, or supermarkets[316]—in Kings Cross, Sydney, where over 20% of all overdose deaths took place in NSW.[317]

Police had "grudgingly tolerated" these shooting galleries, and increasing concern about corruption within the NSW Police Service became the motive for NSW to establish the Royal Commission in 1997.[318] Despite strong evidence that establishing an OPS in Kings Cross would decrease overdose deaths and improve other health outcomes, the Committee voted against a trial facility.[319] Subsequently, a group of "concerned citizens" established an unsanctioned OPS in Kings Cross as an act of civil disobedience.[320] In May 1999, amidst the police raid of the unsanctioned OPS in Kings Cross and a worsening drug overdose crisis, the NSW Drug Summit was forced to consider the possibility of opening an OPS in Sydney again.[321] It recommended that one be trialed in NSW, proposing that the trial take place in Kings Cross.[322]

Originally, the Religious Sisters of Charity, a "congregation of Roman Catholic nuns who run a health service,"[323] were invited to operate the site but were forced to abandon their plans upon instructions from the Vatican.[324] The NSW government ultimately invited Uniting Church in Australia to apply for a license to operate the site, which finally opened after government approval as a trial on May 6, 2001.[325]

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314. UNITING MSIC, *supra* note 310.

315. *Id.*

316. *See* Alex Wodak et al., *The Role of Civil Disobedience in Drug Policy Reform: How an Illegal Safer Injection Room Led to a Sanctioned, "Medically Supervised Injection Center*,*"* 33 J. DRUG ISSUES 609, 610 (2003) (describing how shooting galleries involved faculty instructing clients on safety protocols, knocking on cubicles after injections to check for overdoses, responding with CPR if possible, and providing sterile needles and syringes if available).

317. *See* Matthew Warner-Smith et al., *Heroin Overdose: Prevalence, Correlates, Consequences and Interventions*, NAT'L DRUG & ALCOHOL RSCH. CTR., monograph no. 46, 2000, https://www.hri.global/files/2010/08/20/Heroin_Overdose.pdf (noting NSW, as a state, accounted for half of all drug overdose deaths in Australia at the time).

318. Wodak et al., *supra* note 316, at 609, 612.

319. *Id*. at 609.

320. *See id.* at 609, 614 (discussing how police soon thereafter closed the site, which organizers had called "the Tolerance Room").

321. *Id.* at 617–18.

322. UNITING MSIC, *supra* note 310.

323. Wodak et al., *supra* note 316, at 619.

324. UNITING MSIC, *supra* note 310.

325. *Id*.

B. Legalization of OPSs

Uniting MSIC became legal in Australia through a set of drug policy reforms in NSW.[326] Australia's system of federalism primarily leaves the responsibility of enforcing criminal drug laws to state governments.[327] While Australia has ratified three international treaties on illicit drugs, the direct legislative and enforcement responsibilities of the federal Commonwealth are "restricted to controlling the entrance of illicit drugs into the country through the operation of the Customs Act [of] 1901."[328] Absent federal criminal drug laws in Australia for possession and use of controlled substances and drug paraphernalia, advocates for legalizing Uniting MSIC's operations instead focused on reforming NSW's criminal drug laws.[329]

The main criminal drug law in NSW is the Drug Misuse and Trafficking Act of 1985.[330] It classifies a large range of prohibited drugs and bans the use and possession of small quantities of illicit drugs.[331] In 1999, the Act was amended by the Drug Summit Legislative Response Act of 1999 in NSW, allowing for Uniting MSIC to operate legally.[332] The amendments first added exemptions from criminal liability under the Drug Misuse and Trafficking Act of 1985 for users of the center.[333] Specifically,

> it is not unlawful for a person at a licensed injecting centre: (i) to be in possession of (otherwise than for supply) no more than an exempt quantity of a prescribed drug, or (ii) to be in possession of an item of equipment for use in the administration of a prescribed drug, or (iii) to administer or attempt to administer to himself or herself no more than an exempt quantity of a prescribed drug . . . .[334]

Clients of the center, in other words, cannot be prosecuted for using or being in possession of small amounts of illicit drugs for personal use within the confines of

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326. *See* Kelly & Conigrave, *supra* note 32, at 552–53 (detailing history and process of establishing an OPS in Sydney).

327. Robin MacKay, *National Drug Policy: Australia*, SENATE SPECIAL COMM. ON ILLEGAL DRUGS (Dec. 20, 2011), https://sencanada.ca/content/sen/committee/371/ille/library/robin-e.htm.

328. *See id.* (explaining three treaties ratified by Australia are The Single Convention on Narcotic Drugs (1961) and the Protocol (1972); The Convention on Psychotropic Substances (1971); and the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988)); *see also* Kelly & Conigrave, *supra* note 32, at 553 (describing how Australia's federal government had originally suggested that opening OPSs would violate Australia's international treaty obligations, but because their purpose is to decrease any harms associated with injection drug use, OPSs abide by the treaties' goals and do not violate international law).

329. Kelly & Conigrave, *supra* note 32, at 553–54.

330. *Drug Laws in NSW,* DRUG INFO, https://druginfo.sl.nsw.gov.au/drugs/drugs-and-law/drug-laws-nsw (June 29, 2020).

331. *Id.*

332. *Drug Summit Legislative Response Act 1999* (NSW) (Austl.).

333. *Id.* at div 4, sub-div 36N.

334. *Id.*

Uniting MSIC.[335]

The 1999 amendments additionally included an exemption from criminal liability under the Drug Misuse and Trafficking Act of 1985 for people "engaged in conduct" of the center, stating that "[i]t is not unlawful for a person to engage, participate or otherwise be involved in the conduct of a licensed injecting centre . . . ."[336] The amendments finally created an exemption from civil liability in connection with any conduct of the OPS.[337] The Drug Summit Legislative Response Act of 1999 solely permitted Uniting MSIC to run on a trial basis for eighteen months.[338] The NSW government extended Uniting MSIC's trial status twice before passing legislation in 2010 allowing it to run on an ongoing basis.[339]

Similar to the amendments passed in NSW, the Drugs, Poisons, and Controlled Substances Amendment (Medically Supervised Injecting Centre) Act of 2017 passed to allow the second OPS in Australia to legally open in North Richmond, Victoria in 2018.[340] The Act allowed one "medically supervised injecting centre" to be licensed for a two-year trial period upon approval by the Secretary of Victoria's Department of Health and Human Services.[341] At the conclusion of the trial, an independent panel also recommended that the Victorian government expand it to open another site, this time in Melbourne.[342]

The Act contains similar exemptions to those in NSW—namely exemptions from criminal and civil liability for clients of the center, staff at the center, and the center itself.[343] For example, § 55K states that "[a] person who is a client of the

335. Kate Seear, *Why There's No Legal barrier to a Melbourne Drug Injecting Room, Despite Political Setbacks,* THE CONVERSATION (Feb. 22, 2017, 2:19 PM), https://theconversation.com/why-theres-no-legal-barrier-to-a-melbourne-drug-injecting-room-despite-political-setbacks-73373.

336. *Drug Summit Legislative Response Act 1999* (NSW) div 4, sub-div 36O (Austl.).

337. *Id.* at sub-div 36P.

338. *Id.* at div 1, sub-div 36A(1).

339. UNITING MSIC, *supra* note 310.

340. Lu, *supra* note 33; *Drug, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Act 2017* (Vic) (Austl.).

341. *See* REVIEW OF THE MEDICALLY SUPERVISED INJECTING ROOM, MED. SUPERVISED INJECTING ROOM REV. PANEL 1, 116 (2020), https://www.parliament.vic.gov.au/file_uploads/Review_of_the_Medically_Supervised_Injecting_Room_June_2020_WsP785dN.pdf (explaining how the Act also included an option for the Secretary to extend trial, which did occur for a further three years in 2020).

342. *See Medically Supervised Injecting Room,* VICT. DEP'T. HEALTH (Sept. 26, 2019), https://www.health.vic.gov.au/aod-treatment-services/medically-supervised-injecting-room (having reviewed the medically supervised injection room, an independent panel recommended to the Victorian Government that they expand the current trial to include another supervised injection facility in the City of Melbourne, and the Victorian Government accepted this recommendation); *see also Second Supervised Injecting Room – City of Melbourne,* VICT. DEP'T. HEALTH (Oct. 25, 2021), https://www.health.vic.gov.au/aod-treatment-services/second-supervised-injecting-room-city-of-melbourne (describing how the Victorian Government will work with harm reduction experts, local law enforcement, the City of Melbourne, and other notable stakeholders to expand supervised injection rooms and reduce the burden on Victoria's strained hospital systems, connecting more people to support and treatment services).

343. *Drug, Poisons and Controlled Substances Amendment (Medically Supervised Injecting*

licensed medically supervised injecting centre who uses, supplies, possesses or administers a drug of dependence that is an injecting centre drug in a permitted quantity of injecting centre drug in the centre is exempt from liability . . . " from crimes around supply, possession, or administration of illicit drugs.[344] By creating such exemptions, the Victorian government has permitted OPSs to open without fear that clients of the site—or the site itself—will face criminal repercussions.

C. Issues with Australia's Current Legal Landscape

State governments, specifically the governments of NSW and Victoria, have spearheaded Australia's approach to the legalization of OPSs. These governments have carved out necessary exemptions in their criminal drug laws to allow OPS to operate legally.[345] Due to Australia's system of federalism, federal law did not contain any legal barriers to their opening.[346] Rather, once states amended their laws to provide exemptions around the use and possession of drugs and drug paraphernalia for participants—in addition to essential liability shields for OPS staff—OPSs became legal in those states.

Significantly, this approach has disallowed the legalization of OPSs in states *other than* NSW and Victoria, like Western Australia and Queensland. The rate of opioid-induced deaths in Western Australia, a state without a government-sanctioned OPS, is higher than that of both NSW and Victoria.[347] Furthermore, the rate in Queensland is about the same as that in NSW and Victoria.[348] Due to Australia's path of state-by-state legalization—and absent any federal action—IDUs in these states cannot access government-sanctioned OPSs in their communities. Australia's current legal landscape around OPSs thus prevents IDUs from receiving legal safe consumption services nationwide.

VI. NOTABLE COMPARISONS FOR U.S. ADVOCATES OF OPSS

This Part will draw upon the previous sections detailing the legalization of OPSs in Australia and Canada to inform U.S. advocates and policymakers about best practices for their own implementation efforts. Section A will make comparisons between the United States and Canada for federal action implementing OPSs.[349] Section B will then draw similar comparisons between the

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Centre) Act 2017 (Vic) (Austl.).

344. *Id.* at div 2, sub-div 55K.

345. *See Dr Drug Summit Legislative Response Act 1999* (NSW) (Austl.) (amending NSW's Drug Misuse and Trafficking Act of 1985, which allowed for Uniting MSIC to operate and added exemptions for criminal liability for users of the center); *Drug, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Act 2017* (Vic) (Austl.) (describing how sub-div 55K exempts OPS users from liability, including for crimes of supply, possession, or administration).

346. Seear, *supra* note 335.

347. Australian Bureau of Statistics, *Opioid-Induced Deaths in Australia*, CAUSES OF DEATH, AUSTL. (Sept. 9, 2019), https://www.abs.gov.au/articles/opioid-induced-deaths-australia.

348. *Id.*

349. See *infra* Part VI.A for an analysis of comparisons between United States' and other jurisdictions' federal approaches to implementing OPSs.

United States, Canada, and Australia for state and local action implementing OPSs.[350] Section C will pay particular attention to the role that civil disobedience has had in the implementation campaigns of both Canada and Australia, noting the importance of these acts for any campaign to legalize OPSs in the United States.[351]

A. Comparisons for Federal Action Implementing OPSs

Though Canada does not have an equivalent of the U.S. federal "crack house" statute, policymakers and advocates in the United States should look to Canada for guidance on possible implementation of OPSs by federal action, either in the form of executive or congressional action. Since Australia has taken a state-by-state path for its implementation, it does not serve as a useful comparison for U.S. federal action. Subsection 1 of this Section will discuss federal pathways for U.S. implementation of OPSs given its current legal landscape.[352] Subsection 2 will then analyze Canada's framework and clarify lessons for U.S. policymakers and advocates.[353]

1. U.S. Federal Pathways for Implementing OPS

Under the current U.S. legal landscape, executive action by the Biden administration in the form of a memorandum from the Department of Justice (DOJ) stating the agency's intention not to prosecute any OPSs under the federal "crack house" statute is the first federal pathway for implementing government-sanctioned OPSs akin to the pathway for legalization in Canada.[354] President Biden's Office of National Drug Control Policy recently issued a statement on its drug policy priorities for year one, and among the priorities is a call to "support on the clinical effectiveness of emerging harm reduction practices in real world settings and test strategies to best implement these evidence-based practices."[355]

President Biden himself has a substantial history with the "crack house" statute as a former senator from Delaware.[356] In 1986, he was an original co-sponsor of the Anti-Drug Abuse Act which first added the statute to the CSA,[357]

350. See *infra* Part VI.A for an analysis of comparisons between United States' and other jurisdictions' state and local approaches to implementing OPSs.

351. See *infra* Part VI.C for an analysis of the use of civil disobedience and other advocacy measures to implement OPSs.

352. See *infra*, Part VI,.A.1 for an analysis of federal pathways to implementing OPSs in the United States.

353. See *infra*, Part VI.A.2 for an analysis of the Canadian federal approach to implementing OPSs and how the United States can learn from this approach.

354. See *supra* Part III.B for a discussion of the federal "crack house" statute.

355. Office of National Drug Control Policy, *The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One*, EXEC. OFF. OF THE PRESIDENT (Apr. 1, 2021), https://www.whitehouse.gov/wp-content/uploads/2021/03/BidenHarris-Statement-of-Drug-Policy-Priorities-April-1.pdf.

356. *See* Zachary A. Siegel, *Joe Biden's 'Crack House' Crusade*, THE APPEAL (Sept. 11, 2019), https://theappeal.org/joe-biden-crack-house-statute.

357. Anti-Drug Abuse Act of 1986, S. 2878, 99th Cong. (1986); The 99th Congress, *Anti-Drug Abuse Act of 1986, S. 2878*, https://www.congress.gov/bill/99th-congress/senate-bill/2878/cosponsors (last visited Oct 10, 2022, 2:28 PM).

and in 2003, he introduced the Illicit Drug Anti-Proliferation Act, which amended the "crack house" statute into its current form.[358] Senator Biden also introduced the RAVE Act in 2001, which first introduced the "crack house" statute amendment but never came to a vote.[359] As chairperson of the Senate Judiciary Committee, he proudly declared "I'm the guy who authored the crack house legislation" during a March 2001 hearing on the RAVE Act.[360]

Senator Biden's championing of the "crack house" statute has led to its current broad interpretation and application.[361] However, in the floor debates of the Illicit Drug Anti-Proliferation Act, he stated that "rogue promoters" charged under § 856(a)(2) must "not only know that there is drug activity at their event but also *hold the event for the purpose of illegal drug use or distribution* . . . . Let me be clear. Neither current law nor my bill seeks to punish a promoter for the behavior of their patrons."[362] Seeing as the Third Circuit declined to consider this history in *Safehouse*,[363] President Biden now has an opportunity to clarify the interpretation of the "crack house" statute as its initial writer and sponsor.

To best take this action, President Biden can instruct Attorney General Merrick Garland to issue a memorandum that makes use of attorneys' prosecutorial discretion; it would state that federal prosecutors will not charge any OPS with a federal crime under the "crack house" statute considering President Biden's clarification of the "for the purpose" language during 2003 floor debates. This approach would follow the DOJ's approach to marijuana legalization through the Cole Memorandum in 2013, when then-Deputy Attorney General James Cole stated that the DOJ would not enforce federal marijuana prohibition in states that "legalized marijuana in some form . . . and implement strong and effective regulatory and enforcement mechanisms."[364]

Continued appellate litigation, especially in the case of *Safehouse*, is the other possible federal mechanism for U.S. implementation of OPSs under the current legal landscape. Though the *Safehouse* case is on remand, the district court has not weighed in on Safehouse's Commerce Clause or RFRA arguments.[365] Furthermore, negotiations between Safehouse and the DOJ are ongoing, which could lead the Department to drop the suit in recognition by the Biden administration that the federal "crack house" statute does not apply to OPSs.[366] Similar suits could also arise in other federal jurisdictions—perhaps in the Second

358. Illicit Drug Anti-Proliferation Act of 2003, S. 226, 108th Cong. (2003).

359. RAVE Act, S. 2633, 107th Cong. (2002).

360. *RAVE Act: Hearing on S.2633 Before the S. Comm. on the Judiciary,* 107th Cong. (2003) (statement of Sen. Joseph R. Biden Jr.).

361. 149 CONG. REC. S1678 (2003) (statement of Sen. Joe Biden).

362. *Id.* (emphasis added).

363. *See* United States v. Safehouse, 985 F.3d 225, 238 (3d Cir. 2021), *cert. denied*, 142 S.Ct. 345 (2021) ("Safehouse asks us to look beyond the statute's text to consider Congress's intent. The public-policy debate is important, but it is not one for courts.").

364. Memorandum from James M. Cole, Deputy Attorney Gen., to U.S. Attorneys (Aug. 29, 2013) (on file with the U.S. Dep't of Just.) [hereinafter "Cole Memorandum"].

365. See *supra* Part III.C for a discussion of the litigation surrounding Safehouse.

366. *Id.*

Circuit where both government-sanctioned OPSs in NYC are located.[367] Though the Third Circuit's holding in *Safehouse* could be persuasive, it is not binding precedent outside the circuit itself.[368]

2. Canada's Federal Framework and Lessons for the United States

To address the "crack house" statute itself and other federal legal barriers to the implementation of OPSs, like criminalizing drug and drug paraphernalia use and possession, U.S federal actors can take direct action for reform similar to actions taken by the Canadian government, in particular its passing of Bills C-2 and C-37 to outline guidelines for an exemption under Canada's CDSA.[369] Congress can carve out a specific exemption for OPSs within the language of § 856(a) that declares OPSs outside the purview of the legislation. Alternatively, if federal courts became more receptive to the legality of OPSs under federal law, the Biden administration could clarify guidelines on how OPSs should be implemented to avoid violations of federal law, bypassing any direct Congressional action.

Again, in Canada, OPSs must apply for an annual exemption from federal law to operate[370] after the Supreme Court of Canada ruled in 2011 that not allowing OPSs to operate would violate Canada's *Charter of Rights and Freedoms*.[371] U.S. policymakers and advocates must be careful that any exemption within the CSA or guidelines for OPSs do not create bureaucratic obstacles for those applying, as is the case in Canada. The need to affirmatively apply for an exemption—rather than a baseline presumption that OPSs do not violate the "crack house" statute or other provisions of the CSA—can lengthen the process for an OPS to open, especially when it must reapply for an exemption every year.[372]

Furthermore, requiring potential OPSs to satisfy certain prerequisites, such as community consultations and a lack of impact on crime, before they can legally open can be burdensome for short-staffed and underfunded programs.[373] Significant research has already provided support that OPSs do not increase drug-related crime,[374] so these bureaucratic requirements only serve to gatekeep OPSs that do not have the resources to assemble an onerous application from opening.

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367. *Geographic Boundaries of United States Courts of Appeal and United States District Courts*, U.S. CTS., https://www.uscourts.gov/sites/default/files/u.s._federal_courts_circuit_map_1.pdf (last visited Sept. 13, 2022).

368. *See* The Writing Center, *Which Court is Binding?*, GEORGETOWN UNIV. L. CTR. (2017), https://www.law.georgetown.edu/wp-content/uploads/2018/07/Which-Court-is-Binding-HandoutFinal.pdf (explaining persuasive authority does not bind courts in other federal circuits).

369. See *supra* Part IV.B for a discussion of the legalization of OPSs in Canada.

370. *Insite Supervised Injection Site Receives Health Canada Exemption,* CBC NEWS (Mar. 25, 2015, 1:55 PM), https://www.cbc.ca/news/canada/british-columbia/insite-supervised-injection-site-receives-health-canada-exemption-1.3009454.

371. Canada (Attorney General) v. PHS Community Services Society, 2011 SCC 44, [2011] 3 S.C.R. 134, para. 136.

372. Groleau, *supra* note 300.

373. *Id.*

374. See *supra* Part I.B, for a discussion of the benefits of OPSs.

In addition to these lessons from Canada on the administration of an exemption in federal drug law, U.S. policymakers and advocates must be cautious of actions by state and local governments limiting the effective operation of OPSs. Like the case in Alberta, where the provincial government required ID to access supervised consumption sites,[375] states and localities in the United States could pass laws that on the surface do not make OPSs illegal but have a prohibitory impact on their operation. In fact, West Virginia recently passed a law with an ID requirement similar to Alberta's for clients of syringe exchanges in the state.[376] Advocates in the United States must watch for these cases of facial neutrality and deterrent impact if OPSs are legalized at the federal level.

B. Comparisons for State or Local Action Implementing OPSs

Despite the presence of the federal "crack house" statute, states and localities could still move forward with allowing OPSs to open via their own legislative actions, similar to the state-by-state implementation of OPSs in Australia. In fact, this method of implementation seems to be the course of action happening in the United States today, with governments sanctioning OPSs in both Rhode Island and New York City.[377]

Rhode Island's legislation permits a two-year pilot program in the state after the state's overdose task force recommends an OPS.[378] The legislation refers to OPSs as "harm reduction centers," defined as "community-based resource[s] for health screening, disease prevention and recovery assistance where persons may safely consume pre-obtained substances."[379] Notably, the bill provides liability protections to property owners, managers, employees, volunteers, clients, or participants for attempting, aiding or abetting, or conspiracy involving any of the state's statutes around drug and drug paraphernalia use and possession.[380]

Laws like the one recently passed in Rhode Island are important for removing legal barriers to OPS implementation other than the federal "crack house" statute, but the risks that states and other localities face in passing these laws are federal lawsuits like *Safehouse* or preemption challenges.[381] The CSA contains a provision, § 903, which states

> No provision of this subchapter shall be construed as indicating an intent on the part of the Congress to occupy the field in which that provision

375. Germano, *supra* note 304.

376. Brad McElhinny, *Legislature Passes a Syringe Exchange Bill with More Restrictions, Including ID Requirement*, METRONEWS (Apr. 10, 2021, 10:23 PM), https://wvmetronews.com/2021/04/10/senate-passes-a-syringe-exchange-bill-with-more-restrictions-including-id-requirement/.

377. Jaeger, *supra* note 24; 23 R.I. GEN. LAWS § 12.10-1(a) (2021).

378. 23 R.I. GEN. LAWS § 12.10-1(a) (2021).

379. *Id.* at § 12.10(b) (requiring centers to make referrals for counseling and other medical treatments).

380. *Id.* at § 12.10-4 (making an additional exception for the statue that deems "any place which is used for the unlawful sale, use, or keeping of a controlled substance" a common nuisance).

381. Beletsky et al., *supra* note 89.

> operates, including criminal penalties, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a positive conflict between that provision of this subchapter and that State law so that the two cannot consistently stand together.[382]

If a state or locality were to pass a law legalizing OPSs, it could then face a preemption lawsuit because that law may be in a direct positive conflict with the federal "crack house" statute. Nevertheless, states have often been seen as "laboratories of democracy" for drug policy, specifically around marijuana legalization.[383] The Cole Memorandum set a precedent in the DOJ that the federal government will generally not interfere with a state's marijuana legalization,[384] so this precedent could also be persuasive in deterring federal preemption challenges. Consequently, state and local action could depend on a memorandum from the Biden DOJ, as previously mentioned.[385]

Absent the legal challenges concerning the federal "crack house" statute in the United States, most laws around the use and possession of illicit drugs and drug paraphernalia are present in state law,[386] as is the case in Australia.[387] These statutes prevent the legal operation of OPSs because participants and staff at the sites can be arrested and prosecuted for the possession or use of illicit drugs and drug paraphernalia;[388] without these laws either being repealed or having exemptions granted in them like they were in Australian state governments, OPSs will remain illegal in the United States. U.S. federal laws do exist that prohibit simple possession,[389] but federal agents mainly focus on trafficking, leaving states to make most arrests for drug use and simple possession.[390] Therefore, state policy makers in the United States can look to Australian states, namely NSW and Victoria, for how to amend these criminal drug laws.

Though Canadian implementation of government-sanctioned OPSs has largely proceeded at the federal level, Health Canada's decision allowing provincial and territorial governments to establish temporary "overdose prevention

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382. 21 U.S.C. § 903.

383. Marijuana Policy Project, *State Marijuana Regulation Laws are Not Preempted by Federal Law,* https://www.mpp.org/issues/legalization/state-marijuana-regulation-laws-are-not-preempted-by-federal-law/ (last visited Aug. 15, 2021).

384. Cole Memorandum, *supra* note 364.

385. Cole Memorandum, *supra* note 364.

386. *Drug Paraphernalia: Summary of State Laws*, LEGIS. ANALYSIS & PUB. POL'Y (Apr. 2022), https://legislativeanalysis.org/wp-content/uploads/2022/09/Drug-Paraphernalia-Summary-of-State-Laws-FINAL.pdf.

387. MacKay, *supra* note 327; *Drug Laws in NSW*, *supra* note 330.

388. Beletsky et al., *supra* note 89.

389. *See* MELISSA K. REIMER, U.S SENT'G COMM'N, WEIGHING THE CHARGES: SIMPLE POSSESSION OF DRUGS IN THE FEDERAL CRIMINAL JUSTICE SYSTEM 1 (Sept. 2016), https://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-publications/2016/201609_Simple-Possession.pdf (discussing U.S. federal laws on simple possession of illegal drugs).

390. *State Drug Possession Laws*, FINDLAW (2021), https://statelaws.findlaw.com/criminal-laws/drug-possession.html.

sites"[391] creates an instructive dynamic between federal and state action for U.S. policymakers and advocates. By making these temporary sites dependent on provincial and territorial governments as an emergency response to the worsening opioid overdose crisis, Health Canada has in practice relinquished its sole authority to approve of safe consumption services. The resulting efforts of some provincial governments, like that of Ontario, to close the temporary OPSs contradicts the endorsement of OPSs by Canada's Supreme Court and federal government.[392] Thus, if the United States were to see federal action legalizing OPSs, federal actors must be careful not to delegate too much implementation authority to states and localities which might be opposed to the federal government's endorsement of OPSs.

C. A Note on Civil Disobedience and Advocacy

Given the history of how government-sanctioned OPSs have opened in both Canada and Australia amidst acts of civil disobedience and advocacy from IDUs, their opening in the United States could—and currently does—follow the same suit. In Canada, more than one OPS operated illegally in Vancouver by community and peer-led groups, such as the "Back Alley" and HRAS, before PHS covertly opened Insite in advance of its official government approval.[393] In Australia, IDUs opened an unsanctioned OPS in Kings Cross, Sydney after the initial proposal for an OPS was rejected; it was only after police raids that the NSW government accepted a newer proposal to open an OPS for a trial period in NSW.[394]

Advocates nationally have been pushing state and local governments to open OPSs for years, using many of the same tactics as the trailblazers in Canada and Australia. For example, one hundred gravestones were set up in West Capital Park in Albany, New York on July 10, 2021, each representing a New Yorker who had lost their life to drug overdose.[395] The group NO OD NY led the protest and continued to pressure former Governor Andrew Cuomo, who had supported OPSs during his 2018 gubernatorial campaign but had since reversed course.[396]

Ultimately, when the two government-sanctioned OPSs opened in NYC in 2021, much of the credit went to organizers like NO OD NY for their advocacy.[397]

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391. See *supra* notes 298–301 for a discussion of Health Canada granting Canadian provinces the right to establish these sites.

392. The Canadian Press, *supra* note 308.

393. Lawrence, *supra* note 240.

394. Wodak et al., *supra* note 316, at 609.

395. Steve Hughes, *Advocates Call on Gov. Andrew Cuomo to Approve Overdose Prevention Centers*, TIMES UNION (July 10, 2021), https://www.timesunion.com/news/article/Advocates-push-for-overdose-prevention-centers-16306221.php.

396. Lee Harris, *Where Are the Safe Injection Facilities Cuomo Promised for New York?*, CITY (Mar. 30, 2021), https://www.thecity.nyc/health/2021/3/30/22357577/safe-injection-facilities-cuomo-promised-new-york.

397. Star-Ledger Editorial Board, Opinion, *NYC Gets it Right: Safe Injection Sites Save Lives,* NJ.COM (Dec. 6, 2021, 7:15 AM), https://www.nj.com/opinion/2021/12/nyc-gets-it-right-safe-injection-sites-save-lives-editorial.html.

While no laws were passed in New York to specifically exempt the OPSs from prosecution, former Mayor Bill DeBlasio, Mayor-elect Eric Adams, the NYPD, and city district attorneys have agreed not to prosecute anyone at the facilities.[398] Cities across the United States could follow suit, but without explicit action by policymakers to amend current laws, OPSs will remain illegal in the United States. With that said, policymakers must continue to listen to the activists who bravely risk criminal repercussions when organizing acts of civil disobedience to promote safe consumption services.

VII. CONCLUSION

OPSs are a proven public health tool to combat the ongoing opioid overdose crisis.[399] Though the Third Circuit did not rule in favor of Safehouse in January 2021, several legal pathways remain for its implementation, such as executive action, congressional action, state or local action, and continued litigation. Policymakers and advocates in the United States must look to Canada and Australia for lessons on how to best proceed down any of these paths.

Canada's federal route has allowed OPSs to open across the country, but with bureaucratic obstacles and hostile provincial governments in their way, implementation has faced some opposition.[400] Australia's state-by-state path has successfully carved exemptions in two of its states' criminal drug laws, but absent any federal action, implementation has yet to expand to all of Australia.[401] Acts of civil disobedience in both nations have facilitated the policy changes that have allowed government-sanctioned OPS to open;[402] U.S. policymakers and advocates must follow their lead when acting to legalize OPSs. With Canada and Australia in mind, they can ensure that government-sanctioned OPSs are soon able to operate nationwide in the United States.

398. *Id.*

399. See *supra* Part II.A for an explanation of what an OPS is.

400. See *supra* Part IV.B for a discussion of Canada's legalization of OPSs.

401. See *supra* Part V.B. for an analysis of how Australia's approach to legalize OPSs was primarily driven by state governments, specifically from NSW and Victoria, which created necessary exemptions in their criminal drug laws to allow OPSs to legally exist and operate. See also *supra* Part V.B for an analysis of how Australia's federalist structure allowed states to be policy-laboratories for the implementation of OPSs, yet limited, and even prevented, OPSs from operating in other states in Australia.

402. See *supra* Part VI.C for a discussion of the role of civil disobedience and other forms of advocacy in the fight for OPSs.