

Advancing Harm Reduction Services in the United States: The Untapped Role of the Americans with Disabilities Act

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Abstract:

Now in its third decade, the overdose crisis continues to worsen. Harm reduction strategies, such as syringe service programs (SSPs), are proven, cost-effective responses to this ongoing public health emergency. Despite extensive research demonstrating that the health and social benefits of harm reduction services far outweigh alleged negative externalities, the number and scope of these programs continue to be severely limited. Restrictive zoning and other discriminatory legal measures figure among key barriers to harm reduction service access. The Americans with Disabilities Act (ADA) and Rehabilitation Act (RA) have recently gained prominence in challenging discrimination against people who seek substance use treatment. But the instrumental potential of these landmark statutes to advance access to harm reduction services has been largely unrealized. By drawing lessons from the emerging success in using Title II of the ADA and Section 504 of the RA in the realm of substance use treatment, we call for urgent deployment of these statutes to expand access to harm reduction services in the United States. In the context of a spiraling crisis, these legal tools offer enormous promise in safeguarding the rights—and lives—of vulnerable people.

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INTRODUCTION

The United States is facing an unprecedented set of public health challenges, at a time when the COVID-19 pandemic has compounded the ongoing overdose crisis. Disruption in treatment and support services, economic shocks, and social isolation wrought by coronavirus have all impeded efforts to bend the overdose curve—now surging again after a momentary deceleration prior to the onset of the pandemic. In 2021, over 107,000 overdose deaths were reported nationally, representing another double-digit increase from the previous calendar year, with disproportionate impact on Black and brown communities.¹ This means that nearly 300 people die each day from a preventable cause. Emergency department visits for non-fatal overdoses also continue to surge.² To make matters worse, there is evidence that people with substance use disorder are more susceptible to COVID-19 infection and its deadly sequelae.³

Prevention and supportive services are vital to safeguarding the health of people who use drugs. Although access to substance use treatment has received substantial attention and support, harm reduction services continue to be largely ignored by policymakers and public health officials. These vital programs include syringe service programs (SSPs), naloxone distribution, drug checking, and supervised consumption facilities. Since their community-based beginnings in the 1980s, SSPs have developed as a grass-roots movement to offer access to sterile syringes and other equipment for consuming drugs more safely. This includes access to a range of additional wrap-around services, such as substance use treatment, infectious disease testing, wound care, and other pertinent assistance. Intended to address the needs of highly stigmatized, criminalized people who use illicit drugs, SSPs have been shown especially effective as

¹ NAT'L CTR. FOR HEALTH STATS., PROVISIONAL DRUG OVERDOSE DEATH COUNTS, <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm#data-tables> [<https://perma.cc/K6Z9-TBFR>] (last visited Mar. 11, 2020).

² See William E. Soares III et al., *Emergency Department Visits for Nonfatal Opioid Overdose During the COVID-19 Pandemic Across Six US Health Care Systems*, 79 ANNALS EMERGENCY MED. 158, 161-163 (2022).

³ Rita Rubin, *Substance Use Disorders and COVID-19 Vaccine Response*, 326 JAMA 2000, 2000 (2020); Robert Csák et al., *Harm Reduction Must Be Recognized an Essential Public Health Intervention During Crises*, 18 HARM REDUCTION J. 1, 1 (2021).

platforms for stemming bloodborne infections, preventing overdose, and facilitating access to a broad range of supports.⁴

As the COVID-19 pandemic has made abundantly clear, public health is highly political—and as with all politics, public health politics are local. Social distancing, mask mandates, testing, and other measures to address this crisis are being met with fervent resistance in many communities, fueled by misinformation and ideological polarization. Many jurisdictions resisted the siting of critical pandemic services, including testing and supportive housing for people infected or at risk of contracting COVID-19. For those working in harm reduction, however, such local opposition is nothing new. In fact, siting of syringe services, substance use treatment facilities, and other services for people who use drugs have frequently been met with community opposition, foreshadowing many of the same challenges on stark display during the historic crisis of the COVID-19 pandemic.⁵

The justification for neighborhood opposition to public health efforts to address substance use disorder (SUD)—and COVID—is often tenuous. Concerns are loosely based on fears for the health and safety of the area’s

⁴ CTRS. FOR DISEASE CONTROL & PREVENTION, SYRINGE SERVICE PROGRAMS (SSPs) FACT SHEET, <https://www.cdc.gov/ssp/syringe-services-programs-factsheet.html> [<https://perma.cc/T2R4-6LAK>] (last visited May 23, 2019); Sara Glick et al., *The Impact of COVID-19 on Syringe Services Programs in the United States*, 24 AIDS & BEHAV. 2466, 2466 (2020) (explaining that “SSPs stressed the importance of their connections with populations with environmental and structural risk factors for serious COVID-19 sequelae, and their commitment to continuing to serve these participants. These connections present the opportunity to offer COVID-19 screening and testing, which some programs are already doing.”).

⁵ See, e.g., Nathaniel Cline, *Neighbors Oppose Planned Residential Youth Treatment Facilities*, LOUDOUN TIMES (Dec. 29, 2021), https://www.loudountimes.com/news/neighbors-oppose-planned-residential-youth-treatment-facilities/article_39d0e1d6-6846-11ec-9523-4b3ce77e4d88.html [<https://perma.cc/AP4Q-CZM3>]; Emily Alpert Reyes & Ben Brazil, *California Backs Syringe Programs. But They’re Nowhere to Be Found in Orange County*, LA TIMES (Mar. 13, 2022), <https://www.latimes.com/california/story/2022-03-13/california-syringe-programs-needle-access-orange-county> [<https://perma.cc/J28W-5CZZ>]; *Itasca Officials Reject Drug Treatment Facility, But Proponents Say Fight May Continue*, NBC CHICAGO (Nov. 2, 2021), <https://www.nbcchicago.com/news/local/itasca-officials-reject-drug-treatment-facility-but-proponents-say-fight-may-continue/2668937/> [<https://perma.cc/GX55-CACT>].

current residents, while not grounded in any science, or sometimes have no basis at all.⁶ Colloquially referred to as not-in-my-back-yard (“NIMBY”) zoning, such tactics have significantly hindered the expansion of lifesaving health screenings, quarantine sites,⁷ housing for homeless populations amid the pandemic,⁸ and access to SSPs and drug treatment. When NIMBY challenges successfully halt or delay the necessary public health response to appropriately address COVID-19 and the drug crisis in America, it will cost many people their lives.

Despite the heightened need for SSPs in the midst of the COVID-19 pandemic, it appears that opposition to their existence has only grown stronger in recent months, as evidenced by several high-profile closures⁹ across the country. In response to these closures, activist organizations, such as the South Jersey AIDS Alliance fighting for Oasis in Atlantic City,¹⁰ have filed lawsuits to prevent policymakers from eliminating SSPs and the valuable resources they provide. However, there are few descriptions of potential legal strategies that may be employed to block shutdowns in such cases. Beyond limited mention in internal materials by

⁶ Nolan Gray, *The NIMBYs of the Coronavirus Crisis*, BLOOMBERG CITYLAB (Mar. 27, 2020), <https://www.citylab.com/perspective/2020/03/coronavirus-fear-covid-19-testing-center-nimby-community/608929/> [<https://perma.cc/8ZFY-X4Z9>].

⁷ See Ivan Pereira, *Feds Backtrack on Transfer of Quarantined Coronavirus Patients to Alabama*, ABC NEWS (Feb. 23, 2020), <https://abcnews.go.com/Health/feds-backtrack-transfer-quarantined-coronavirus-patients-alabama/story?id=69162771> [<https://perma.cc/CR2Y-DZJG>]; Faith Pinho & Hillary Davis, *Costa Mesa’s Objection to Coronavirus Quarantine Based On Fear-Mongering, Officials Say*, L.A. TIMES (Feb. 24, 2020), <https://www.latimes.com/california/story/2020-02-24/costa-mesas-objection-to-coronavirus-quarantine-based-on-fear-mongering-officials-say> [<https://perma.cc/4CSQ-S3PQ>].

⁸ Angelica Acevedo, *Queens Councilman Calls for Closure of Glendale Homeless Shelter Amid Coronavirus Crisis*, QNS (Mar. 19, 2020), <https://qns.com/story/2020/03/19/queens-councilman-calls-for-closure-of-glendale-homeless-shelter-amid-coronavirus-crisis/> [<https://perma.cc/4DKH-SNAW>].

⁹ Jennifer D. Oliva et al., *Defending Syringe Services Programs*, HEALTH AFFS. BLOG (Aug. 23, 2021).

¹⁰ Molly Shelly, *Atlantic City Barred from Shutting Down Syringe Exchange Program Until November Court Date*, THE PRESS OF ATLANTIC CITY (Sept. 30, 2021), https://pressofatlanticcity.com/news/local/atlantic-city-barred-from-shutting-down-syringe-exchange-program-until-november-court-date/article_58469000-21f3-11ec-873d-2f9cd61e8150.html [<https://perma.cc/6Y5C-5VET>].

legal advocates,¹¹ the potential instrumentality of federal anti-discrimination legislation to safeguard harm reduction programs has not, to our knowledge, been previously explored. This is likely due to pervasive stigma and misinformation that applies to harm reduction services and measures in academic and policy circles.

To fill this gap, this Article draws on the case study of an SSP in Kennewick, Washington to advance a legal framework for using the Americans with Disabilities Act (“ADA”) and the Rehabilitation Act (“RA”), two laws that prohibit disability discrimination, to challenge discriminatory zoning practices targeting SSPs. In our analysis, we apply an evolving ADA and RA canon in an analogous, but distinct realm: NIMBY zoning challenges to deter and displace substance use treatment facilities which courts have in several cases found to be facially discriminatory under the ADA and RA. These NIMBY zoning challenges seek to discriminate against people with SUD, who have been recognized as a protected class under the ADA and RA. This Article outlines how litigants can apply this principle, building on the case law related to substance use disorders to overcome NIMBY zoning restrictions on SSPs. The rationale for invoking the ADA and RA to challenge SSP discriminatory regulations is strengthened by the reality that substance use treatment services are physically co-located in a growing number of SSPs—making these programs precisely analogous to facilities where ADA protections have already been established. These substance use treatment services administered by healthcare providers may include prescription of medications for opioid use disorder (MOUD), provision of a variety of psychotherapies, and treatment for other medical comorbidities related to drug use.

While we focus on arguments for combating discriminatory zoning against SSPs, many of our legal arguments can also be used to challenge other NIMBY restrictions on access to health services for COVID-19, drug treatment, and other issues.

¹¹ LEGAL ACTION CTR., EMERGENCY: HOSPITALS CAN VIOLATE FEDERAL LAW BY DENYING NECESSARY CARE FOR SUBSTANCE USE DISORDERS IN EMERGENCY DEPARTMENTS, <https://www.lac.org/resource/emergency-hospitals-can-violate-federal-law-by-denying-necessary-care-for-substance-use-disorders-in-emergency-departments> [<https://perma.cc/E4KD-PK48>].

I. SYRINGE SERVICES ARE CRITICAL TO ADDRESS THE OPIOID CRISIS.

A. *The Importance of SSPs*

Drug overdose is the leading cause of death in the United States for those ages eighteen to forty-five ahead of gun violence and automobile accidents.¹² This crisis is multi-faceted, but two response options offer significant promise in reducing the rate of fatal and non-fatal overdoses. The first is the distribution of naloxone, the opioid overdose antidote, which has been shown to significantly reduce community overdose rates.¹³ The second is improving access to MOUD, such as methadone and buprenorphine.¹⁴ Maintenance therapy deploying these medications slashes individual overdose risk by nearly 60 percent after a year of treatment.¹⁵ Tragically, access to naloxone and MOUD remains inadequate because of logistical, financial, and legal barriers, all propelled by stigma against drug use.¹⁶

¹² CTRS. FOR DISEASE CONTROL & PREVENTION, LEADING CAUSES OF DEATH AND INJURY, <https://cdc.gov/injury/wisqars/LeadingCauses.html/> [<https://perma.cc/XT59-5ESL>] (last visited Apr. 5, 2022).

¹³ Alexander Walley et al., *Opioid Overdose Rates and Implementation of Overdose Education and Nasal Naloxone Distribution In Massachusetts: Interrupted Time Series Analysis*, 346 *BMJ* 1, 4, 10-11 (2013).

¹⁴ The U.S. Department of Justice enforces the ADA to reduce opioid-related deaths by investigating treatment centers preventing access to MOUD. See The United States Attorney's Office, District of Massachusetts, *U.S. Attorney's Office Settles Disability Discrimination Allegations at Skilled Nursing Facility*, U.S. DEP'T JUST. (May 10, 2018), <https://www.justice.gov/usao-ma/pr/us-attorney-s-office-settles-disability-discrimination-allegations-skilled-nursing> [<https://perma.cc/RDR4-Y9BK>]; *Justice Department Reaches Settlement with Selma Medical Associates Inc. to Resolve ADA Violations*, U.S. DEP'T JUST.: OFF. PUB. AFFS. (Jan. 31, 2019), <https://www.justice.gov/opa/pr/justice-department-reaches-settlement-selma-medical-associates-inc-resolve-ada-violations> [<https://perma.cc/K65A-WVZT>] ("Unlawfully denying services to individuals with disabilities because of their medical conditions subjects these individuals to unwarranted stigma and harm, and will not be tolerated by the Department of Justice").

¹⁵ Sarah E. Wakeman et al., *Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder*, *JAMA NETWORK OPEN*, Feb. 2020, at 1.

¹⁶ Leo Beletsky, *21st Century Cures for the Opioid Crisis: Promise, Impact, and Missed Opportunities*, 44 *AM. J. L. & MED.* 359, 363-372 (2018).

In concert with an unprecedented rise in overdose deaths, the United States is also experiencing an increase in sequelae of widespread problematic substance use, including injection-related diseases like hepatitis B, hepatitis C, and HIV.¹⁷ One in every ten new HIV infections is now among people who inject drugs, and many of these individuals are co-infected with hepatitis C.¹⁸ There have been a number of outbreaks of HIV in the wake of the overdose crisis, including in Scott County, Indiana; Lawrence, Massachusetts; and Huntington, West Virginia.¹⁹ Hundreds of additional counties are facing a high risk of outbreaks if prevention measures continue to lag behind.²⁰

The good news is that SSPs can effectively address all of these issues under one roof. SSPs have consistently been shown to be effective at saving lives and reducing the spread of infectious diseases.²¹ Almost universally, SSPs provide a variety of health and social services beyond clean and safe injection supplies. These services may include the provision of—or referrals to—substance use treatment, prevention education for sexually transmitted diseases, HIV counseling and testing, screening for tuberculosis, and primary health care.²²

¹⁷ CTNS. FOR DISEASE CONTROL & PREVENTION, ADDRESSING THE INFECTIOUS DISEASE CONSEQUENCES OF THE U.S. OPIOID CRISIS, <https://www.cdc.gov/nchstp/budget/infographics/opioids.html> [https://perma.cc/BT2N-CYPC] (last visited Mar. 18, 2020).

¹⁸ *Id.*

¹⁹ Kevin Cranston et al., *HIV Diagnoses Among Persons Who Inject Drugs—Northeastern Massachusetts, 2015–2018*, 68 MORBIDITY & MORTALITY WKLY. REP. 253, 253 (2019); Dan Goldberg, *The Nightmare Everyone is Worried About: HIV Cases Tied to Opioids Spike in West Virginia County*, POLITICO (Sept. 2, 2019), <https://www.politico.com/story/2019/09/02/hiv-opioids-cabell-west-virginia-1668389> [https://perma.cc/RQV6-ZKDG]; Lisa Rapaport, *Indiana HIV Outbreak Among Drug Users May Have Been Avoidable*, REUTERS (Oct. 4, 2018), <https://www.reuters.com/article/us-health-hiv-indiana/indiana-hiv-outbreak-among-drug-users-may-have-been-avoidable-idUSKCN1ME2N7> [https://perma.cc/CTE9-F4PX].

²⁰ *Id.* at 1–3.

²¹ UNAIDS, DO NO HARM: HEALTH, HUMAN RIGHTS AND PEOPLE WHO USE DRUGS 15 (2016), https://www.unaids.org/sites/default/files/media_asset/donoharm_en.pdf [https://perma.cc/LH4V-S935].

²² ACLU, FACT SHEET ON NEEDLE EXCHANGE PROGRAMS, <https://www.aclu.org/fact-sheet/needle-exchange-programs-promote-public-safety> [https://perma.cc/KD23-7RR3] (last visited Mar. 12, 2020).

B. SSPs and COVID-19

Although SSPs emerged in the United States in response to the HIV epidemic, their presence has grown dramatically since the start of the ongoing overdose crisis.²³ Over the past two years, they have become a critical tool in the fight against COVID-19. As COVID-19 surges across the United States, people with substance use disorder are uniquely vulnerable to contracting the virus and becoming severely ill. Substance use disorder is strongly associated with homelessness²⁴ and major medical comorbidity²⁵, two factors that greatly increase the risk of becoming seriously ill from COVID-19.²⁶ Additionally, the COVID-19 pandemic has overwhelmed the already overburdened systems that serve this vulnerable population. Across the country, hospitals scramble to meet the demands of an influx of patients, with many lacking necessary resources to safely combat the virus. Local governments face new challenges in providing food and shelter to the homeless as shelters stop taking new entrants²⁷ and foodbanks fight to keep their doors open.²⁸ SSPs provide vital health services, including access to sterile syringes to prevent

²³ The United States is in the midst of a crisis in drug overdose, addiction, and bloodborne infectious disease linked to syringe sharing among people who inject drugs. See NAT'L CTR. FOR HEALTH STATS., *supra* note 1, at 1.

²⁴ Erin J. Stringfellow et al., *Substance Use Among Persons with Homeless Experience in Primary Care*, 37 SUBSTANCE ABUSE 534, 536 (2016).

²⁵ Eric Sarlin, *Substance Use Disorders Are Associated With Major Medical Illnesses and Mortality Risk in a Large Integrated Health Care System*, NIDA, (Oct. 24, 2017), <https://www.drugabuse.gov/news-events/nida-notes/2017/10/substance-use-disorders-are-associated-major-medical-illnesses-mortality-risk-in-large-integrated> [<https://perma.cc/E3GB-7EFX>].

²⁶ Homeless Research Institute, *Population At-Risk: Homelessness and the COVID-19 Crisis*, NAT'L ALL. TO END HOMELESSNESS (2020), <https://endhomelessness.org/wp-content/uploads/2020/03/Covid-Fact-Sheet-3.25.2020-2.pdf> [<https://perma.cc/7LFR-PK8G>].

²⁷ Samantha Melamed, *'It's Heartbreaking': Coronavirus Puts Philly Homeless Services in Survival Mode*, PHILADELPHIA INQUIRER (Mar. 19, 2020), <https://www.inquirer.com/health/coronavirus/philadelphia-coronavirus-covid-19-homeless-response-social-distancing-20200319.html> [<https://perma.cc/624L-YH2W>].

²⁸ Yelena Dzhanova, *Food Banks Are Closing and Losing Their Workforce Because of the Coronavirus*, CNBC (Apr. 28, 2020), <https://www.cnbc.com/2020/04/28/coronavirus-food-banks-are-closing-and-losing-their-workforce.html> [<https://perma.cc/BV9P-ZKYL>].

bloodborne disease, provision of naloxone to reverse overdoses, various diagnostic services, wound care, and access to substance use treatment and other supportive services. In many cities and states, SSPs have been deemed “essential” and are allowed to keep their doors open amid the pandemic, notwithstanding the forced shutdown of other businesses and nonprofits.²⁹ In the face of this crisis, SSPs are one of last places where people with substance use disorder can receive vital care.

C. NIMBY Challenges to SSPs

While there has been some recent progress as an increasing number of states pass laws permitting the formation of SSPs,³⁰ many local governments are employing a variety of legal tactics to thwart this progress. Discriminatory zoning ordinances have been one of the principal instruments in suppressing the lifesaving and cost-saving potential of SSPs. Through such tactics, numerous programs throughout the country have shut down or have been prevented from opening their doors at all.³¹

²⁹ NYC HEALTH DEP'T, COVID:19: ESSENTIAL SERVICE GUIDANCE FOR SYRINGE SERVICE PROGRAMS (May 23, 2020), <https://www1.nyc.gov/assets/doh/downloads/pdf/imm/syringe-service-programs.pdf> [<https://perma.cc/XM5D-T545>] (New York); Letter from North Carolina Department of Health and Human Services (Apr. 6, 2020), <https://files.nc.gov/ncdhhs/documents/files/covid-19/Safer-Syringe-Programs-are-Essential-Services-Memo.pdf> [<https://perma.cc/VH7H-GRYX>] (North Carolina); Jake Ellison, *Large Majority of State's Heroin Users Want to Reduce Use; Syringe Programs Helping During COVID-19 Crisis*, UW NEWS (Apr. 10, 2020), <https://www.washington.edu/news/2020/04/10/large-majority-of-states-heroin-users-want-to-reduce-use-syringe-programs-helping-during-covid-19-crisis/> [<https://perma.cc/N72L-SLXS>] (Washington); Aneri Pattani, *Syringe Exchanges Deemed 'Life-Sustaining' During PA Coronavirus Shutdown, Raising Hopes For Eventual Legalization*, PHILADELPHIA INQUIRER (Mar. 30, 2020), <https://www.inquirer.com/news/pennsylvania/spl/pennsylvania-coronavirus-syringe-exchange-life-sustaining-legalization-20200330.html> [<https://perma.cc/5X4C-6WUU>] (Pennsylvania).

³⁰ Marcelo H. Fernandez-Vina et al., *State Laws Governing Syringe Services Programs and Participant Syringe Possession, 2014-2019*, 135 PUBLIC HEALTH REPS. 128S (Supp. I 2020).

³¹ Amelia Ferrell Knisely, *Hepatitis C Numbers Soar in Kanawha Following Syringe Exchange Closure*, CHARLESTON GAZETTE-MAIL (Oct. 1, 2019), <https://www.wvgazettemail.com/news/health/hepatitis-c-numbers-soar-in-kanawha->

In October 2019, SSPs in Kennewick, Washington, came under attack by local lawmakers through a seemingly benign proposal to amend local zoning laws. The Kennewick City Attorney's Office proposed amendments to designate limited zones where SSPs could operate within the municipality and to impose stringent requirements on their manner of operation, such as imposing burdensome distance restrictions from residential zones, schools, parks, and public facilities as well as limitations on time of operation and number of syringes provided to each attendant.³² In response, members of the affected community mounted a challenge to the proposed zoning provision.³³

The hearing on the proposed ordinance in Washington was a replay of analogous proceedings in Indiana, California, and a number of other jurisdictions where SSPs are up against increasingly antagonistic zoning and other ordinances. A medical student-run SSP in Claremont, New Hampshire, was forced to shut down after local officials concluded that the program was not allowed to operate within 1,000 feet of a school zone.³⁴ Commissioners in Asheville, North Carolina, have attempted to rebrand SSPs as resembling "shelters" to justify their closure by claiming

following-syringe-exchange-closure/article_0577f072-4b6e-5dc3-821f-b4d4479f4e26.html [https://perma.cc/4RR8-9V8R]; German Lopez, *An Indiana County Just Halted a Lifesaving Needle Exchange Program, citing the Bible*, VOX (Oct. 20, 2017), <https://www.vox.com/policy-and-politics/2017/10/20/16507902/indiana-lawrence-county-needle-exchange> [https://perma.cc/F8KV-HV3P]; Alicia Robinson, *Court Decision Means Needle Exchange Program Can't Operate in Orange County*, THE ORANGE COUNTY REGISTER (Oct. 25, 2019), <https://www.oregister.com/2019/10/25/court-decision-means-needle-exchange-program-cant-operate-in-orange-county/> [https://perma.cc/YWF9-C99U].

³² The changes were proposed in Kennewick's Proposed Zoning Ordinance Amendment # 19-07/AMD-2019-02719. KENNEWICK CITY ATTORNEY'S OFFICE, STAFF REPORT ON SYRINGE EXCHANGE PROGRAMS: AMENDMENTS TO TITLE 18 (2019), https://www.go2kennewick.com/AgendaCenter/ViewFile/Agenda/_10212019-1198 [https://perma.cc/8PMP-RFVQ].

³³ CITY OF KENNEWICK CITY COUNCIL, REGULAR MEETING MINUTES, at 3 (2019), <https://docs.ci.kennewick.wa.us/SearchForms/CouncilMinutes.htm> [https://perma.cc/QBX6-H5ZE].

³⁴ Nora Doyle-Burr, *Claremont Needle Exchange Program Searches for a New Home*, VALLEY NEWS (Nov. 11, 2017), <https://www.vnews.com/Claremont-Officials-Seek-Legal-Exemption-to-Allow-Needle-Exchange-to-Relocate-to-Hospital-Near-School-13661092> [https://perma.cc/6N5P-NP63].

that the sites did not possess proper permits for operation.³⁵ Colloquially referred to as not-in-my-back-yard (“NIMBY”) challenges, these zoning restrictions have been used in the past to limit mental health and drug treatment facilities from being established in communities either through new construction or repurposing of older buildings.

Many of these NIMBY challenges are backed by unsupported claims regarding the potential harms of SSPs. For instance, many who oppose SSPs claim that the provision of harm reduction services will promote drug use amongst individuals who would not have used otherwise and increase crime. However, thirty years of research have found that SSPs do not increase drug use or crime in the communities they serve,³⁶ and studies have even shown a higher likelihood in treatment participation amongst attendees.³⁷ Others claim that SSPs increase discarded drug paraphernalia,³⁸ while studies show the opposite.³⁹ Finally, opponents decry worries that SSPs will attract large groups of people who use drugs to the area and subsequently drive down surrounding property values. Beyond finding these claims to be inappropriate as they are extremely stigmatizing towards people who use drugs, there are few, if any, studies that substantiate such concerns.

However, in Kennewick, the City Council faced a novel legal argument when attempting to institute NIMBY zoning laws. Its actions, the advocates asserted, would violate protections from discriminatory

³⁵ Brailey Sheridan, *City of Asheville Tries to Shut Down Syringe Exchange*, THE BLUE BANNER (Oct. 9, 2018), <https://thebluebanner.net/city-of-asheville-tries-to-shut-down-syringe-exchange/> [<https://perma.cc/57JY-TCW2>].

³⁶ CTRS. FOR DISEASE CONTROL & PREVENTION, SUMMARY OF INFORMATION ON THE SAFETY AND EFFECTIVENESS OF SYRINGE SERVICES PROGRAMS (SSPS), <https://cdc.gov/ssp/syringe-services-programs-summary.html/> [<https://perma.cc/B7AD-LB2P>] (last visited Apr. 5, 2022).

³⁷ Hilary L. Surratt, et al., *Motivation to Change and Treatment Participation Among Syringe Service Program Utilizers in Rural Kentucky*, 36 J. RURAL HEALTH 224, 228-229 (2020).

³⁸ Danny Jones & Robin Young, *'You Don't Sacrifice a Whole City' Over Needle Exchange, West Virginia Mayor Says*, HERE AND NOW: WBUR-BOSTON (May 16, 2018), <https://www.wbur.org/hereandnow/2018/05/15/needle-exchange-charleston-west-virginia> [<https://perma.cc/KM49-YKYX>].

³⁹ Harry Levine et al., *Syringe Disposal Among People Who Inject Drugs Before and After Implementation of a Syringe Services Program*, 202 DRUG & ALCOHOL DEPENDENCE 13, 15 (2019).

practices, such as those outlined in the Title II of the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act (RA).⁴⁰ These arguments ultimately carried the day, with Kennewick City Council sending the ordinance back to the Planning Commission for further consideration.⁴¹

We focus on the use of the ADA and the RA to tackle discriminatory NIMBY zoning restrictions; however, we admit that there many other strategies to block SSPs that may fall outside of this approach. For instance, in 2017, local lawmakers in Lawrence County, Indiana, successfully halted an SSP from opening its doors despite state-level approval of the program.⁴² The blockage of the program at the local level was possible because Indiana law stringently requires county approval of SSPs on an annual basis and stipulates that SSPs may only be operated under a public health emergency, granting considerable leeway for officials in discerning the need for such services.⁴³ In the case of Lawrence County, one commissioner cited the Bible and morality as justification.⁴⁴

The following year in West Virginia, despite positive outcomes and a marked reduction of hepatitis C cases, the needle exchange portion of the Kanawha-Charleston Health Department’s harm reduction program was suspended after a local police chief imposed severe regulations which, among other things, required government-issued identification to access clean syringes.⁴⁵ Similar regulations were further codified into law when West Virginia Governor Jim Justice signed a bill that created licensure requirements for the operation of SSPs. This licensure requires patrons to provide West Virginia identification, one-to-one needle exchange, provision of “unique” syringes that may be tracked to specific sites, necessitates a statement of support from city councils that may be revoked

⁴⁰ KENNEWICK CITY ATTORNEY’S OFFICE, *supra* note 32, at 3.

⁴¹ CITY OF KENNEWICK CITY COUNCIL, *supra* note 33, at 3.

⁴² Leigh Hedger, *2nd Indiana County Ends Needle Exchange, With 1 Official Citing Moral Concerns*, INDYSTAR (Oct. 23, 2017), <https://www.indystar.com/story/news/2017/10/23/2nd-indiana-county-ends-needle-exchange-one-official-citing-moral-concerns/787740001/> [<https://perma.cc/34RF-U3K2>].

⁴³ Lopez, *supra* note 31, at 1.

⁴⁴ *Id.* at 1.

⁴⁵ Knisely, *supra* note 31.

at any time, and imposes \$500 to \$10,000 fees per violation.⁴⁶ Such hefty regulations effectively eliminate the sustainability of SSPs that are already strapped for resources.

Next, in October 2019, after three counties in California sued to block an Orange County SSP from launching a mobile service that would serve four different cities, a San Diego County Superior Court Judge issued an order that required the state to rescind its approval of the SSP.⁴⁷ Local leaders in opposition to the Orange County SSP claimed that the program would be a nuisance and a public health and safety hazard, arguing that the state failed to comply with environmental laws when it approved the SSP.⁴⁸ Specifically, local officials argued that the SSP led to increases in improperly discarded syringes in the surrounding area, despite evidence⁴⁹ demonstrating the opposite. Even though such arguments lack an empirical basis, they often railroad discussions and are used to determine the fate of SSPs. This judicial rescission means that organizers will have to reapply, and the state will need to hold an environmental review before their SSP is approved.⁵⁰

The extreme limitations written into laws that guide the operation of SSPs can in part be explained by the presence of drug paraphernalia laws in most states that predated SSPs and made illegal the distribution and possession of a syringe with the intent of using drugs. In response, laws governing SSPs are forced to carve a narrow set of circumstances for their operation, which leaves them vulnerable to a variety of attacks, including zoning laws used to enact NIMBY agendas. One solution for these assaults is state legislation that bans NIMBY actions by explicitly preempting or otherwise limiting the application of other laws to the context

⁴⁶ Lauren Peace, *Judge Rules Law Restricting West Virginia Needle Exchange Programs Can Stand*, MOUNTAIN STATE SPOTLIGHT (July 15, 2021), <https://mountainstatespotlight.org/2021/07/15/law-restricting-wv-needle-exchange-programs-can-stand/> [https://perma.cc/BL2V-CPUY].

⁴⁷ Robinson, *supra* note 31.

⁴⁸ Luke Money & Faith E. Pinho, *Court Order All But Bans Mobile Needle Exchange Program In Costa Mesa, Other O.C. Cities*, L.A. TIMES (Oct. 25, 2019), <https://www.latimes.com/socal/daily-pilot/news/story/2019-10-25/court-order-all-but-bans-mobile-needle-exchange-program-in-costa-mesa-other-o-c-cities> [https://perma.cc/9E49-NXRV].

⁴⁹ CTRS. FOR DISEASE CONTROL, *supra* note 4.

⁵⁰ Robinson, *supra* note 31.

of SSPs. One recent example of this is a recent California law that will block lawsuits citing environmental regulations in order to shut down SSPs.⁵¹

II. THE ADA AND RA PROVIDE LEGAL REMEDIES FOR PERSONS WITH SUBSTANCE USE DISORDER TO CHALLENGE FACIALLY DISCRIMINATORY ZONING PROVISIONS.

Disability anti-discrimination laws are another avenue to challenge discriminatory NIMBY zoning of SSPs, given the success of these laws in striking down discriminatory zoning of substance use disorder treatment centers. This may be a particularly wise legal strategy in states and legal jurisdictions that have proven hostile to SSPs, as this is a federal approach, with relief possible through either federal courts or action from federal agencies. The current Biden Administration, in particular, has expressed support of SSPs in the form of increased funding for such programs as a means of promoting health for people with SUD and seeking to mitigate the opioid crisis.⁵² In April 2022, the Department of Justice published guidance claiming that people with opioid use disorder (OUD) are protected under the ADA and that “a town [refusing] to allow a treatment center for people with OUD to open after residents complained that they did not want ‘those kind of people’ in their area” may violate the ADA.⁵³ In this Part, we describe prior cases related to zoning for treatment center locations; in the next Part, we turn to the novel application of anti-discrimination laws to zoning ordinances for SSPs.

⁵¹ State Department of Public Health: Needle and Syringe Exchange Services, A.B. 1344, 2021–2022 Leg., Reg. Sess. (Cal. 2021), https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1344 [<https://perma.cc/ZZ46-5AX2>].

⁵² American Rescue Plan Act of 2021, Pub. L. No 117-2 §§ 2702–2706, 135 Stat. 4, 45–47 (2021), <https://www.congress.gov/bill/117th-congress/house-bill/1319/text> [<https://perma.cc/UY9K-55YQ>].

⁵³ U.S. DEP’T JUST., THE AMERICANS WITH DISABILITIES ACT AND THE OPIOID CRISIS: COMBATING DISCRIMINATION AGAINST PEOPLE IN TREATMENT OR RECOVERY, https://www.ada.gov/opioid_guidance.pdf [<https://perma.cc/9F6R-K4RR>] (last visited Apr. 16, 2022).

Passed into law and signed in 1990, Title II of the Americans with Disabilities Act (ADA) prohibits disability discrimination by public entities, including state and local governments.⁵⁴ Likewise, Section 504 of the Rehabilitation Act of 1973 (RA) prohibits recipients of federal financial assistance from discriminating on the basis of disability in their programs and activities.⁵⁵ Both laws only protect people with qualifying disabilities, which includes people who have a physical or mental impairment that substantially limits major life activities, people who have a record of such impairment, or people who are regarded as having such an impairment.⁵⁶ Private rights of action are available to allege intentional or facial discrimination,⁵⁷ as well as disparate impact claims.⁵⁸ If a plaintiff can establish that the ordinance violates the ADA or RA, a municipality that attempts to pass a discriminatory ordinance, at minimum, may be enjoined from enforcing the wrongful ordinance and, if shown to be intentionally discriminatory, may be held liable for monetary damages including attorneys' fees.⁵⁹ Both the ADA and RA abrogate

⁵⁴ 42 U.S.C. §§ 12131–32 (2018) (“Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”).

⁵⁵ 29 U.S.C. § 794 (“No otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”).

⁵⁶ 45 C.F.R. § 84.3(j) (2021).

⁵⁷ *Chapman v. Pier 1 Imports (U.S.) Inc.*, 631 F.3d 939, 946 (9th Cir. 2011) (citing *Trafficante v. Metro. Life Ins. Co.*, 409 U.S. 205, 209, (1972)).

⁵⁸ *Alexander v. Choate*, 469 U.S. 287 (1985). The text of the Rehabilitation Act and the ADA do not expressly state whether disparate impact claims are permitted. In *Choate*, the Supreme Court indicated a willingness to consider some disparate impact claims, however. The topic was to be revisited by the Supreme Court in *CVS Pharmacy v. Doe* but the parties settled before the case could be decided. See *CVS Pharmacy v. Doe*, 141 S. Ct. 2882 (2021). For more on the topic, see Jessica L. Roberts & Hannah Eichner, *Disability Rights in Health Care Dodge a Bullet*, 3 JAMA HEALTH FORUM e221353 (2022).

⁵⁹ This is because the only way to alter a facially discriminatory ordinance is to remove the discriminating language, which would render the ordinance a nullity. Additionally, it is worth noting that a facial challenge precludes the government from asserting a reasonable accommodation defense. See *Bay Area Addiction Research & Treatment, Inc. v. City of Antioch*, 179 F.3d 725, 735 (9th Cir. 1999) (concluding that the reasonable

sovereign immunity, clearly permitting suits against states, local governments, and their officials. Federal government agencies may also issue injunctions against violating laws.

These provisions have been successfully employed through facial challenges to discriminatory zoning ordinances targeting substance use treatment programs.

Twenty years ago, in *Bay Area Addiction Research & Treatment, Inc. v. City of Antioch*, the Ninth Circuit established that the ADA and the RA apply to zoning restrictions targeting substance use treatment facilities because “zoning is a normal function of a government entity.”⁶⁰ The court reasoned that the “sweeping language [of the ADA]—most noticeably Congress’s analogizing the plight of the disabled to that of ‘discrete and insular minorit[ies]’ like racial minorities—strongly suggests that § 12132 [the section of the ADA prohibiting discrimination by public entities] should not be construed to allow the creation of spheres in which public entities may discriminate on the basis of an individual’s disability.”⁶¹ The court then struck down an emergency moratorium prohibiting the operation of methadone clinics within 500 feet of residential areas as facially discriminatory on the basis of the plaintiff’s disability and a per se violation of Title II of the ADA.⁶² The court also stated, however, that a city might defend its ordinance with the “direct threat” test by showing that a clinic poses a significant risk to the health or safety of the community and that it is ameliorating that risk through reasonable modifications.⁶³ The court stressed, though, that there must be evidence of a real and significant risk, it “may not be based on generalizations or stereotypes about the effects of a particular disability.”⁶⁴

modifications test does not apply to facially discriminatory laws and that facially discriminatory laws present per se violations of § 12132); *MX Grp. Inc. v. City of Covington*, 293 F.3d 326, 334 (6th Cir. 2002) (holding that plaintiff not required to request reasonable accommodation because the blanket prohibition of all methadone clinics from the entire city was discriminatory on its face).

⁶⁰*Bay Area Addiction Research & Treatment, Inc.*, 179 F.3d at 731.

⁶¹ *Id.*

⁶² *Id.* at 737.

⁶³ *Id.*

⁶⁴ *Id.*

Three years later, in *MX Group, Inc. v. City of Covington*, the Sixth Circuit invalidated an ordinance limiting the number of all SUD treatment clinics to one facility for every 20,000 persons in the city, finding that “the blanket prohibition of all methadone clinics from the entire city was discriminatory on its face” in violation of the ADA.⁶⁵ In that case, the court emphasized that the zoning ordinance was clearly motivated by prejudice against people with addictions and, furthermore, that this prejudice underscored their status as people with disabilities:

Plaintiff adduced sufficient evidence to show that the reason the city denied Plaintiff the zoning permit was because the city feared that Plaintiff’s clients would continue to abuse drugs, continue in their drug activity, and attract more drug activity to the city. In other words, based on fear and stereotypes, residents believed that the drug addiction impairment of Plaintiff’s potential clients, at the very least, limited the major life activity of productive social functioning, as their status as recovering drug addicts was consistently equated with criminality. The record also supports the district court’s finding that the Board of Adjustment denied Plaintiff’s permit primarily for these reasons.⁶⁶

Similarly, the Third Circuit in *New Directions Treatment Servs. v. City of Reading* struck down a state statute imposing a ban on the establishment of SUD treatment clinics within 500 feet of schools, churches, and residential housing developments, holding that the statute “facially singles out methadone clinics, and thereby methadone patients, for different treatment, thereby rendering the statute facially discriminatory.”⁶⁷ The case of *New Directions Treatment Servs.* as well as others rely on proof of intentional discrimination under the ADA and RA. While future cases employing this strategy may be weakened significantly if intentional discrimination cannot be proven and they instead must rely on demonstrations of disparate impact, this rarely comes into play given the discriminatory language used in NIMBY zoning laws:

⁶⁵ *MX Grp., Inc. v. City of Covington*, 293 F.3d 326, 345 (6th Cir. 2002).

⁶⁶ *Id.* at 342 (citing *Ross v. Campbell Soup Co.*, 237 F.3d 701, 706 (6th Cir. 2001)).

⁶⁷ *New Directions Treatment Servs. v. City of Reading*, 490 F.3d 293, 304 (3d Cir. 2007).

The only way to alter a facially discriminatory ordinance is to remove the discriminating language. The Antioch ordinance could only have been “rendered facially neutral by expanding the class of entities that may not operate within 500 feet of a residential neighborhood to include all clinics at which medical services are provided, or by striking the reference to methadone clinics entirely,” and, “[either modification. would fundamentally alter the zoning ordinance, the former by expanding the covered establishments dramatically, and the latter by rendering the ordinance a nullity.”⁶⁸

Additionally, the court rejected the “direct threat” defense by the government, clarifying the standard for determining whether a clinic poses a risk: “we cannot base our decision on the subjective judgments of the people purportedly at risk, the Reading residents, City Council, or even Pennsylvania citizens, but must look to objective evidence in the record of any dangers posed by methadone clinics and patients.”⁶⁹

There are a number of other cases where the ADA and RA have been successfully invoked to strike down discriminatory zoning provisions targeting SUD treatment and rehabilitative services.⁷⁰ In White Plains, New York, an SSP was denied a permit to open an office space for counseling after vehement public opposition on the grounds that this space would fit under “hospital or sanitarium” use, despite no physicians or prescribing taking place at the location. The SSP went on to win an injunction allowing for its operation in this space on the grounds that restricting this use represented discrimination under the ADA and RA, as it was determined that allocation of zoning permits constituted a “service,

⁶⁸ *Id.* at 303.

⁶⁹ *Id.* at 306.

⁷⁰ *Innovative Health Sys., Inc. v. City of White Plains*, 117 F.3d 37 (2d Cir. 1997) (holding the ADA and RA applied to defendant city’s zoning decision); *New Directions Treatment Servs.*, 490 F.3d 293 (3d Cir. 2007) (holding restrictions on methadone clinic violative of Title II of the ADA); *New Directions in Freedom Healthcare Servs. v. Zoning Hearing Bd. of the City of New Castle*, 983 A.2d 1286 (Pa. Commw. Ct. 2009) (reversing zoning board’s denial of a special use application to run a methadone clinic); *Habit OPCO v. Borough of Dunmore*, 2011 Pa. Commw. Unpub. LEXIS 319 (Commw. Ct. Apr. 21, 2011) (denying zoning board restriction on methadone clinic).

program, or activity” as defined in Section 508 of the RA.⁷¹ In Reading, Pennsylvania, the opening of a methadone clinic was contested under a state zoning statute stipulating that “a methadone treatment facility shall not be established or operated within 500 feet of an existing school, public playground, public park, residential housing area, child-care facility, church, meetinghouse or other actual place of regularly stated religious worship established prior to the proposed methadone treatment facility”⁷²

The application of this statute was overturned by the Third Circuit which ruled that it facially discriminated against individuals with substance use disorder under Title II of the ADA and the RA.⁷³ This past litigation teaches us that zoning ordinances resulting in outright bans of facilities providing SUD treatment and rehabilitative services directly fall under the purview of the ADA and RA and ultimately do not withstand judicial scrutiny

III. LEGAL PRINCIPLES APPLIED IN THE LINE OF ADA SUBSTANCE USE TREATMENT CASES ARE APPLICABLE TO SYRINGE SERVICE PROGRAMS.

Here we propose the novel argument that discriminatory zoning ordinances targeting SSPs are facially discriminatory in violation of the ADA and the RA, much like the courts have concluded with respect to SUD treatment centers.

To demonstrate the applicability of this framework to SSPs, we use the proposed Kennewick zoning ordinance by way of example. Proposed Section 18.12.245 of the Kennewick Municipal Code bears many similarities to the ordinances that were struck down in the series of substance use treatment cases invoking the ADA and RA discussed above. Similar to the ordinances in *Bay Area* and *New Directions*, proposed Section 18.12.245(2) provides in relevant part:

No Syringe Exchange Program, shall be located (a) Within 500 feet of any residential or urban mixed use zone; (b) Within 500

⁷¹ *Innovative Health Sys.*, 117 F.3d at 37.

⁷² 53 PA. CONS. STAT. § 10621 (2021).

⁷³ *New Directions Treatment Servs.*, 490 F.3d at 293.

feet of any public or private school, or any trade or vocational school that on a regular basis has at least one student under the age of 18; (c) Within 500 feet of any park or any public facility or institution; (d) Within 1,000 feet of another syringe exchange program⁷⁴

Furthermore, this provision, in conjunction with proposed Section 18.12.245(4) (limiting business hours for SSPs to “daytime hours”),⁷⁵ Section 18.12.245(9) (the “One for One Plus” 10 requirement)⁷⁶ and Section 18.12.245(10) (the syringe marking provision)⁷⁷ amount to intentional discrimination that approach an outright ban of SSPs, as it would be practically impossible to maintain an SSP anywhere in the jurisdiction. As such, a successful legal challenge could have been mounted if the proposed ordinance had been approved.

A. Is There a Protected Class?

In 1985, the Supreme Court failed to classify disability as a protected class under the Fourteenth Amendment in *City of Cleburne, Texas v. Cleburne Living Center, Inc.*⁷⁸ Thus, the ADA represents one of the only legal mechanisms to offer protections for individuals with disabilities. In the case of SSPs, first, the plaintiffs must be persons with disabilities. Courts have recognized that persons with SUD are “disabled” within the meaning of the ADA.⁷⁹ In fact, the Department of Health and Human Services specifically provides that “drug addiction, including an addiction

⁷⁴ Beaton, *supra* note 32, at 10 (Proposed Ordinance No. 5840).

⁷⁵ Beaton, *supra* note 32, at 10 (Proposed Ordinance No. 5840).

⁷⁶ The “One for One Plus” basis provides a one for one exchange of needles. The municipality further proposed that SSPs could only provide 10 extra syringes regardless of the number of syringes brought in by a participant, and capped the total number of syringes given to each person at 100 syringes per visit. *Id.*

⁷⁷ The proposed ordinance provided: “The syringes and needles that are distributed to a program participant shall have an identifiable unified color or mark to identify the source as being the Syringe Exchange Program.” *Id.*

⁷⁸ 473 U.S. 432 (1985).

⁷⁹ *MX Grp., Inc. v. City of Covington*, 106 F. Supp. 2d 914, 918–20 (finding that recovering heroin addicts are “persons with a disability” within the meaning of the ADA).

to opioids, is a disability under Section 504 of the Rehabilitation Act [and] the Americans with Disabilities Act . . . when the drug addiction substantially limits a major life activity.”⁸⁰ The prior cases addressing zoning discrimination also dealt with people with SUDs, and the courts permitted them to proceed under claims of disability discrimination under both the ADA and RA. As one example, in *MX Group*, where plaintiffs sought access to a methadone clinic, the court viewed people with SUD as having a qualifying disability under each of the three prongs of the ADA.⁸¹ They had a physical impairment that limits a major life activity because their addiction was severe enough to require their admittance to a facility, disrupting their ability to work, parent, and live independently or with their families.⁸² The plaintiffs also had a record of a disability, as they had to show proof their addiction had lasted at least one year.⁸³ Lastly, they were regarded as having a disability, because they were denied public services because of wrongful stereotypes (for instance, assumptions the plaintiffs were associated with criminal activity).⁸⁴

With respect to SSPs, the similar or same population is seeking out the service. These are individuals with SUD who require access to a given service to maintain their health and well-being. Some may argue these individuals would not meet the first prong of a disability, as their addiction may not arguably affect a major life activity in the same ways as individuals who have demonstrated a need for institutional care. Although it is inappropriate to generalize about how severely an addiction impacts any single person’s life, people who meet the diagnostic criteria for a substance use disorder under DSM-5 have a “clinically significant impairment or distress.”⁸⁵ We might assume that these individuals may have the level of impairment needed to meet the first prong of the

⁸⁰ U.S. DEP’T HEALTH & HUMAN SERVICES OFF. FOR C.R., *Fact Sheet: Drug Addiction and Federal Disability Rights Laws* (Oct. 25, 2018), <https://www.hhs.gov/sites/default/files/drug-addiction-aand-federal-disability-rights-laws-fact-sheet.pdf> [<https://perma.cc/8PQX-MHKH>].

⁸¹ *MX Grp.*, 106 F. Supp. 2d at 918–20.

⁸² *Id.* at 918.

⁸³ *Id.* at 918–19.

⁸⁴ *Id.* at 919.

⁸⁵ AM. PSYCHIATRIC ASS’N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (5th ed. 2013).

definition of a disability under the ADA. Moreover, these individuals would likely qualify under one of the other prongs, especially being regarded as having a disability, as they are experiencing the same stereotyping of criminality that plaintiffs experienced in treatment site cases. This stereotyping may be even more pronounced in the case of SSPs as harm reduction services are often even further stigmatized as patrons of these facilities do not have to commit to abstinence-based treatment in order to benefit from their services that reduce the negative effects of drug use.

B. Are Covered Entities Involved?

The successful zoning ordinance challenges related to SUD treatment centers involved state and local laws.⁸⁶ In the cases dealing with treatment centers, courts held states and local government to be covered entities under the ADA and RA.⁸⁷ The ADA expressly covers state and local governments under Title II, while the RA covers entities receiving federal financial assistance which includes local and state governments.

Discriminatory zoning ordinances impeding or blocking access to SSPs are also being issued by state and, more typically, local government entities. These actions are squarely covered under both the ADA and RA.

C. Is the Conduct Covered Behavior?

Courts have held discriminatory zoning decisions to be covered activity under the ADA and RA. In *Bay Area*, the court considered this as a matter of first impression and held that the ADA and RA applied to zoning decisions, noting, “Although we recognize that zoning is a traditionally local activity, Congress has spoken.”⁸⁸ The court did not believe it appropriate to apply the ADA to some activities of public officials but not

⁸⁶ See, e.g., *Bay Area Addiction Research & Treatment, Inc. v. City of Antioch*, 179 F.3d 725, 731 (9th Cir. 1999) (“[Title II of the ADA] thus constitutes a general prohibition against discrimination by public entities.”); see also *New Directions Treatment Servs. v. City of Reading*, 490 F.3d 293, 301 (3d Cir. 2007) (holding that the Rehabilitation Act and ADA reach actions of public officials as well as private actors).

⁸⁷ *Bay Area Addiction Rsch. & Treatment, Inc.*, 179 F.3d at 731; *New Directions Treatment Servs.*, 490 F.3d at 301.

⁸⁸ *Bay Area Addiction Rsch. & Treatment, Inc.*, 179 F.3d at 732.

others. In *MX Group*, the court agreed with this sentiment, noting that the ADA forbids discrimination by public officials, regardless of the context.⁸⁹

Just as in the discriminatory treatment center cases, the action by public officials in NIMBY zoning against SSPs is discriminatory zoning ordinances., bringing them under the ADA and RA.

D. Is the Conduct Discriminatory?

Lastly, NIMBY zoning against SSPs is arguably discriminatory in the same way as those bans against treatment sites. De facto bans such as these are simply a denial of health services to persons with SUD in contravention of the ADA and RA, and courts have repeatedly struck down closely analogous provisions in the past, as detailed above.

In *New Directions*, the court struck down a zoning restriction on a methadone clinic as a form of facial discrimination, because the ordinance ““singles out methadone clinics, and thereby methadone patients, for different treatment, thereby rendering the statute facially discriminatory.”⁹⁰ In *MX Group*, under similar facts, the court likewise found the ordinance to be facially discriminatory: “The ordinance under consideration is a blanket prohibition of all methadone clinics from the entire city. It is discriminatory on its face and thus violative of the ADA and void.”⁹¹ In *Bay Area*, a NIMBY ordinance was also viewed as facially discriminatory by singling out methadone clinics. The court mused that the only way to make the ordinance not discriminatory would be to impose the same bans on all clinics of all kinds, not just methadone clinics.⁹²

The tenor of these arguments is likely to be applicable to most SSP zoning restrictions if these zoning ordinances impose restrictions on SSPs only and not other kinds of public health or health care centers. To analogize to the logic of the *New Directions* court, ordinances that single out SSPs, and therefore people who inject drugs, are being facially discriminatory based on disability.

⁸⁹ *MX Grp., Inc.*, 106 F. Supp. 2d 914 at 920.

⁹⁰ *New Directions Treatment Servs.*, 490 F.3d at 304.

⁹¹ *MX Grp., Inc.*, 106 F. Supp. 2d 914 at 920.

⁹² *Bay Area Addiction Rsch. & Treatment, Inc.*, 179 F.3d at 734.

In short, NIMBY attacks against SSPs appear to be one in the same with the earlier attacks on SUD treatment centers. Thus, courts are likely to view them similarly as intentional forms of discrimination against people with disabilities.

IV. OVERCOMING DEFENSES

While there are many possible defenses that governments may use to block claims of intentional discrimination, we advance two key defenses worth addressing: (1) that SSPs threaten their residents and (2) that individuals that use illegal drugs may not qualify as disabled.

First, jurisdictions may mount a defense on the grounds that their citizens face a direct threat from the SSPs, similar to the defenses raised in the *Bay Area* case. Such defenses failed in the past because state and local governments could not substantiate the claims that SUD treatment facilities placed their residents in harm's way. Fueled by misinformation, policymakers hypothesize that SSPs will increase rates of crime, encourage illegal drug use amongst people who would not otherwise use illegal drugs, and increase the number of improperly discarded syringes in the surrounding area.⁹³ However, no evidence exists to support such claims; to the contrary, the presence of these treatment centers does not change rates of crime nor increase enrollment in treatment for addiction, and in fact, reduces improperly discarded drug paraphernalia.⁹⁴ Though a full review of the data is beyond the scope of this Article, the opposition to SSPs appears to be akin to that of SUD treatment centers, rooted in bias

⁹³ Mitch Legan, *Indiana Needle Exchange That Helped Contain a Historic HIV Outbreak to Be Shut Down*, NPR (June 3, 2021), <https://www.npr.org/sections/health-shots/2021/06/01/1001278712/indiana-needle-exchange-that-helped-contain-an-hiv-outbreak-may-be-forced-to-clo> [https://perma.cc/6KMC-VANK]; Joe Atmonavage, *Atlantic City Votes to Close State's Largest Needle Exchange Program, Drawing Outrage*, NJ.COM (July 22, 2021), <https://www.nj.com/news/2021/07/atlantic-city-votes-to-close-states-largest-needle-exchange-program-drawing-outrage.html> [https://perma.cc/KTF2-32BT]; John C. Messinger & Leo Beletsky, *Misinformation Is Fueling the Overdose Crisis*, COMMONWEALTH MAG. (Jan. 16, 2022), <https://commonwealthmagazine.org/drug-addiction/misinformation-is-fueling-the-overdose-crisis/> [https://perma.cc/5EY5-YWRX].

⁹⁴ CTRS. FOR DISEASE CONTROL, *supra* note 4, at 1.

and stigma against people who use drugs rather than any real and objective claims that these centers generate crime or violence.⁹⁵

Second, despite recognition of SUD as a disability by the courts, a municipality may counter that protection under the ADA and the RA does not extend to clients of SSPs, as current users of illegal drugs may not be “qualified individual[s] with a disability.”⁹⁶ Both statutes contain limited carve-outs exempting discrimination protections from those who are “currently engaging in the illegal use of drugs” when the “covered entity acts on the basis of” the plaintiff’s illegal use of drugs.⁹⁷ The SUD treatment cases outlined above have not considered this defense because the patients in question were participating in rehabilitation programs and presumably no longer using illegal drugs.⁹⁸ However, with SSPs, at least some of the services provided include providing needles for safe drug use, making this a more likely defense that cities and states may try to put forth.

However, we argue that this defense would not succeed because these statutory exclusions are inapplicable in the present context. Both statutes limit their “current use” exception (excluding current users of drugs from disability anti-discrimination protections) with safe harbor provisions guaranteeing the protection of health services to individuals who currently use illegal drugs. Both the ADA and RA maintain that covered entities⁹⁹

⁹⁵ Michael Botticelli, *Stigma and Substance Use Disorder: Breaking Down Barriers to Treatment and Sound Public Policy*, HEALTH CITY (May 23, 2019), <https://healthcity.bmc.org/policy-and-industry/stigma-key-barrier-sud-treatment-and-sound-public-policy> [<https://perma.cc/U6N6-S598>].

⁹⁶ 42 U.S.C. § 12131 (2018); 29 U.S.C. § 794 (2018).

⁹⁷ See 42 U.S.C. § 12210(a) (2018); 29 U.S.C. § 705(20)(C)(i) (2018).

⁹⁸ See *New Directions Treatment Servs. v. City of Reading*, 490 F.3d 293, 309 (3d Cir. 2007) (“The ADA and Rehabilitation Act specifically provide that a person who has completed a supervised rehabilitation program or is currently participating in such a program and “is no longer engaging” in drug use shall be deemed a qualified individual”); *MX Grp. Inc. v. City of Covington*, 293 F.3d 326, 339 (6th Cir. 2002) (“Indeed, the statute itself contemplates that individuals participating in drug rehabilitation programs, who are no longer using drugs or presumably impaired by their effects, are covered by the Act”).

⁹⁹ U.S. DEP’T HEALTH & HUMAN SERVS. OFF. FOR C.R., *Fact Sheet: Drug Addiction and Federal Disability Rights Laws* (Oct. 25, 2018), <https://www.hhs.gov/sites/default/files/drug-addiction-aand-federal-disability-rights-laws-fact-sheet.pdf> [<https://perma.cc/BB6U-SGQR>] (“Covered entities may include, but

are prohibited from denying “health services, or services provided in connection with drug rehabilitation” to an individual on the basis of that individual’s current illegal use of drugs, if they are otherwise entitled to such services.¹⁰⁰ As discussed above, many SSPs provide, among other things, SUD treatment, wound care, infectious disease testing, and overdose prevention supplies. Therefore, SSPs are bona fide health services facilities, providing essential services to those with SUD—a recognized disability under the ADA. While courts have yet to consider the applicability of the safe harbor provision to SSPs, ample reasoning supports the contention that patients of SSPs would fall under the protections of the safe harbor provision.

An analysis of the legislative reasoning behind the adoption of the statutory carve-out supports the contention that the safe harbor provision would be applicable in the present context. The statutory exemption excluding ADA protection for individuals currently using illegal drugs was adopted to serve an employment function: the legislative purpose was focused on ensuring that employers could discharge employees who may have been under the influence or otherwise impaired while at work and that employers could not discharge employees who were recovering from SUD.¹⁰¹ The fact that Congress, through the safe harbor provision, explicitly provided for an exception for patients seeking health services, even if those individuals are currently using drugs, is important.¹⁰² As one

are not limited to: Substance Use Disorder Treatment Programs, Hospitals and Health Clinics, Pharmacies, Contracted Service Providers, Medical and Dental Providers, Nursing Homes, Child Welfare Agencies, State Court Systems. In addition, state and local governments are prohibited from discriminating on the basis of disability.”)

¹⁰⁰ 42 U.S.C. § 12210(c) (2018); 29 U.S.C. § 705(20)(C)(iii) (2018).

¹⁰¹ See *New Directions Treatment Servs.*, 490 F.3d at 309 (quoting *Brown v. Lucky Stores, Inc.*, 246 F.3d 1182, 1188 (9th Cir. 2001)); citing H.R. Rep. No. 101–596, at 62 (1990); U.S. Code Cong. & Admin. News 1990, pp. 565, 570–571 (Conf.Rep.).

¹⁰² The U.S. Department of Health and Human Services Center for Substance Abuse Treatment has provided guidance on this regulation, stating that as an example that “a hospital that specializes in treating burn victims could not refuse to treat a burn victim because he uses illegal drugs, nor could it impose a surcharge on him because of his addiction.” U.S. DEP’T HEALTH & HUMAN SERVS. CTR. FOR SUBSTANCE ABUSE TREATMENT, SUBSTANCE ABUSE TREATMENT FOR PERSONS WITH HIV/AIDS 187 (2008), https://www.ncbi.nlm.nih.gov/books/NBK64923/pdf/Bookshelf_NBK64923.pdf [<https://perma.cc/P9CW-NAX6>].

Federal District Court judge reasoned, “[i]f the [ADA] and [RA] were interpreted to exempt from its protections individuals with drug addictions seeking help . . . section (c) would be reduced to a nullity and mere surplusage . . . Whether any of the prospective patients were engaging in the use of illegal drugs is orthogonal to the question of whether the ADA or [RA] provides protection for them.”¹⁰³ Under this line of reasoning, patients of SSPs who are currently using illegal substances are still within the protection of the ADA through the application of the safe harbor provision.

In sum, zoning ordinances that approach a de facto ban on SSPs anywhere in the jurisdiction, such as the one successfully challenged in Kennewick, result in an effective denial of health services to persons with SUD in direct violation of the safe harbor provisions in both the ADA and the RA.

V. EXPANDING APPLICATION OF THE ADA TO COVID-19 TESTING SITES

Unfortunately, COVID-19 testing sites, like SSPs, have also come under attack by discriminatory zoning laws similar to those we have addressed in this Article. In late March, plans for a drive-thru COVID-19 test site in Darien, Connecticut, were canceled amid opposition from neighbors, despite a surging demand to expand the county’s testing capacities.¹⁰⁴ Just one week earlier before the closure in Connecticut, a drive-thru coronavirus test site in Ewin, New Jersey, was shut down after the building’s landlord issued a cease-and-desist letter to the operator of the test site citing complaints about “too much commotion” in the parking lot.¹⁰⁵ The Ewin drive-thru facility was one of only three coronavirus test sites in the entire state of New Jersey.¹⁰⁶ These complaints echo many of

¹⁰³ *RHJ Med. Ctr., Inc. v. City of DuBois*, 754 F. Supp. 2d 723, 750 (W.D. Pa. 2010).

¹⁰⁴ Sandra Diamond Fox & Lidia Ryan, *Twitter Slams CT Town for Cancelling Coronavirus Testing Site*, THE STANFORD ADVOCATE (Mar. 20, 2020), <https://www.stanfordadvocate.com/news/coronavirus/article/CT-cancels-coronavirus-testing-neighbor-complains-15146002.php> [<https://perma.cc/6L6F-MMM3>].

¹⁰⁵ Isaac Avilucea, *Ewing Coronavirus Drive-thru Center Shut Down Over Apparent Landlord Flap*, THE TRENTONIAN (Mar. 18, 2020), <https://www.trentonian.com/2020/03/18/ewing-coronavirus-drive-thru-center-shut-down-over-apparent-landlord-flap/> [<https://perma.cc/U3Q9-46X2>].

¹⁰⁶ *Id.*

those that have been launched against SSPs since their inception, which view these services as a threat to property values or the general quality of the neighborhood. Across the country, efforts to track and contain the spread of COVID-19 and harm reduction services aimed at reducing the burden of the overdose epidemic are met with fierce opposition by vocal community members who wish to maintain community boundaries and shift the burden of these public health crises elsewhere. While this Article focuses on ADA law as a tool to tackle zoning restrictions on SSPs, we acknowledge that restrictions on COVID-19 testing sites are also a public health crisis for people with addictions and others, and that some of our legal approaches could be used to remedy NIMBY restrictions on testing sites, too.

VI. CONCLUSION

As the overdose crisis continues to spiral, many of the legal tools deployed to address it have missed the mark by myopically focusing on supply reduction measures. Meanwhile, harm reduction strategies have remained under-utilized, under-funded, and under attack by discriminatory policies and practices. There is little doubt that expansion in the number and scope of SSPs across the United States is crucial to addressing the overdose crisis and its attendant harms. The critical role SSPs serve has become increasingly apparent as lawmakers across the country make timely decisions as to which services are absolutely essential and must remain open in the face of the pandemic. In the context of an ongoing crisis, the ADA and RA offer enormous promise in safeguarding the rights—and lives—of vulnerable people who use drugs. While their wide deployment does not offer a comprehensive political solution to this problem, it presents an important instrument for advancing public health through the law. Rights-based litigation based on these statutes also offers an opportunity to highlight the individual and community benefits of SSPs, opening the door to educating decision-makers, the public, and the press about key misconceptions and helping harm reduction win in the court of public opinion.