

6-23-2020

Federal Ignorance and the Battle for Supervised Injection Sites

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Recommended Citation

Ben Longnecker, *Federal Ignorance and the Battle for Supervised Injection Sites*, 74 U. Miami L. Rev. 1145 (2020)

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NOTE:

Federal Ignorance and the Battle for Supervised Injection Sites

BEN LONGNECKER*

From 1999 to 2017, over 400,000 people have died from opioid overdoses. The federal government recognizes the opioid epidemic as a crisis, yet it has failed to slow the surge of overdose deaths. Some states are, therefore, looking at the implementation of supervised injection sites. There are over 100 supervised injection sites around the world in twelve different countries, and these sites have produced hopeful data on counteracting the opioid crisis's negative societal effects. However, the federal government has seemingly ignored any empirical evidence and continues to threaten state-sponsored supervised injection sites with criminal prosecution. This Note argues that any federal challenge to these supervised injection sites should be unsuccessful and will also dispel federal authorities' conclusory allegations that these sites do not practically combat the harms of the opioid crisis.

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On May 5, 2017, Joseph “Blake” Hadden was found dead in his apartment.¹ He was hours away from walking across a stage to receive his diploma from Furman University in Greenville, South Carolina.² Blake died from an overdose of an opioid-based substance named fentanyl, a drug thirty times more deadly than heroin.³ Blake was among the 70,000 estimated deaths due to drug overdose in

¹ Angelia Davis & Anna Lee, *Furman Student Died from Fentanyl Overdose*, STATE (June 17, 2017, 9:53 PM), <https://www.thestate.com/news/state/south-carolina/article156811924.html>.

² *Id.*

³ *Id.*

2017.⁴ Around 30,000 of those overdoses can be attributed to fentanyl and similar synthetic opioids.⁵ That is eighty-one overdoses each day, a forty-five percent increase in fentanyl-related deaths compared to 2016.⁶ In comparison, twice as many people died from fentanyl in 2017 than from murders and non-negligent homicides⁷—enough for the entire undergraduate student population of Furman University (Blake Hadden’s would-be *alma mater*) to fatally overdose ten times.⁸

This Note will address the debate over establishing supervised injection sites in the United States to combat the opioid crisis—which the federal government has labeled a “public health emergency.”⁹ Though the problems associated with the opioid crisis extend beyond potential solutions like supervised injection sites, the results of injection sites abroad have been unequivocally successful in reducing overdoses, blood-borne diseases, and referring marginalized populations to drug treatment services.¹⁰ This Note argues that these supervised injection sites are practical solutions based on empirical evidence from around the world¹¹ and dispels federal authorities’ conclusory allegations that these sites are “dangerous.”¹² In addition, this Note criticizes the simplistic approach other

⁴ *Overdose Death Rates*, NAT’L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates> (last updated Jan. 2019).

⁵ *Id.*

⁶ Josh Katz & Margot Sanger-Katz, ‘*The Numbers Are So Staggering.*’ *Overdose Deaths Set a Record Last Year.*, N.Y. TIMES (Nov. 29, 2018), <https://www.nytimes.com/interactive/2018/11/29/upshot/fentanyl-drug-overdose-deaths.html>.

⁷ *Total Number of Murders in the United States in 2017, by State*, STATISTA, <https://www.statista.com/statistics/195331/number-of-murders-in-the-us-by-state/> (last visited Mar. 7, 2020).

⁸ *Furman University: Facts*, FURMAN U., <https://www.furman.edu/about/facts/> (last visited Mar. 7, 2020) (listing undergraduate enrollment at 2,800 students).

⁹ *Ending America’s Opioid Crisis*, WHITE HOUSE, <https://www.whitehouse.gov/opioids/> (last visited Mar. 7, 2020).

¹⁰ *See infra* notes 81–117.

¹¹ *See infra* notes 81–117.

¹² *See, e.g.*, Rod J. Rosenstein, Opinion, *Fight Drug Abuse, Don’t Subsidize It*, N.Y. TIMES (Aug. 27, 2018), <https://www.nytimes.com/2018/08/27/opinion/opioids-heroin-injection-sites.html>.

scholarly publications have taken when applying relevant Supreme Court jurisprudence to answer this question: does the federal government overstep its authority by challenging the creation of supervised injection sites?

Part I briefly discusses the beginnings of the opioid crisis, the current ineffective responses from the federal government, and the need for innovative solutions like supervised injection sites. Part II details how these supervised injection sites operate and examines empirical evidence from existing supervised injection sites around the world and in the United States. Part III describes the federal government's position against supervised injection sites to lay a foundation for Part IV, which evaluates the "state versus federal" conflict and how a future court may resolve the matter. This Note concludes on an optimistic note. Supervised injection sites save lives and are an effective response to the opioid crisis. These sites may have an uphill battle when facing the federal government, but their existence is hope for the United States as it attempts to stabilize the opioid crisis.

I. A HISTORICAL AND MODERN ACCOUNT OF THE OPIOID CRISIS

While this Note primarily focuses on the legality of state-sponsored, supervised injection sites as a response to individuals who inject dangerous opioids, a brief historical account of the opioid crisis is necessary to understand why opioid use became a public emergency—and why federal intervention has been ineffective.

A. *The War on Drugs: A Primer*

Modern federal anti-opioid policies have roots in the infamous "War on Drugs."¹³ In the 1960s, the federal government had a militant stance against illegal drug use based on a simple assumption: drugs are dangerous and linked to violent crime.¹⁴ The Nixon administration coined the phrase "War on Drugs," after passing the Controlled Substances Act.¹⁵ This act gave law enforcement more

¹³ Ti'a Latice Hazel, *Who Can Handle Marijuana the Best? The States' Failure to Regulate Marijuana and the Federal Government's Sole Power to Regulate Marijuana*, 11 CHARLESTON L. REV. 495, 498 (2017).

¹⁴ Shima Baradaran, *Drugs and Violence*, 88 S. CAL. L. REV. 227, 233 (2015).

¹⁵ See Hazel, *supra* note 13, at 498.

power to combat illegal drug use, primarily through incarceration.¹⁶ In addition, the Controlled Substances Act also recognized the need for a long-term federal drug policy that encompassed the creation of effective health programs to minimize the harms of drug abuse.¹⁷

The “War on Drugs” has continued to this day, and scholars have critiqued federal drug policy for being applied in a racially disproportionate manner,¹⁸ failing to reduce the use of illegal drugs,¹⁹ and further exacerbating the dangers associated with illegal drug use.²⁰ However, federal authorities claim that the Department of Justice’s aggressive stance against illegal drug use is delivering “results”²¹ and adamantly oppose the creation of supervised injection sites as an innovative solution to confront drug abuse.²² But, as explained below, the current federal drug policies have not meaningfully impacted the surge of citizens who abuse opioids.²³

B. Opioids Explained, and the Rise of the Opioid Crisis

Opioid abuse is a relatively new crisis that began in the 1990s.²⁴ Pharmaceutical companies facilitated a new era of treating pain

¹⁶ *Id.* at 498–500.

¹⁷ 21 U.S.C. § 1101 (2012).

¹⁸ Gabriel J. Chin, *Race, the War on Drugs, and the Collateral Consequences of Criminal Conviction*, 6 J. GENDER RACE & JUST. 253, 262 (2002).

¹⁹ See Baradaran, *supra* note 14, at 232.

²⁰ Scott Burris et al., *Federalism, Policy Learning, and Local Innovation in Public Health: The Case of the Supervised Injection Facility*, 53 ST. LOUIS U. L.J. 1089, 1098 (2009).

²¹ Rosenstein, *supra* note 12. In terms of general “results,” the federal government has seized millions of pounds of drugs a year. Robert Longley, *Statistics from the War on Drugs Tell a Story*, THOUGHTCO. (Jan. 14, 2018), <https://www.thoughtco.com/statistics-from-the-war-on-drugs-4083707>. However, prohibition of any drug—at its foundation—is too simplistic of an approach to deter the use of harmful substances. See CHRISTOPHER J. COYNE & ABIGAIL R. HALL, CATO INST., *FOUR DECADES AND COUNTING: THE CONTINUED FAILURE OF THE WAR ON DRUGS* 3–4 (2017), <https://www.cato.org/sites/cato.org/files/pubs/pdf/pa-811-updated.pdf>.

²² See Rosenstein, *supra* note 12.

²³ See Robert Parker Tricarico, *A Nation in the Throes of Addiction: Why A National Prescription Drug Monitoring Program Is Needed Before It Is Too Late*, 37 WHITTIER L. REV. 117, 118 (2016).

²⁴ See *infra* notes 46–49 and accompanying text.

management through the prescription of opioids,²⁵ a class of drug naturally derived from or artificially produced to mimic the chemical structure of the opium poppy plant.²⁶ Opioids work by activating certain nerve receptors in the brain that trigger the same biochemical brain processes that reward people with feelings of pleasure—leading doctors to prescribe them as pain relievers.²⁷ As someone routinely takes opioids, their nerve receptors become less responsive, requiring increased dosages to produce pleasure comparable to previous drug-taking episodes.²⁸ However, repeat exposure to escalating dosages alters the brain to function normally only if opioids are in one’s system,²⁹ which can lead to daily drug use to avert the unpleasant symptoms of drug withdrawal; further prolonged use may permanently alter the part of the brain that enables compulsive drug-seeking behavior.³⁰ While modern science acknowledges that opioid pain relievers are generally safe when taken for a short time, continued use has dangerous risks of developing the type of dependence that could lead to overdoses and death.³¹

Though physicians have historically been concerned with long-term opioid treatment,³² this new era of opioids originated from a seemingly innocuous correspondence published in the 1980 edition of the *New England Journal of Medicine*.³³ One paragraph of the letter stated—with minimal statistical evidence, citing only a single study of approximately 11,000 people—that “despite widespread use of narcotic drugs in hospitals, the development of addiction is

²⁵ *Opioid Overdose Crisis*, NAT’L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis> (last updated Feb. 2020).

²⁶ *Prescription Opioids: What are Prescription Opioids?*, NAT’L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/publications/drugfacts/prescription-opioids> (last updated June 2019).

²⁷ Thomas R. Kosten & Tony P. George, *The Neurobiology of Opioid Dependence: Implications for Treatment*, SCI. & PRAC. PERSP., July 2002, at 13, 14.

²⁸ *Id.* at 15.

²⁹ *Id.* at 14.

³⁰ *Id.* at 15.

³¹ *Opioids: Brief Description*, NAT’L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/drugs-abuse/opioids> (last visited Mar. 8, 2020).

³² Jack Hubbard et al., *Opioid Abuse: The Fall of A Prince*, 21 QUINNIPIAC HEALTH L.J. 159, 167 (2018).

³³ Art Van Zee, *The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy*, 99 AM. J. PUB. HEALTH 221, 223 (2009).

rare in medical patients with no history of addiction.”³⁴ Subsequently, this correspondence was cited in over 400 medical papers to support the idea that addiction is not likely to occur in patients treated with opioids.³⁵

Pharmaceutical companies, such as Purdue Pharma, used this letter to aggressively market opioids and trained their sales representatives to falsify that the addiction risk of pain-relieving opioids was “less than one percent.”³⁶ This misrepresentation was brought to light in 2007, when several executives at an affiliate of Purdue Pharma pled guilty to criminal charges of misrepresenting the harmful effects of opioid addiction and were forced to pay over \$600 million in fines.³⁷ By that time, however, many physicians had become comfortable prescribing opioids for patients that suffered from acute and chronic pain, marking the beginning of the modern-day opioid crisis.³⁸

Scholars note two additional factors that may have contributed to the opioid crisis. The first occurred in 2001 when the Joint Commission—a non-profit organization that accredits over 22,000 health care organizations and programs in the United States³⁹—established Pain Management Standards that classified pain as a “fifth vital sign.”⁴⁰ This new mandate required that health care providers ask every patient about their relative pain levels.⁴¹ Advocates have since argued that this pain standard led physicians to conclude that pain was being undertreated and resulted in increased issuance of opioids

³⁴ Jane Porter & Hershel Jick, *Addiction Rare in Patients Treated with Narcotics*, 302 NEW ENGLAND J. MED. 123, 123 (1980).

³⁵ Hubbard et al., *supra* note 32, at 167.

³⁶ Purdue Pharma also relied upon a separate study on the treatment of burn units to rationalize their advocacy for the widespread use of opioids to treat pain—though this study also lacked detailed statistical evidence. See Van Zee, *supra* note 33, at 223.

³⁷ *Id.*

³⁸ Hubbard et al., *supra* note 32, at 168.

³⁹ *Facts About the Joint Commission*, JOINT COMMISSION, <https://www.joint-commission.org/about-us/facts-about-the-joint-commission/> (last visited Mar. 8, 2020).

⁴⁰ Kristina Fiore, *Opioid Crisis: Scrap Pain as 5th Vital Sign?*, MEDPAGE TODAY (Apr. 13, 2016), <https://www.medpagetoday.com/publichealthpolicy/publichealth/57336>.

⁴¹ *Id.*

to patients.⁴² Further, some scholars note that a recent shift towards patient-centric care had the unintended consequence of increased opioid prescriptions.⁴³ The argument is that patients dealing with acute or chronic pain have come to expect opioid prescriptions, and those doctors who do not fulfill that expectation are given poor satisfaction ratings.⁴⁴ Because these satisfaction ratings may be correlated to the salary or retention of a physician, a doctor may feel incentivized to dispense opioids to meet patient expectations.⁴⁵

As a result, the amount of opioid-based prescriptions exploded.⁴⁶ From 1997 to 2002, the United States saw a 226% increase in the prescription rate of fentanyl, 73% increase in the rate of morphine, and 402% increase in oxycodone.⁴⁷ By 2005, opioids ranked second only to marijuana in terms of illegal drug use.⁴⁸ The total sales of opioid pain relievers quadrupled from 1999 to 2008—alongside a corresponding quadrupling of the overdose death rate and a sixfold increase of the substance abuse treatment rate.⁴⁹

C. *The Modern Crisis and Ineffective Governmental Response*

Though Congress recognized the 2000s as the “Decade of Pain Control,” the federal government has largely been ineffective and slow to respond to this nationwide crisis.⁵⁰ In 2008, the Food and Drug Administration concluded that opioids should remain a Schedule III drug,⁵¹ which is defined as a substance or chemical with a

⁴² Hubbard et al., *supra* note 32, at 168.

⁴³ Aleksandra Zgierska, Michael Miller & David Rabago, *Patient Satisfaction, Prescription Drug Abuse, and Potential Unintended Consequences*, 307 J. AM. MED. ASS’N 1377, 1378 (2012).

⁴⁴ *Id.* at 1377.

⁴⁵ *Id.* at 1378.

⁴⁶ Van Zee, *supra* note 33, at 224.

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ Leonard J. Paulozzi et al., *Vital Signs: Overdoses of Prescription Opioid Pain Relievers — United States, 1999–2008*, 60 MORBIDITY & MORTALITY WKLY. REP. 1487, 1488 (2011).

⁵⁰ Tricarico, *supra* note 23, at 118.

⁵¹ Barry Meier & Eric Lipton, *F.D.A. Shift on Painkillers Was Years in the Making*, N.Y. TIMES (Oct. 27, 2013), https://www.nytimes.com/2013/10/28/business/fda-shift-on-painkillers-was-years-in-the-making.html?_r=0&pagewanted=all&pagewanted=print. Notably, the federal government reclassified

moderate to low potential for physical and psychological dependence.⁵² Opioid misuse and overdoses continued to rise, and in 2011, the Centers for Disease Control and Prevention (“CDC”) released a report stating that opioid overdoses had reached “epidemic levels.”⁵³ That same year, the federal government responded, and the Office of National Drug Control Policy released a strategic plan to reduce opioid drug abuse.⁵⁴ This plan included expanding federal intervention into four major areas: education, tracking and monitoring, proper medication disposal, and law enforcement.⁵⁵ Despite this federal action, overdose deaths from opioids have continued to rise.⁵⁶ Between 2010 and 2017, the rate of heroin-related overdose deaths has increased by nearly 400%.⁵⁷ In addition, overdose deaths from synthetic opioids nearly doubled between 2013 and 2014,⁵⁸ and they doubled again between the years 2015 to 2016.⁵⁹

dangerous opioids as a Schedule II drug in 2013 to allow for stricter regulation. See Tricarico, *supra* note 23, at 125.

⁵² *Drug Scheduling and Penalties*, CAMPUS DRUG PREVENTION, <https://www.campusdrugprevention.gov/content/drug-scheduling-and-penalties> (last visited Mar. 8, 2020).

⁵³ Press Release, Ctrs. for Disease Control & Prevention, Prescription Painkiller Overdoses at Epidemic Levels (Nov. 1, 2011), https://www.cdc.gov/media/releases/2011/p1101_flu_pain_killer_overdose.htm.

⁵⁴ See *Office of National Drug Control Policy: Prescription Drug Abuse*, OBAMA WHITE HOUSE, <https://obamawhitehouse.archives.gov/ondcp/prescription-drug-abuse1> (last visited Mar. 8, 2020).

⁵⁵ EXEC. OFFICE OF THE PRESIDENT OF THE U.S., EPIDEMIC: RESPONDING TO AMERICA’S PRESCRIPTION DRUG ABUSE CRISIS (2011), https://www.ncjrs.gov/pdffiles1/ondcp/rx_abuse_plan.pdf.

⁵⁶ *Opioid Overdose: Understanding the Epidemic*, CENTERS FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/epidemic/index.html> (last updated Dec. 19, 2018) [hereinafter *Understanding the Epidemic*].

⁵⁷ *Opioid Overdose: Heroin*, CENTERS FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/opioids/heroin.html> (last updated Dec. 19, 2018).

⁵⁸ Rose A. Rudd et al., *Increases in Drug and Opioid Overdose Deaths — United States, 2000–2014*, 64 MORBIDITY & MORTALITY WKLY. REP. 1378, 1379 (2016) (data not including overdoses from methadone).

⁵⁹ HOLLY HEDEGAARD ET AL., NAT’L CTR. FOR HEALTH STATISTICS, DRUG OVERDOSE DEATHS IN THE UNITED STATES, 1999–2016, at 1 (2017), <https://www.cdc.gov/nchs/data/databriefs/db294.pdf> (data not including overdoses from methadone).

D. Injection Drug Users and an Introduction of the Need for Supervised Injection Sites

Though a significant number of the 400,000 total opioid overdoses from 1999 to 2017 resulted from the misuse of prescription opioids,⁶⁰ a corresponding increase in injection-based opioid users is now apparent.⁶¹ The CDC estimates that between 2004 and 2014, there has been a 93% increase in admissions to substance use disorder treatment facilities for injection-based opioids.⁶² Other studies indicate that an estimated 10% to 20% of people who abuse prescription opioids move to injection-based opioids.⁶³ These injection drug users are at a high risk of acquiring blood borne illnesses such as Hepatitis C or human immunodeficiency virus (“HIV”).⁶⁴ Consequently, the CDC observed a 133% increase in the spread of Hepatitis C infections between 2004 and 2014.⁶⁵ In addition, anxiety about social rejection and arrest deter the use of health and preventative services, forcing injection drug users into hidden locations that are poorly suited for hygienic injection and which make the users more likely to contract a blood borne disease.⁶⁶ Needle-syringe exchange programs and increased access to drug treatment programs

⁶⁰ See *Understanding the Epidemic*, *supra* note 56.

⁶¹ Press Release, Ctrs. for Disease Control & Prevention, Increase in Hepatitis C Infections Linked to Worsening Opioid Crisis (Dec. 21, 2017), <https://www.cdc.gov/nchhstp/newsroom/2017/hepatitis-c-and-opioid-injection-press-release.html>.

⁶² *Id.*

⁶³ Lindsey Dawson & Jennifer Kates, *HIV and the Opioid Epidemic: 5 Key Points*, KAISER FAM. FOUND. (Mar. 27, 2018), <https://www.kff.org/hiv/aids/issue-brief/hiv-and-the-opioid-epidemic-5-key-points/>; Alia A. Al-Tayyib, Stephen Koester & Paula Riggs, *Prescription Opioids Prior to Injection Drug Use: Comparisons and Public Health Implications*, 65 ADDICTIVE BEHAVIORS 224, 225 (2016).

⁶⁴ Burris et al., *supra* note 20, at 1096.

⁶⁵ Press Release, Ctrs. for Disease Control & Prevention, Increase in Hepatitis C Infections Linked to Worsening Opioid Crisis (Dec. 21, 2017), <https://www.cdc.gov/nchhstp/newsroom/2017/hepatitis-c-and-opioid-injection-press-release.html>.

⁶⁶ Beletsky et al., *The Law (and Politics) of Safe Injection Facilities in the United States*, 98 AM. J. PUB. HEALTH 231, 231 (2008). Shooting galleries are described as “structures such as homes—privately owned, abandoned, and otherwise—that are frequented by [injection drug users] for the purpose of injecting.” *Id.*

have ameliorated some of these risks,⁶⁷ but they do not address the lack of a supervised and hygienic setting for injection⁶⁸—nor the fear of legal consequences that witnesses and drug users face when confronting a potentially deadly overdose.⁶⁹

Many different countries have therefore turned to an innovative solution: supervised injection sites.⁷⁰ There are over one hundred supervised injection sites around the world that were created to address unsupervised drug consumption.⁷¹ The theory is straightforward: allow people who are determined to consume pre-obtained drugs to use the drugs, but under the supervision of trained staff who can reduce the health risks often associated with public drug consumption.⁷² Additionally, these sites “provide counseling and referrals to vital social services and treatment options.”⁷³ Though these supervised injection sites are widely recognized as successful abroad,⁷⁴ the creation of supervised injection sites in the United States remains highly controversial.⁷⁵

⁶⁷ *Syringe Services Programs (SSPs)*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/ssp/index.html> (last updated May 23, 2019).

⁶⁸ *See Syringe Services Programs (SSPs) FAQs*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/ssp/syringe-services-programs-faq.html> (last updated May 23, 2019) (explaining that, while needle exchanges offer resources like Naloxone and sterile syringes to users, the programs do not provide sterile, safe locations to inject drugs).

⁶⁹ *See* Melissa Tracy et al., *Circumstances of Witnessed Drug Overdose in New York City: Implications for Intervention*, 79 *DRUG & ALCOHOL DEPENDENCE* 181, 183 (2005).

⁷⁰ *See infra* notes 81–109 and accompanying text.

⁷¹ *Supervised Consumption Services*, DRUG POL’Y ALLIANCE, <http://www.drugpolicy.org/issues/supervised-consumption-services> (last visited Mar. 9, 2020).

⁷² *See id.*

⁷³ Jessica Cohen, *Supervised Injection Facilities Face Obstacles, But That Shouldn’t Stop Them*, HEALTH AFF. (Nov. 29, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20181127.121405/full/>.

⁷⁴ *See, e.g.*, EUROPEAN MONITORING CTR. FOR DRUGS & DRUG ADDICTION, *DRUG CONSUMPTION ROOMS: AN OVERVIEW OF PROVISION AND EVIDENCE* (2018), http://www.emcdda.europa.eu/system/files/publications/2734/POD_Drug%20consumption%20rooms.pdf [hereinafter *DRUG CONSUMPTION ROOMS*].

⁷⁵ *See* Elana Gordon, *What’s the Evidence that Supervised Drug Injection Sites Save Lives?*, NPR (Sept. 7, 2018, 2:40 PM),

II. HOW SUPERVISED INJECTION SITES OPERATE AND EMPIRICAL EVIDENCE

A. *A Look Inside a Supervised Injection Site*

As mentioned above, a supervised injection site is a facility where injection drug users may inject drugs that are obtained elsewhere while under the supervision of healthcare providers who are well-equipped to administer Naloxone—the overdose antidote for opioids—if necessary.⁷⁶ Legislation creating supervised injection sites does not legalize or encourage use of opioids.⁷⁷ It simply gives high-risk, vulnerable populations a sterile place to inject the drugs—as opposed to using a nonsterile environment.⁷⁸ More significantly, supervised injection sites aim to connect and refer those socially marginalized populations to treatment and rehabilitation services.⁷⁹ Medical professionals do not assist with any injections or handle any drugs, but instead they offer general medical advice and recommendations on how to prevent the spread of blood-borne diseases.⁸⁰

B. *The Empirical Evidence*

Approximately 120 legal supervised injection sites currently operate across Australia, Canada, Denmark, France, Germany, Luxembourg, the Netherlands, Norway, Spain, and Switzerland.⁸¹ One unsanctioned, research-based supervised injection site operated in the United States from 2014 to 2016.⁸² The following Sections briefly summarize some empirical data for these sites around the world.

<https://www.npr.org/sections/health-shots/2018/09/07/645609248/whats-the-evidence-that-supervised-drug-injection-sites-save-lives>.

⁷⁶ Mary Clare Kennedy & Thomas Kerr, *Overdose Prevention in the United States: A Call for Supervised Injection Sites*, 107 AM. J. PUB. HEALTH 42, 42 (2017).

⁷⁷ See Cohen, *supra* note 73.

⁷⁸ *Id.*

⁷⁹ See Beletsky et al., *supra* note 66, at 231.

⁸⁰ *Id.*

⁸¹ See *Supervised Consumption Services*, *supra* note 71.

⁸² Alex H. Kral & Peter J. Davidson, *Addressing the Nation's Opioid Epidemic: Lessons from an Unsanctioned Supervised Injection Site in the U.S.*, 53 AM. J. PREVENTIVE MED. 919, 919–20 (2017).

1. SUPERVISED INJECTION SITES OUTSIDE THE UNITED STATES

Australia has one supervised injection site (referred to as a “medically supervised injecting centre”) that has operated since 2001 in Kings Cross, Sydney.⁸³ As of 2015, this facility has supervised more than 900,000 injections and responded to almost 6000 overdoses—without a single fatality.⁸⁴ A study of the facility found that seventy percent of the people who used this service had never accessed any local health service before, more than 12,000 referrals were made to health and social welfare services, overdose-related ambulance calls were reduced by eighty percent, and the local municipality observed a fifty percent reduction in discarded needles.⁸⁵

Canada’s supervised injection sites began in Vancouver, British Columbia,⁸⁶ but are now active in six major cities across the country.⁸⁷ As in Australia, there have been no fatal overdoses reported at any site.⁸⁸ After the first facility opened in 2002, Vancouver has observed a thirty-five percent decrease in the rate of overdoses⁸⁹ and a sixty-seven percent decrease in ambulance calls for treating overdoses.⁹⁰ Furthermore, eighteen percent of users visiting the site began a detoxification program during follow-up appointments.⁹¹

Germany has twenty-four supervised injection sites in fifteen different cities,⁹² operating since the “3rd Amendment of German

⁸³ *Medically Supervised Injecting Centres*, ALCOHOL & DRUG FOUND. (Feb. 17, 2017), <https://adf.org.au/insights/medically-supervised-injecting-centres/>.

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ See Evan Wood et al., *Attendance at Supervised Injecting Facilities and Use of Detoxification Services*, 354 NEW ENGLAND J. MED. 2512, 2512–13 (2006).

⁸⁷ See *Interactive Map: Canada’s Response to the Opioid Crisis*, GOV’T CAN., <http://health.canada.ca/en/health-canada/services/drugs-medication/opioids/responding-canada-opioid-crisis/map.html> (last updated Feb. 28, 2020) (displaying the locations of the forty supervised injection sites across Canada through an interactive map).

⁸⁸ Jennifer Ng et al., *Does Evidence Support Supervised Injection Sites?*, 63 CANADIAN FAM. PHYSICIAN 866, 866 (2017).

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ See Wood et al., *supra* note 86, at 2512–13.

⁹² DRUG CONSUMPTION ROOMS, *supra* note 74.

Narcotics Law” was passed in 2000.⁹³ Between 2001 and 2009, over 3200 drug emergencies were treated, 710 people were saved through “immediate resuscitation measures,” and an estimated 75,000 drug users were referred to drug treatment services.⁹⁴

Luxembourg has two supervised injection sites, with the first opening in 2005.⁹⁵ Since their inception, the facilities have supervised more than 56,000 injections⁹⁶ and managed 1025 overdoses.⁹⁷ The total number of overdose deaths decreased from twenty-seven in 2007 to five in 2011.⁹⁸

The Netherlands established supervised injection sites in 1994 and has thirty-one sites across twenty-five cities.⁹⁹ While there is no direct empirical data surrounding these facilities, the Netherlands has the lowest rate of injection drug users in the European Union, one of the lowest percentages of HIV transmission, and a drug overdose death rate of 0.5 per 100,000 people.¹⁰⁰

Norway has two supervised injection sites in two cities.¹⁰¹ Since opening in 2005, these supervised injection sites have not had a

⁹³ DEUTSCHE AIDS-HILFE & AKZEPT E.V., DRUG CONSUMPTION ROOMS IN GERMANY: A SITUATIONAL ASSESSMENT BY THE AK KONSUMRAUM 8 (2011), https://www.akzept.org/pdf/aktuel_pdf/DKR07af1Eng.pdf.

⁹⁴ *See id.* at 30.

⁹⁵ EUROPEAN MONITORING CTR. FOR DRUGS & DRUG ADDICTION, LUXEMBOURG COUNTRY DRUG REPORT 2017, at 11 (2017), <http://www.emcdda.europa.eu/system/files/publications/4517/TD0616153ENN.pdf>.

⁹⁶ *Id.*

⁹⁷ *Luxembourg Overview*, INT’L NETWORK DRUG CONSUMPTION ROOMS, <http://www.drugconsumptionroom-international.org/index.php/locations/2015-09-27-13-37-46/location-luxembourg> (last visited Mar. 9, 2020).

⁹⁸ *Id.*

⁹⁹ EUROPEAN MONITORING CTR. FOR DRUGS & DRUG ADDICTION, NETHERLANDS COUNTRY DRUG REPORT 2017, at 12 (2017), <http://www.emcdda.europa.eu/system/files/publications/4512/TD0616155ENN.pdf>.

¹⁰⁰ Georgiy Vanunts, “*It’s Something Like a Living Room*”: *My Experience of a Safe Drug Use Room in Amsterdam*, TALKINGDRUGS (Feb. 25, 2017), <https://www.talkingdrugs.org/its-something-like-a-living-room-my-experience-of-safe-drug-use-room-in-amsterdam>.

¹⁰¹ THOMAS CLAUSEN, THE ROLE OF THE SAFE INJECTION FACILITY IN OSLO AND THE OPENING HOURS ON PATTERNS OF AMBULANCE CALL-OUTS FOR OVERDOSE 2 (2017),

single reported fatality,¹⁰² and between 2015 and 2016, the supervised injection site in Oslo supervised almost 70,000 injections and prevented 600 overdoses.¹⁰³

Spain's first site opened its doors in 2001.¹⁰⁴ In its first year, nearly 2900 injection users visited the site, and doctors prevented 157 overdoses and 113 acute reactions to drug toxicity.¹⁰⁵ Spain additionally observed a decrease in HIV infections for its drug users between 2004 and 2008 from 19.9% to 8.2%, respectively.¹⁰⁶

Switzerland established twelve supervised injection sites in eight cities¹⁰⁷ in an attempt to curb the highest HIV rates in Western Europe.¹⁰⁸ In the ten years since the sites opened, the rates of both HIV infections and overdose mortality rates were reduced by fifty percent.¹⁰⁹ Further, seventy percent of current drug users now receive treatment—one of the highest global rates.¹¹⁰

2. EVIDENCE FROM THE UNITED STATES' UNSANCTIONED SUPERVISED INJECTION SITE

In September 2014, a social service agency located in an undisclosed urban area in the United States opened an underground, research-based supervised injection site.¹¹¹ This unsanctioned site collected qualitative data from its clients, and the resulting evaluations

<http://www.emcdda.europa.eu/system/files/attachments/6240/Safe%20consumption%20room%202017%20SIF%20and%20overdose%20Oslo%20-%20Thomas%20Clausen%2C%20Norway.pdf>.

¹⁰² *Id.* at 5.

¹⁰³ *Id.*

¹⁰⁴ Andy Malinowski, *The Vein in Spain: Viability of Safe Injection Rooms*, DRUGLINK, Nov.-Dec. 2002, at 20, 22.

¹⁰⁵ *Id.*

¹⁰⁶ *Spain Overview*, INT'L NETWORK DRUG CONSUMPTION ROOMS, <http://www.drugconsumptionroom-international.org/index.php/locations/2015-09-27-13-39-55/location-spain> (last visited Mar. 9, 2020).

¹⁰⁷ DRUG CONSUMPTION ROOMS, *supra* note 74.

¹⁰⁸ Stephanie Nebehay, *Swiss Drug Policy Should Serve as Model: Experts*, REUTERS (Oct. 25, 2010, 1:06 PM), <https://www.reuters.com/article/us-swiss-drugs/swiss-drug-policy-should-serve-as-model-experts-idUSTRE69O3VI20101025>.

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ Kral & Davidson, *supra* note 82, at 919.

were reviewed and approved by the Institutional Review Board of the University of California, San Diego.¹¹² The purpose was to test the criticism directed at proposed supervised injection sites in the United States: despite the evidence that supervised injection sites have been unambiguously successful abroad, such programs would not benefit the public's health.¹¹³

In the first two years, medical personnel supervised 2574 injections.¹¹⁴ Two overdoses occurred, and both were reversed using Naloxone.¹¹⁵ In addition, the following statistics were observed: around ninety-two percent of participants reported that they would have otherwise injected in a public restroom, street, park, or parking lot; sixty-seven percent reported a "very high" rate of unsafe disposal of used equipment before using the site; and around thirty percent had experienced or witnessed an overdose outside of this particular site.¹¹⁶ No fatalities or incidents of violence occurred in the two years that this supervised injection site was operating and delivering data.¹¹⁷

III. THE FEDERAL GOVERNMENT'S RESPONSE TO PROPOSED SUPERVISED INJECTION SITES

The Federal Government is unequivocally opposed to the establishment of any supervised injection site.¹¹⁸ In responding to proposed supervised injection sites in Vermont, the U.S. Attorney's Office for the District of Vermont—without citing any evidence—released the following press statement:

¹¹² *Id.* at 920.

¹¹³ Janet Burns, *Research Finds Signs of Recovery, Solidarity at Underground Safe Injection Site*, FORBES (Jan. 2, 2018, 10:00 AM), <https://www.forbes.com/sites/janetwburns/2018/01/02/research-finds-signs-of-recovery-community-at-underground-safe-injection-site/#4d4d9bde5d23>.

¹¹⁴ *See* Kral & Davidson, *supra* note 82, at 920.

¹¹⁵ *Id.*

¹¹⁶ *Id.* at 920–21.

¹¹⁷ *Id.* at 920.

¹¹⁸ *See, e.g.*, Press Release, U.S. Dep't of Justice, Statement of the U.S. Attorney's Office Concerning Proposed Injection Sites (Dec. 13, 2017), <https://www.justice.gov/usao-vt/pr/statement-us-attorney-s-office-concerning-proposed-injection-sites> [hereinafter Statement of the U.S. Attorney's Office Concerning Proposed Injection Sites].

SIFs [(Supervised Injection Facilities)] are counter-productive and dangerous as a matter of policy, and they would violate federal law.

As to policy, the proposed government-sanctioned sites would encourage and normalize heroin use, thereby increasing demand for opiates and, by extension, risk of overdose and overdose deaths. Opiate users, moreover, all-to-often [sic] believe they are purchasing heroin when, in fact, they are purchasing its common substitute, fentanyl, ingestion of which gives rise to greatly enhanced dangers of overdose and fatality. Introduction of fentanyl to SIFs would create additional public health risks, not only for the users, but for SIF staff members who might come in contact with that highly potent substance Such facilities would also threaten to undercut existing and future prevention initiatives by sending exactly the wrong message to children in Vermont: the government will help you use heroin. Indeed, by encouraging and normalizing heroin injection, SIFs may even encourage individuals to use opiates for the first time, or to switch their method of ingestion from snorting to injection, the latter carrying greatly increased risk of fatality and overdose.

Of equal importance, the proposed SIFs would violate several federal criminal laws, including those prohibiting use of narcotics and maintaining a premises for the purpose of narcotics use. It is a crime, not only to use illicit narcotics, but to manage and maintain sites on which such drugs are used and distributed. Thus, exposure to criminal charges would arise for users and SIF workers and overseers.¹¹⁹

Rod Rosenstein, the then-acting Deputy Attorney General of the United States, reiterated this federal opposition to supervised

¹¹⁹ *Id.*

injection sites in an opinion article published in the *New York Times* on August 27, 2018, titled *Fight Drug Abuse, Don't Subsidize It*.¹²⁰ Rosenstein argued that supervised injection sites are “very dangerous and would only make the opioid crisis worse”—and, further, that increased federal prosecutions are slowing the “surge in overdose deaths.”¹²¹ These sites, according to him, would “normalize drug use and facilitate addiction,” and Rosenstein called establishing “any location for the purpose of facilitating illicit drug use” illegal,¹²² and violators should expect “swift and aggressive action” by the federal government.¹²³ To end the opioid crisis, Rosenstein asserted that the focus of the federal government should be on education, treatment, and prosecution.¹²⁴

Rosenstein was primarily responding to locally-proposed supervised injection sites in cities such as New York,¹²⁵ Philadelphia,¹²⁶ San Francisco,¹²⁷ and Seattle.¹²⁸ After Rosenstein’s article, California’s governor, Jerry Brown, vetoed a supervised injection site bill, citing his fear of “expos[ing] local officials and health care professionals to potential federal criminal charges.”¹²⁹ Other locations,

¹²⁰ Rosenstein, *supra* note 12.

¹²¹ *Id.*

¹²² *Id.*

¹²³ *Id.*

¹²⁴ *Id.*

¹²⁵ See, e.g., William Neuman, *De Blasio Moves to Bring Safe Injection Sites to New York City*, N.Y. TIMES (May 3, 2018), <https://www.nytimes.com/2018/05/03/nyregion/nyc-safe-injection-sites-heroin.html?smtyp=cur&smid=tw-nytmetro>.

¹²⁶ See, e.g., Kristen De Groot, *This City Wants to Allow Supervised Drug Injection Sites to Combat the Opioid Epidemic*, YAHOO! (Jan. 23, 2018), <https://www.yahoo.com/news/city-wants-allow-supervised-drug-000038369.html>.

¹²⁷ See, e.g., German Lopez, *The Trump Administration’s Threat Against Safe Injection Sites is Working*, VOX (Oct. 2, 2018, 1:00 PM), <https://www.vox.com/policy-and-politics/2018/10/2/17927864/safe-injection-site-trump-jerry-brown-california>.

¹²⁸ See, e.g., *Seattle Budget Includes Money for Safe-Injection Site*, KIRO7, <https://www.kiro7.com/news/local/seattle-budget-includes-money-for-safe-injection/651500019> (last updated Nov. 21, 2017, 9:40 AM).

¹²⁹ See Lopez, *supra* note 127.

like Philadelphia, began moving forward with plans to open supervised injection sites, despite explicit federal opposition.¹³⁰

The federal government responded to this movement on February 5, 2019,¹³¹ when U.S. Attorney for the Eastern District of Pennsylvania, William McSwain, filed a civil lawsuit opposing Philadelphia's supervised injection site.¹³² McSwain asked a federal judge to declare supervised injection site operations illegal under federal law.¹³³ The federal judge disagreed with the United States' position and reasoned that the relevant Controlled Substances Act statute (discussed below)¹³⁴ was never intended to extend to medical treatment programs that are built for harm reduction purposes.¹³⁵ McSwain responded with the statement that "[t]oday's opinion is merely the first step in a much longer legal process that will play out. This case is obviously far from over. We look forward to continuing to litigate it, and we are very confident in our legal position."¹³⁶

IV. STATE VERSUS FEDERAL: THE FIGHT OVER SUPERVISED INJECTION SITES

Putting politics aside, this looming "state versus federal" conflict raises several legal questions that this Note will seek to answer. (1) Do states have the authority to create supervised injection sites? (2) If so, does the existing federal law apply to supervised injection

¹³⁰ See, e.g., Aubrey Whelan, *Here's How Safehouse, Philly's Proposed Safe-injection Site, Will Operate*, PHILA. INQUIRER (Oct. 8, 2018), <http://www.philly.com/philly/health/addiction/safe-injection-site-philadelphia-safehouse-faq-20181008.html>.

¹³¹ Complaint for Declaratory Judgment at 1, *United States v. Safehouse*, 408 F. Supp. 3d 583 (E.D. Pa. 2019) (No. 19-0519).

¹³² Larissa Morgan, *The Regulatory Battle Over Safe Injection Sites*, REG. REV. (Oct. 8, 2019), <https://www.theregreview.org/2019/10/08/morgan-regulatory-battle-over-safe-injection-sites/>.

¹³³ *Id.*

¹³⁴ See *infra* notes 195–200 and accompanying text.

¹³⁵ *Safehouse*, 408 F. Supp. 3d at 614.

¹³⁶ Press Release, U.S. Dep't of Justice, Statement of United States Attorney McSwain on Today's Opinion in the *United States v. Safehouse* Litigation (Oct. 2, 2019), <https://www.justice.gov/usao-edpa/pr/statement-united-states-attorney-mcswain-today-s-opinion-united-states-v-safehouse>.

sites? (3) And, if that is true, should the federal government be able to successfully prosecute these individuals?

A. State and Local Authority to Create Supervised Injection Sites

There is little question as to whether a state or local municipality has the authority to create a supervised injection site. This authority is founded in “police powers,” which historically have granted local governments the authority to regulate their respective public’s health, safety, and morals.¹³⁷ The police power represents the sovereign power afforded to states under the United States’ federal system, and only excludes those areas explicitly surrendered to the federal government under the Constitution.¹³⁸ Though police powers are not limitless, courts typically construe them broadly.¹³⁹ These powers legitimize state actions to ensure that communities live safely in environments conducive to proper health and moral standards, as well as promoting broadly-defined social goods.¹⁴⁰

In the particular context of public health, police powers include those laws or regulations aimed at improving relevant populations’ morbidity and mortality rates.¹⁴¹ The police powers allow state and local governments to pass laws preventing injury and disease,¹⁴² promoting vaccinations,¹⁴³ and regulating sanitation,¹⁴⁴ waste disposal,¹⁴⁵ and air quality.¹⁴⁶ Though the creation of any supervised injection site arguably runs contrary to federal law,¹⁴⁷ states have

¹³⁷ LAWRENCE O. GOSTIN, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* 92 (rev. 2d ed. 2008).

¹³⁸ *See* *Gibbons v. Ogden*, 22 U.S. (1 Wheat.) 1, 11 (1824).

¹³⁹ *E.g.*, *United States v. Darby*, 312 U.S. 100, 118 (1941); *see* Randy E. Barnett, *The Proper Scope of the Police Power*, 79 *NOTRE DAME L. REV.* 429, 485 (2004).

¹⁴⁰ *See* GOSTIN, *supra* note 137, at 92.

¹⁴¹ *Id.* at 94.

¹⁴² *See* TOM CHRISTOFFEL & STEPHEN P. TERET, *PROTECTING THE PUBLIC: LEGAL ISSUES IN INJURY PREVENTION* 25–29 (1993).

¹⁴³ *See, e.g.*, *Zucht v. King*, 260 U.S. 174, 177 (1922).

¹⁴⁴ *See, e.g.*, *People of City of Lakewood by & on Behalf of People v. Haase*, 596 P.2d 392, 394 (Colo. 1979).

¹⁴⁵ *See, e.g.*, *Singleton v. City of Hamilton*, 515 N.E.2d 8, 13 (Ohio Ct. App. 1986).

¹⁴⁶ *See, e.g.*, *Bortz Coal Co. v. Air Pollution Comm’n*, 279 A.2d 388, 392 (Pa. Commw. Ct. 1971).

¹⁴⁷ *See infra* notes 190–206 and accompanying text.

still passed laws that are prohibited under federal law or disfavored by federal policymakers.¹⁴⁸ For instance, many state governments have passed medical marijuana laws, exempting those qualified users from state criminal prosecution¹⁴⁹—though under federal law, marijuana still remains illegal to possess or consume per the Controlled Substances Act.¹⁵⁰ So, while federal authorities have expressed their opinion that supervised injection sites are unlawful as a matter of federal law, this apparent federal hostility is not enough to prevent states from establishing supervised injection sites in accordance with their lawful police powers.¹⁵¹ In addition, using state legislation to create a supervised injection site would eliminate any uncertainty about such a facility conflicting with state laws or constitutions, and those states would be on the strongest footing to resist challenges from the federal government.¹⁵²

A supervised injection site may also be enacted through a local municipality, as all states delegate some police powers to counties, cities, or towns to pass laws or ordinances in the name of public well-being.¹⁵³ These programs must be supported by reasonable evidence that they will be effective in combatting an existing health threat.¹⁵⁴ A local government could enact an ordinance to create a supervised injection site, consistent with other public health policy innovations like needle prescription laws.¹⁵⁵ However, locally-passed ordinances or laws could be subjected to claims that they are

¹⁴⁸ See Burris et al., *supra* note 20, at 1107.

¹⁴⁹ See *State Medical Marijuana Laws*, NAT'L CONF. ST. LEGISLATURES (Oct. 16, 2019), <https://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx>.

¹⁵⁰ 21 U.S.C. §§ 812, 844 (2018).

¹⁵¹ See Beletsky et al., *supra* note 66, at 233.

¹⁵² Burris et al., *supra* note 20, at 1106–07.

¹⁵³ See, e.g., *Ass'n of Home Appliance Manufacturers v. City of New York*, 36 F. Supp. 3d 366, 372 (S.D.N.Y. 2014) (explaining that while “[p]olice powers repose with the states, . . . New York State delegates certain of such powers—e.g., legislative authority relating to local safety, health and well-being—to its municipalities through the state constitution, the Municipal Home Rule Law and the General Cities Law”) (citations omitted).

¹⁵⁴ See Beletsky et al., *supra* note 66, at 233.

¹⁵⁵ *Id.*

in conflict with state law and, therefore, preempted.¹⁵⁶ To avoid those potential constitutional problems, states would be better off establishing a supervised injection site through their state legislature.

B. Prosecuting a Supervised Injection Site

Before the “War on Drugs” began, the federal government’s role in prosecuting drug crimes was relatively modest.¹⁵⁷ However, the passage of the Controlled Substances Act of 1970 empowered the federal government with almost unlimited jurisdiction¹⁵⁸ after Congress rationalized that the trafficking, possession, or use of illegal drugs “ha[d] a substantial and detrimental effect on the health and welfare of the American people.”¹⁵⁹ Although state governments are not necessarily obligated to follow federal drug laws,¹⁶⁰ the federal government has mentioned two different theories of prosecution, which would potentially criminalize the operation and use of supervised injection sites: (1) 21 U.S.C. § 844 (addressing simple possession),¹⁶¹ and (2) 21 U.S.C. § 856 (otherwise known as the “Crack House Statute”).¹⁶² Both of these statutes will be addressed accordingly.

1. SIMPLE POSSESSION

Under § 844, it is “unlawful for any person knowingly or intentionally to possess a controlled substance.”¹⁶³ However, under its theory of prosecution, the federal government would be limited to prosecuting the injection drug users, not the site workers.¹⁶⁴ Unless supervised injection site employees actually possess, hold, or

¹⁵⁶ See *id.* (“[T]he attempt in Atlantic City, NJ, to implement an syringe exchange program was successfully challenged in court by the local prosecutor, who argued that it was prohibited by state drug law.”).

¹⁵⁷ Burris et al., *supra* note 20, at 1113.

¹⁵⁸ *Id.*

¹⁵⁹ 21 U.S.C. § 801 (2018).

¹⁶⁰ See, e.g., *State Medical Marijuana Laws*, *supra* note 149.

¹⁶¹ 21 U.S.C. § 844.

¹⁶² 21 U.S.C. § 856; see also Jacob A. Epstein, Note, *Molly and the Crack House Statute: Vulnerabilities of A Recuperating Music Industry*, 23 U. MIAMI BUS. L. REV. 95, 102–03 (2014).

¹⁶³ 21 U.S.C. § 844.

¹⁶⁴ See *id.*

control the drugs brought into the facilities, the federal government should be unable to successfully bring criminal charges against them.¹⁶⁵ Indeed, the supervised injection site patients maintain sole control and dominion over their drugs while in the facilities, so at no time would any health care professional directly handle any of the drugs.¹⁶⁶ The operators of supervised injection sites act, instead, as health, drug treatment, and safe-injection resources, prepared to help any overdosing individual.¹⁶⁷

The government may be able to assert that these healthcare officials were in “constructive” possession of these substances,¹⁶⁸ but this should be an attenuated and unsuccessful argument. To have constructive possession over a narcotic, a person must know of its presence and have the power to exercise dominion and control over it,¹⁶⁹ though if a person has exclusive control over the premise where the contraband is found, then knowledge and control may be inferred.¹⁷⁰ But if no individual has that exclusive control over a supervised injection site, any claim of constructive possession would be seemingly defeated—“[m]ere proximity to contraband, presence on property where it is found, and association with a person or persons having control of it are all insufficient to establish constructive possession.”¹⁷¹ In essence, the government would have to prove that these operators had the ultimate control over the drugs,¹⁷² which any health official at a given site would likely deny since no supervised injection employee directly assists with injections.¹⁷³ The use of simple possession statutes should thus be limited to the individuals entering and leaving a supervised injection site.¹⁷⁴ However, as Rod Rosenstein mentioned in his article, the federal government’s best

¹⁶⁵ Beletsky et al., *supra* note 66, at 231.

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*

¹⁶⁸ *See, e.g.,* United States v. Rebolledo-Delgado, 820 F.3d 870, 875 (7th Cir. 2016).

¹⁶⁹ *E.g.,* United States v. Schocket, 753 F.2d 336, 340 (4th Cir. 1985).

¹⁷⁰ *E.g.,* United States v. Rodriguez, 761 F.2d 1339, 1341 (9th Cir. 1985).

¹⁷¹ United States v. Duenas, 691 F.3d 1070, 1084 (9th Cir. 2012) (quoting United States v. Rodriguez, 761 F.2d 1339, 1341 (9th Cir. 1985)).

¹⁷² *E.g.,* United States v. Manzella, 791 F.2d 1263, 1266 (7th Cir. 1986).

¹⁷³ *See* Beletsky et al., *supra* note 66, at 231.

¹⁷⁴ *See* 21 U.S.C. § 844 (2018).

argument against the establishment of these supervised injection sites is likely through the application of the “Crack House Statute.”¹⁷⁵

2. THE “CRACK HOUSE STATUTE”

In 1986, the federal government amended the Controlled Substances Act by adding § 856, which would be known as the “Crack House Statute.”¹⁷⁶ This statute was designed to punish those who used their property to run drug businesses in the midst of the 1980s crack epidemic.¹⁷⁷ In particular, this statute prohibited the operation of houses or buildings—such as crack houses—where crack, cocaine, or other drugs are manufactured and used.¹⁷⁸ Section (a)(1) of this statute originally stated that it shall be unlawful to “knowingly open or maintain any place for the purpose of manufacturing, distributing, or using any controlled substance.”¹⁷⁹ Section (a)(2) made it illegal to do the following:

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.¹⁸⁰

This statute, however, was amended in 2003 by further broadening the language to reach “any place,” whether operating “permanently or temporarily.”¹⁸¹ This amendment was originally proposed

¹⁷⁵ See Rosenstein, *supra* note 12 (describing how the federal government could use the “Crack House Statute” to prosecute the operators of supervised injection sites).

¹⁷⁶ See Epstein, *supra* note 162, at 102–03.

¹⁷⁷ *Id.* at 103; *e.g.*, United States v. Verners, 53 F.3d 291, 296 (10th Cir. 1995).

¹⁷⁸ Richard Belfiore, Annotation, *Validity, Construction, and Application of Federal “Crack-House Statute” Criminalizing Maintaining Place for Purpose of Making, Distributing, or Using Controlled Drugs*, 21 U.S.C.A. § 856, 116 A.L.R. Fed. 345 (1993) (detailing the different courts’ interpretations of Section 856).

¹⁷⁹ 21 U.S.C. § 856 (1988).

¹⁸⁰ *Id.*

¹⁸¹ 21 U.S.C. § 856 (2006).

as the “Reducing Americans’ Vulnerability to Ecstasy”¹⁸² Act or the RAVE Act.¹⁸³ Though eventually passed as the “Illicit Drug Anti-Proliferation Act of 2003,” the initial title of the RAVE Act is indicative of the congressional purpose behind amending the “Crack House Statute,” i.e., directly targeting the producers of dance events, such as raves, at which drugs like methylenedioxymethamphetamine (“MDMA,” colloquially known as “ecstasy”) were often used.¹⁸⁴ This increased federal jurisdiction covered not only those places where drugs are made or consumed, but also those premises that make available or profit off illegal drug use on their respective properties.¹⁸⁵

United States v. Chen illustrates how the “Crack House Statute” has been applied.¹⁸⁶ There, the defendant, a motel owner, encouraged his tenants to use, purchase, and sell drugs out of his motel rooms—so long as the participants continued to pay rent.¹⁸⁷ The defendant was ultimately convicted.¹⁸⁸ Similarly, in *United States v. Meshack*, the defendant ran a bar-b-que shop that operated simultaneously as a location to purchase drugs.¹⁸⁹ Like in *Chen*, the defendant was also convicted.¹⁹⁰

In both cases, the Fifth Circuit found that drug distribution was a significant purpose surrounding the businesses, and the “Crack House Statute” was lawfully applied.¹⁹¹ Although a supervised injection site will not distribute, encourage, or profit off the consumption of illegal opioids, the federal government may nonetheless argue—as Rod Rosenstein claimed—that the purpose of these sites is

¹⁸² See Mariah Blake, *This Law Made It a Lot More Dangerous to Take Ecstasy*, MOTHER JONES (Jan. 9, 2015), <https://www.motherjones.com/politics/2015/01/joe-biden-raves-mdma-death/>.

¹⁸³ MARK EDDY, CONG. RESEARCH SERV., IB10113, WAR ON DRUGS: LEGISLATION IN THE 108TH CONGRESS AND RELATED DEVELOPMENTS 9 (2004).

¹⁸⁴ *Id.*

¹⁸⁵ *See id.*; *see also* 21 U.S.C. § 856(a)(2) (2018).

¹⁸⁶ *United States v. Chen*, 913 F.2d 183, 186 (5th Cir. 1990).

¹⁸⁷ *Id.*

¹⁸⁸ *Id.* at 183.

¹⁸⁹ *United States v. Meshack*, 225 F.3d 556, 571 (5th Cir. 2000), *amended on reh’g in part*, 244 F.3d 367 (5th Cir. 2001).

¹⁹⁰ *Id.* at 583.

¹⁹¹ *Id.* at 583; *Chen*, 913 F.2d at 193.

to facilitate drug use, which would potentially bring these sites within the purview of the federal government's reach.¹⁹²

B. Does Section 856 Preempt State Legislation Authorizing a Supervised Injection Site?

Federal opposition to supervised injection sites asserts that these facilities fall plainly under subsection (a)(1) of the "Crack House Statute"¹⁹³ and that any state law creating a site would therefore be preempted as explicitly indicated by 21 U.S.C. § 901, which provides the following:

No provision of this subchapter shall be construed as indicating an intent on the part of the Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a positive conflict between that provision of this subchapter and that State law so that the two cannot consistently stand together.¹⁹⁴

As in all preemption cases, congressional purpose is the "ultimate touchstone."¹⁹⁵ When considering preemption, the starting assumption is that the historic police powers of the states are not to be "superseded by [a] Federal Act unless that was the clear and manifest purpose of Congress."¹⁹⁶ The explicit purpose of Congress when crafting the Controlled Substances Act was to preempt those state

¹⁹² See Rosenstein, *supra* note 12.

¹⁹³ See Statement of the U.S. Attorney's Office Concerning Proposed Injection Sites, *supra* note 118.

¹⁹⁴ 21 U.S.C. § 903; The power for the federal government to preempt state law is rooted in the Supremacy Clause of the United States Constitution, which states that the "Constitution, and the laws of the United States . . . shall be the supreme Law of the Land . . . any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. CONST. art. VI, cl. 2.

¹⁹⁵ *E.g.*, *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996) (citations omitted).

¹⁹⁶ *Wisconsin Pub. Intervenor v. Mortier*, 501 U.S. 597, 605 (1991) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). In interpreting potential 'Supremacy Clause' cases, the Supreme Court analyzes local ordinances in the same way as state laws. See *Hillsborough Cty., Fla. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 713 (1985).

laws that “positive[ly] conflict” with its sections, “so that the two cannot consistently stand together.”¹⁹⁷ It is not entirely clear, though, that the creation of a supervised injection site would positively conflict with § 856.

The language of § 856 seemingly excludes bona fide medical and scientific interventions involving controlled drugs.¹⁹⁸ The statute generally forbids facilitating or using “any controlled substance,”¹⁹⁹ but, as mentioned below, the federal government has not typically applied this statute to prosecute a facility whose purpose involves a legitimate medical practice.²⁰⁰ Indeed, courts have found that § 856 is not implicated when the consumption of drugs is “merely incidental” to the purpose of maintaining that particular residence.²⁰¹ The reasoning behind this exception is that the primary purpose of enacting the “Crack House Statute” was “to punish those who use their property to run drug businesses—hence, the more characteristics of a business that are present, the more likely it is that the property is being used ‘for the purpose of’ those drug activities prohibited by § 856(a)(1).”²⁰² These supervised injection sites can therefore be interpreted as falling outside of § 856 because their purpose is to minimize the threat to the public’s health and welfare resulting from unsafe, public injections of illegal opioids—far removed from the targeted drug-profiting establishments.²⁰³

For similar reasons, these supervised injection sites are wholly consistent with the entirety of the Controlled Substances Act. The Act puts a particular emphasis on establishing long-term federal strategies that include both effective law enforcement and health programs, “recogni[zing] that education, treatment, rehabilitation,

¹⁹⁷ 21 U.S.C. § 903 (2018).

¹⁹⁸ See 21 U.S.C. § 856.

¹⁹⁹ See 21 U.S.C. § 856.

²⁰⁰ See *United States v. Safehouse*, 408 F. Supp. 3d 583, 588 (E.D. Pa. 2019) (“But the Third Circuit has not yet considered the proper construction of 21 U.S.C. § 856(a), and although other courts of appeals have addressed that subsection, no court has yet considered its application to medically supervised consumption sites.”).

²⁰¹ See, e.g., *United States v. Shetler*, 665 F.3d 1150, 1161–62 (9th Cir. 2011).

²⁰² *United States v. Verners*, 53 F.3d 291, 296–97 (10th Cir. 1995).

²⁰³ See *Supervised Consumption Services*, *supra* note 71.

research, training, and law enforcement efforts are interrelated.”²⁰⁴ As noted by the Supreme Court in *United States v. Moore*, the Controlled Substances Act is not simply focused on the general use of drugs, but also “the diversion of drugs from legitimate channels to illegitimate channels.”²⁰⁵ The act explicitly acknowledges that many controlled substances may have legitimate medical use and “are necessary to maintain the health and general welfare of the American people.”²⁰⁶ Thus, if these facilities can be viewed as more than “a taxpayer-sponsored haven to shoot up,”²⁰⁷ and instead as medical centers where health care providers are ameliorating general public health risks, then a supervised injection site should be reasonably considered to be legitimate medical practice under the Controlled Substances Act.²⁰⁸

C. *The Gonzales Cases and Federal Preemption*

Considering the uncertainty surrounding the interpretation of a supervised injection site as a legitimate medical facility, the preemption analysis is not straightforward. The federal government has not, and likely will not, view any established supervised injection site as serving a legitimate medical purpose, which puts these state-sponsored facilities and their users in direct conflict with both the “Crack House Statute” and the Controlled Substances Act.²⁰⁹ However, two cases exemplify how a court may analyze this potential conflict.

The first case involves a federal official’s authority to unilaterally interpret what constitutes a legitimate medical practice—an issue decided in *Gonzales v. Oregon*.²¹⁰ In essence, this case illustrates the extent of federal authority to interpret whether a supervised injection site constitutes a legitimate medical facility and, consequently, whether its establishment falls under federal jurisdiction.²¹¹

²⁰⁴ 21 U.S.C. § 1101(6).

²⁰⁵ *United States v. Moore*, 423 U.S. 122, 135 (1975).

²⁰⁶ 21 U.S.C. § 801(1).

²⁰⁷ *See* Rosenstein, *supra* note 12.

²⁰⁸ *See* 21 U.S.C. § 801.

²⁰⁹ *See, e.g.*, Statement of the U.S. Attorney’s Office Concerning Proposed Injection Sites, *supra* note 118; Rosenstein, *supra* note 12.

²¹⁰ *Gonzales v. Oregon*, 546 U.S. 243, 249 (2006).

²¹¹ *See* Beletsky et al., *supra* note 66, at 234 & n.85.

In 1994, Oregon voters enacted the Oregon Death With Dignity Act (“ODWDA”), which allowed physician-assisted suicide for patients with incurable, irreversible diseases that would otherwise die within six months.²¹² Under the law, the administering physician is required to follow particular medical procedures, keep records, and be registered both with the state Board of Medical Examiners and the federal Drug Enforcement Administration.²¹³ The doctor may only dispense the prescription, but may not administer it.²¹⁴ However, on November 9, 2001, the acting attorney general issued an Interpretive Rule that determined that using substances to assist in suicide is not a legitimate medical practice; therefore, any doctor who dispenses or prescribes these drugs is arguably acting unlawfully under the Controlled Substances Act.²¹⁵ Several plaintiffs challenged this Interpretive Rule, as it would substantially disrupt the ODWDA regime.²¹⁶

The Supreme Court answered the question of whether the attorney general, or any other executive official, had the authority to independently interpret federal law.²¹⁷ The Court explained in *Gonzales v. Oregon* that the Controlled Substances Act does not manifest an intent to “regulate the practice of medicine generally.”²¹⁸ Instead, Congress regulated medical practice insofar as trafficking or dealing illegal drugs.²¹⁹ The Act’s silence in defining exactly what constitutes a legitimate medical practice, according to the Court, is “understandable given the structure and limitations of federalism, which allow the States ‘great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons.’”²²⁰ Without an explicit statute to say otherwise or give proper definitions congruent with the Interpretive Rule, the Supreme Court explained, the Attorney General was not authorized to bar

²¹² See *Gonzales*, 546 U.S. at 251–52.

²¹³ *Id.* at 252.

²¹⁴ *Id.*

²¹⁵ *Id.* at 253–54; see also Dispensing of Controlled Substances to Assist Suicide, 66 Fed. Reg. 56607-02 (Nov. 9, 2001).

²¹⁶ See *Gonzales*, 546 U.S. at 254.

²¹⁷ *Id.* at 263.

²¹⁸ *Id.* at 270.

²¹⁹ *Id.*

²²⁰ *Id.* (citations omitted).

dispensing controlled substances for assisted suicides in the face of a state medical regime permitting such conduct.²²¹

When comparing the analysis of *Gonzales v. Oregon* to the creation of supervised injection sites, apparent differences emerge because of the existence of the “Crack House Statute.” Since the Controlled Substances Act was silent on the legality of physician-assisted suicides, the Court agreed that the State of Oregon, not the Attorney General, was authorized to define whether that action constituted legitimate medical practice.²²² This differs from the “Crack House Statute,” which expressly opposes any place that operates for the purposes of using illegal drugs.²²³ Therefore, the challenge to state-sanctioned supervised injection sites would more closely parallel *Gonzales v. Raich*, a case involving a conflict between the Controlled Substances Act and an enacted medical marijuana law in California.²²⁴

D. *Gonzales v. Raich and the Federal Government’s Overreach to Supervised Injection Sites*

Like a federal challenge to supervised injection sites, the situation presented in *Gonzales v. Raich* did not have clear-cut supremacy clause preemption, even in the face of apparently conflicting federal and state laws.²²⁵ In 1996, California passed a state law that allowed physicians to prescribe medical marijuana to patients and primary caregivers without fear of state prosecution.²²⁶ The law also protected the patients and caregivers from local prosecution for either possession or cultivation of marijuana, so long as their prescription had been lawfully approved.²²⁷ After a federal raid into one of the respondents’ homes, which destroyed several marijuana plants, an action was brought against the Attorney General and DEA seeking injunctive relief from the enforcement of the Controlled Substances Act.²²⁸ The State of California challenged the Controlled

²²¹ *Id.* at 274.

²²² *Id.*

²²³ 21 U.S.C. § 856(a) (2018).

²²⁴ *Gonzales v. Raich*, 545 U.S. 1, 9 (2005).

²²⁵ *Id.*

²²⁶ *Id.* at 5–6.

²²⁷ *Id.*

²²⁸ *Id.* at 7.

Substances Act’s categorical prohibition on the manufacture and possession of marijuana, arguing that this prohibition exceeded Congressional authority under the Commerce Clause.²²⁹

This Congressional authority is derived from Article I of the United States Constitution, which states that “Congress shall have Power To . . . regulate Commerce . . . among the several States.”²³⁰ In essence, a portion of the congressional authority has been defined as the power to regulate activities that affect interstate commerce.²³¹ The Commerce Clause’s authority, however, is not unlimited. In seeking to preserve a system of dual sovereignty—where Congress’s powers are restricted to those enumerated in the Constitution—local economic activity must “substantially affect interstate commerce,” or the relevant federal law gives way to state legislation.²³² To illustrate, the Supreme Court has struck down federal criminal laws purporting to regulate interstate commerce that, in fact, encroached on state police power—central to those decisions was that both statutes were *noneconomic* in nature.²³³ The Court worried that “[w]ere the Federal Government to take over the regulation of entire areas of traditional state control—areas having nothing to do with the regulation of commercial activities—the boundaries between the spheres of federal and state authority would blur.”²³⁴

In analyzing whether Congress overstepped its authority under the Commerce Clause, the *Raich* Court ruled against California, holding that the conflicting portions of the Controlled Substances Act were a valid exercise of the federal government’s Commerce Clause power.²³⁵ Unlike those statutes in the above-mentioned Commerce Clause cases, the activities regulated by the Controlled Substances Act are “quintessentially economic.”²³⁶ The California

²²⁹ *Id.* at 15.

²³⁰ U.S. CONST. art. I, § 8, cl. 3.

²³¹ *See Raich*, 545 U.S. at 17; *see also* *Perez v. United States*, 402 U.S. 146, 150 (1971).

²³² *See, e.g.*, *United States v. Morrison*, 529 U.S. 598, 609 (2000) (citations omitted).

²³³ *See id.* at 610; *United States v. Lopez*, 514 U.S. 549, 561 (1995).

²³⁴ *Lopez*, 514 U.S. at 577.

²³⁵ *Raich*, 545 U.S. at 22.

²³⁶ *Id.* at 25.

statute in question permitted both possession and cultivation of an illegal drug, and when those local activities were aggregated across the entire state, the Court found little question of its economic effect on interstate commerce, therefore holding that the federal law governed.²³⁷

Importantly for the argument to establish a supervised injection site, however, the Court analyzed *Gonzales v. Raich* in terms of “whether Congress’ power to regulate interstate markets for medicinal substances encompasses the portions of those markets that are supplied with drugs produced and consumed locally”²³⁸—as opposed to a supervised injection site, which would not legalize, encourage, or otherwise authorize the cultivation of opioids.²³⁹ Scholarly writing about supervised injection has pointed to this holding in *Gonzales v. Raich* as being detrimental to the programs’ lawful establishment, with the assumption that these supervised injection sites will have a parallel impact on interstate commerce.²⁴⁰ Yet, this simplistic assumption ignores all empirical data known about supervised injection sites, which, according to a collection of modern research, do not increase drug use in surrounding areas.²⁴¹ Without any effect on the usage of opioids in cities that have established supervised injection sites, there can be no rational link to the interstate supply or demand of that specific illegal commodity. Therefore, to say that utilizing supervised injection sites is “economic” in the same way that the legalization of a controlled substance for a medical purpose is considered “economic” defies rational, evidence-based thought.

Indeed, supervised injection sites will not decriminalize possession or encourage cultivation of injection-based opioids, but instead

²³⁷ *Id.* at 33. Using *Wickard v. Filburn*, 317 U.S. 111 (1942), and other relevant Commerce Clause jurisprudence, the Court considered the aggregation of local activity in determining its effect on interstate commerce. *Raich*, 545 U.S. at 17–22.

²³⁸ *Raich*, 545 U.S. at 9.

²³⁹ See Cohen, *supra* note 73.

²⁴⁰ See, e.g., Beletsky et al., *supra* note 66, at 234 & n.78; Burris et al., *supra* note 20, at 1142; Cylas Martell-Crawford, *Safe Injection Facilities: A Path to Legitimacy*, 11 ALB. GOV’T L. REV. 124, 137 (2018).

²⁴¹ See Chloé Potier et al., *Supervised Injection Services: What Has Been Demonstrated? A Systematic Literature Review*, 145 DRUG & ALCOHOL DEPENDENCE 48, 50–62 (2014).

will allow those *already obtained* to be safely injected in a sanitary location.²⁴² The differences between the circumstances in the *Raich* case compared to any challenges to a supervised injection site are apparent. Whereas the *Raich* Court could rationally speculate an effect on interstate commerce for a law that authorizes the production of a controlled substance, supervised injection sites simply are mechanisms to protect vulnerable populations from the harmful effects of injection-based opioids. Further, the above-mentioned research on supervised injection sites refutes any notion that these sites will cause illegal markets for injection-based opioids to grow. Without any empirical evidence to the contrary, the federal government's use of the "Crack House Statute" to prosecute future supervised injection sites would be infringing on the type of local, non-economic activity that the Supreme Court has explicitly allocated to the states. Supervised injection sites should not be federally preempted, and states will likely be successful in defending against inevitable federal prosecution.

CONCLUSION

While states like California have been quick to 'bend the knee' to federal threats regarding supervised injection sites,²⁴³ the federal government's grounds for prosecution are weak. Even so, on January 15, 2020, Surgeon General Jerome Adams reiterated the government's opposition to these sites, stating that he has "seen little to no data suggesting they are overall more effective than expanding syringe services programs."²⁴⁴ Hopefully, states will continue to push for the creation of supervised injection sites to sensibly reduce harms associated with unsafe, public injection of opioids. Although it is impossible to know whether the presence of a supervised injection site may have saved someone like Blake Hadden and allowed him to walk across the stage at Furman University, the empirical

²⁴² See *Supervised Consumption Services*, *supra* note 71.

²⁴³ See Lopez, *supra* note 127.

²⁴⁴ Kimberly Leonard, *Trump Surgeon General Criticizes Supervised Injection Sites as Opioid Crisis Response*, WASH. EXAMINER (Jan. 15, 2020, 1:53 PM), <https://www.washingtonexaminer.com/policy/healthcare/trump-surgeon-general-criticizes-supervised-injection-sites-as-opioid-crisis-response>.

evidence is promising that these sites will begin to reverse some of the detrimental effects from the opioid crisis and give some people—who would otherwise overdose—another day to live.²⁴⁵

²⁴⁵ See Potier et al., *supra* note 241, at 50–62.