Toward Healthy Drug Policy in the United States — The Case of Safehouse

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In 2017, a committee convened by the mayor of Philadelphia as part of a task force on the opioid-overdose crisis recommended opening safe consumption sites in the city. The core function of the more than 165 such facilities operating globally is to provide a place where people can consume drugs they have obtained elsewhere under the observation of trained staff, who are available to reverse any overdoses that might occur. The facilities, also known as overdose-prevention sites, typically distribute equipment to facilitate sterile consumption (syringes, swabs, and water) and other health supplies such as naloxone, which can then be used in the community. Most offer wraparound services, including medical care and referrals to substance use treatment and social support programs. Numerous peer-reviewed studies have found that this intervention reduces overdose deaths and drug-related risk behaviors, increases access to treatment and other risk-reduction services, and reduces public injection and syringe litter. Such facilities have not been found to increase crime or drug use.[1]

Supported by Philadelphia's mayor and health commissioner, a nonprofit group led by former Pennsylvania governor and Philadelphia mayor Edward Rendell announced plans to operate Safehouse, which would be the country's first openly operated overdose-prevention site. As the group was gathering funds and seeking other support, William M. McSwain, the U.S. attorney for the Eastern District of Pennsylvania intervened in early 2019 with a preemptive lawsuit asking a federal court to declare that such a facility would violate the Controlled Substances Act (CSA). The government's lawsuit claimed that overdose-prevention sites are explicitly prohibited by section 856 of the Act — the "crack house statute" — which states that "it shall be unlawful to . . . manage or control any place . . . for the purpose of unlawfully . . . using a controlled substance."

On October 2, 2019, in a 56-page opinion, Judge Gerald McHugh, Jr., rejected this argument. His detailed analysis focused on whether Safehouse would in fact be operated "for the purpose of unlawfully . . . using a controlled substance." Here, the decision gets interesting — and says something broader about the future of U.S. drug policy.

To begin with, the judge gave substantial weight to the facts. In finding an overdose-prevention site to be a legitimate public health measure, he relied on the consistent scientific evidence that such facilities have both therapeutic value for participants and public health benefits. This respect for international evidence was striking, given how great a barrier the CSA has been to applying health services innovations and research findings from peer countries in the United States.

The judge's next step was to reject the U.S. attorney's restrictive interpretation of the law. McHugh started by observing that "no credible argument can be made that facilities such as safe injection sites were within the contemplation of Congress either when it adopted § 856(a) in 1986, or when it amended the statute in 2003." Adopting a conservative approach to statutory interpretation, McHugh was disinclined to stretch the law to prohibit an activity that Congress had not considered. He used the rest of his opinion to consider whether the statute's language was even applicable to Safehouse.

"While I agree that, taking each of the statute's words literally, it might be possible to read § 856(a) to apply to Safehouse, I am not convinced," McHugh wrote, "that a plain or ordinary reading of the statute allows that application." Rather, he interpreted the word "purpose" as it is commonly defined in the dictionary, to refer to an actor's objective, end, or goal. With that meaning in mind, he considered the Safehouse operators' purpose. It is certainly inherent to the intervention that people would use drugs in the facility, but that is not the operators' objective. Their purpose is to save lives; drug use is just an incidental consequence.

This decision is a victory for proponents of overdose-prevention sites in Philadelphia, along with the many people who would benefit from the vital services such facilities would provide. Since several Philadelphia residents die from overdoses every day, the city urgently needs additional preven-

tion tools. It has a large population of marginally housed and underserved people who inject drugs, which makes it an apt site for an attempt at a safe consumption intervention. This decision does not end the Safehouse litigation, but it means that one initial hurdle to the creation of this facility has been cleared. Although the U.S. attorney has vowed to appeal and deploy other legal strategies to halt this effort, a protracted legal battle may provide sufficient time for the facility to open and demonstrate public health and safety value.

Whatever happens next with Safehouse, the decision is an important legal development. Although the ruling is not binding on any courts outside the Eastern District of Pennsylvania, it has certainly put some wind in the sails of other states and cities considering overdose-prevention sites. Other judges will consider Judge McHugh's reasoning and findings. State and local politicians who support allowing such facilities will be heartened that the claim of legality was accepted. Policymakers who have used legal questions to justify opposition to this public health strategy will now find their rationale weakened.

On the occasion of this small but meaningful legal victory, it's worth reflecting on what we believe is the broader absurdity of the legal battle over public health interventions in the drug domain. Beyond their public health value, harm-reduction interventions such as naloxone distribution, syringe-exchange programs, and overdose-prevention sites have always been important for challenging the punitive "War on Drugs" and its codification in federal and state law. The role of the CSA as a persistent barrier to harm-reduction measures is tragically ironic: Nearly 50 years after its passage, the statute has failed to "control" psychoactive drugs in both the pharmaceutical and illicit markets. In fact, the need for harm-reduction interventions has arisen largely because of this failure.

The continuing death toll from overdoses is a reflection of the fact that at least 24 million people in the United States use street drugs.[2] This number has increased over the past decade in part because of the current regime's failure to properly regulate the prescription-opioid market. Heroin has been cheap and plentiful in the United States for decades,[3] and new markets have opened in recent years.[4] The increasing penetration of illegally manufactured fentanyl into the illicit drug supply is now driving the overdose crisis. The failure of the U.S. Drug Enforcement Agency and its partners to prevent and remedy this development is the latest instance in a historical pattern in which drug-trafficking organizations respond to upticks in supply-side enforcement by turning to higher-potency, more easily smuggled products.[5] The Safehouse decision marks a shift from this course by not allowing an ideology of punitive drug control to deprive people with substance use disorders of the benefits of a tested, sensible public health service.

The Philadelphia case is another invitation to everyone who cares about people who use drugs and the harms associated with drug use to face the failure of the criminal justice model of drug control. The need to replace this model with one that focuses on furthering individual and public health has never been more apparent. There has been much useful discussion of the effects of too much incarceration, racial disparities in the enforcement of the CSA, and law-induced high-risk behavior. But we believe that far too little critique has focused on the more fundamental failure of the CSA model to do the main thing the law was intended to do: control the supply of drugs — both licit and illicit — and thereby reduce drug-related harms. If leaders and the public can face this fact, we will be able to start developing the kind of approach to regulating drugs that we have needed for decades — one that minimizes both the harm caused by drugs and the harm caused by drug regulation itself.

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