

**APPEALS COURT OF THE
COMMONWEALTH OF MASSACHUSETTS**

COMMONWEALTH OF MASSACHUSETTS

V.

MARIA LANDRY

**BRIEF OF AMICI CURIAE
INFECTIOUS DISEASES SOCIETY OF AMERICA, BOSTON
PUBLIC HEALTH COMMISSION, CAMBRIDGE CARES ABOUT
AIDS, TAPESTRY HEALTH SYSTEMS, PROVINCETOWN AIDS
SUPPORT GROUP, CAMBRIDGE PUBLIC HEALTH
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MASS, FENWAY COMMUNITY HEALTH CENTER,
MASSACHUSETTS ASIAN AIDS PREVENTION PROJECT,
NORTH SHORE AIDS HEALTH PROJECT**

(Additional Amici continued on inside cover)

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LEGAL SERVICES, NANTUCKET AIDS NETWORK**

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INTEREST OF AMICI CURIAE

The *Amici Curiae* joining this brief -- Infectious Diseases Society of America, Boston Public Health Commission, Cambridge Cares About AIDS, Tapestry Health Systems, Provincetown AIDS Support Group, Cambridge Public Health Department, American Public Health Association, Massachusetts Public Health Association, National Alliance of State and Territorial AIDS Directors, Massachusetts Nurses Association, AIDS Action Committee of Massachusetts, AIDS Project Worcester, Lynn Health Task Force, Multicultural AIDS Coalition, Latin-American Health Institute, Health Care of Southeastern Massachusetts, Fenway Community Health Center, Massachusetts Asian AIDS Prevention Project, North Shore AIDS Health Project, Strongest Link AIDS Services, Treatment on Demand, Victory Programs, New England Prevention Alliance, Disability Law Center, Justice Resource Institute Health Law Institute, CAB Health & Recovery Services, North Shore AIDS Collaborative, Neighborhood Legal Services of Lynn, and Nantucket AIDS Network -- consist of a wide range of medical, public health, substance abuse treatment, disease prevention, and social service organizations, as well as the agencies which operate the four needle exchange programs in Massachusetts.¹ A description of each of the *Amici* is contained in the Addendum to this brief.

Amici have first-hand knowledge of the devastating social costs and loss of life caused by the skyrocketing epidemics of human immunodeficiency virus (HIV), hepatitis C virus (HCV), and hepatitis B virus (HBV) among injection drug users. Needle exchange programs are both a scientifically proven intervention to reduce the

¹ Boston Public Health Commission, Cambridge Cares About AIDS, Tapestry Health Systems, and Provincetown AIDS Support Group operate needle exchange programs implemented by the Massachusetts Department of Health.

transmission of these incurable, often fatal diseases, as well as an effective mechanism to engage the high-risk population of injection drug users in substance abuse treatment services. *Amici* submit this brief to bring to the Court’s attention the body of scientific knowledge relevant to the issues this case presents, and to urge the Court to construe G.L. c. 111, § 215 and G.L. c. 94C, § 27(f) consistent with the Legislature’s goal to implement the proven benefits of needle exchange in response to a public health emergency.

STATEMENT OF THE ISSUES

1. Whether an individual who lawfully obtains sterile needles through a program implemented by the Department of Public Health (DPH) under G.L. c. 111, § 215 may lawfully possess those needles anywhere in the Commonwealth, in light of the provision in G.L. c. 94C, § 27(f) that possession of those needles “shall not be a crime,” and the absence of any geographical restriction in the statutory language.

2. Whether the Legislature intended that a person who squarely comes within one of the exemptions in G.L. c. 94C, § 27 creating classes of persons who may lawfully possess hypodermic needles -- from doctors, to diabetics who have a prescription to inject insulin, to participants in a needle exchange program -- are immune from arrest, or whether all such persons should be forced to prove their exemption at trial.

STATEMENT OF THE CASE

Amici accept the Statement of the Case as set forth in the brief of the defendant-appellant.

STATEMENT OF FACTS

Amici accept the Statement of Facts as set forth in the brief of the defendant-appellant.

SUMMARY OF ARGUMENT

1. Needle exchange programs are a scientifically proven intervention to reduce the epidemics of HIV, HCV and HBV among injection drug users. The Surgeon General of the United States, the federal Department of Health and Human Services, the National Institutes of Health, the United States Centers for Disease Control and Prevention (CDC), and the American Medical Association, among many, agree that there is conclusive scientific evidence that needle exchange reduces disease transmission, does not increase substance abuse, and is a successful gateway to substance abuse treatment services. (pp. 5-11).

2. The plain and unambiguous language of the needle exchange statutory scheme demonstrates that once a person lawfully obtains needles from a program implemented by the Department of Public Health under G.L. c. 111, § 215, G.L. c. 94C, § 27(f) provides that possession of those needles “shall not be a crime,” without any geographical restriction or requirement that the person exclusively remain in the city or town in which the program is sited. (pp. 11-20).

3. Any person who falls within one of the classes who may lawfully possess hypodermic needles under G.L. c. 94C, § 27 -- whether a doctor, diabetic with a prescription to inject insulin, or a participant on a needle exchange program -- may not be arrested. Under Commonwealth v. Couture, 407 Mass. 178 (1990), there is no probable cause for such arrest. The Legislature could not have intended that the hundreds of thousands of persons who come within § 27 should be arrested, and then must prove the validity of their exemption at trial. With respect to needle exchange programs under G.L. c. 111, § 215 and G.L. c. 94C, § 27(f), the Legislature delegated to DPH the complete

authority to establish program requirements. Because DPH recognized that injection drug users were unlikely to participate in a program requiring the disclosure of names, DPH created an anonymous enrollment system and identification card. In light of the Legislature's expansive delegation to DPH, this Court should not second-guess the form of the needle exchange identification card as sufficient indicia of the statutory exemption. (pp. 20-27).

4. This Court should construe the needle exchange statutory scheme in a manner which effectuates the Legislature's public health goals. Needle exchange reduces disease transmission, does not increase drug use or crime, increases enrollment in substance abuse treatment, discourages the unsafe disposal of dirty needles in streets, parks or other public areas, and saves billions of dollars in future medical costs. (pp. 27-31).

ARGUMENT

I. INTRODUCTION TO THE CRITICAL PUBLIC HEALTH ROLE OF NEEDLE EXCHANGE PROGRAMS TO PREVENT TRANSMISSION OF HIV, HCV, AND HBV.

A. Injection Drug Use As A Primary Factor In The Proliferation Of The HIV, HCV And HBV Epidemics.

The epidemics of HIV,² HCV,³ and HBV⁴ are a medical and public health crisis in this country, causing “thousands of deaths and millions of dollars in preventable health care expenditures every year.”⁵ It is estimated that 650,000 to 900,000 Americans are now living with HIV and that 40,000 new infections occur every year.⁶ Since 1981,

² HIV, the causative agent of acquired immune deficiency syndrome (AIDS), progressively destroys the immune system. AIDS is the advanced stage of HIV disease and is characterized by a range of “opportunistic” infections and malignancies which would not generally be life-threatening to a person with a normally functioning immune system. See CDC, *What Is AIDS? What Causes AIDS?* (November 1998) at <http://www.cdc.gov/hiv/pubs/faq/faq2.htm>. HIV is transmitted by sexual contact with the exchange of bodily fluids; perinatally from mother to child; or by direct exposure to blood or blood products. See CDC, *HIV And Its Transmission* (January 2001) at <http://www.cdc.gov/hiv/pubs/facts/transmission.htm>.

³ HCV is transmitted by exposure to blood. It is not generally sexually transmitted. See CDC, *Viral Hepatitis C - Factsheet* (August 2001) at <http://www.cdc.gov/ncidod/diseases/hepatitis/c/fact.htm>. HCV is the leading cause of death from chronic liver disease and the leading indicator for liver transplantation in this country. See John Wong, *Pharmacoeconomics of Combination Therapy for HCV* (2000) at <http://www.hepnet.com/hepc/ulibd00/wong.html>.

⁴ Like HIV, HBV may be transmitted by sexual contact, perinatally, or exposure to blood. HBV can result in severe liver disease. See CDC, *Viral Hepatitis B – Factsheet* (December 2001) at <http://www.cdc.gov/ncidod/diseases/hepatitis/b/fact.htm>.

⁵ See American Bar Association AIDS Coordinating Committee, *Deregulation of Hypodermic Needles and Syringes As a Public Health Measure: A Report on Emerging Policy and Law in the United States* (Scott Burris, ed., 2001) at xiii.

⁶ See CDC, *New Attitudes & Strategies: A Comprehensive Approach to Preventing Blood-Borne Infections Among IDUS* (August 2001) at <http://www.cdc.gov/idu/idu.htm>.

753,907 cases of AIDS have been reported nationally.⁷ There are currently 13,307 people living with HIV or AIDS in Massachusetts.⁸ Although the subject of less public awareness, the hepatitis epidemic equals HIV in its devastation. More than 2.7 million people in the United States have chronic HCV infection.⁹ Between 1 and 1 ¼ million Americans have active hepatitis b, with between 130,000 to 320,000 new infections occurring every year.¹⁰

Injection drug use is now a primary factor in the proliferation of the HIV, HCV and HBV epidemics.¹¹ A study of the prevalence of bloodborne viral infections among injection drug users found overall HCV and HBV prevalences of 76.9% and 65.7%,

⁷ *Id.*

⁸ See Massachusetts Department of Public Health, *Massachusetts HIV/AIDS Surveillance* (January 2002) at <http://www.state.ma.us/dph/cdc/aids/quarterly/county.pdf>.

⁹ See Wong, *supra*, note 3.

¹⁰ See CDC, *New Attitudes & Strategies*, *supra*, note 6.

¹¹ See U.S. Department of Health and Human Services, *Evidence-Based Findings On the Efficacy of Syringe-Exchange Programs: An Analysis From the Assistant Secretary For Health And Surgeon General of the Scientific Research Completed Since April 1998* (2000) (hereinafter “Evidence-Based Findings”) at <http://www.harmreduction.org/issues/surgeongenrev/surgreview.html> (statement of Surgeon General that “injection drug use continues to fuel the HIV epidemic”); Patricia Case et al., *Arrests and Incarceration of Injection Drug Users For Syringe Possession in Massachusetts: Implications For HIV Prevention*, 18 (Suppl. 1) *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, S71-S75 at S71 (1998) (“Multiperson use of syringes is a major risk behavior responsible for the spread of HIV, hepatitis B, and hepatitis C”).

respectively, in a group that had been injecting drugs for 6 years or less.¹² Half of new HIV infections nationally are caused by the sharing of contaminated injection equipment.¹³ An estimated three out of four AIDS cases among women are due to injection drug use or heterosexual contact with someone infected with HIV through injection drug use.¹⁴ More than three quarters of new HIV infections in children result from the consequences of injection drug use in a parent.¹⁵ Women of color and their children are disproportionately affected by HIV/AIDS due to injection drug use.¹⁶ In Massachusetts, injection drug use constitutes the single greatest cause of new HIV infections and accounts for more than a third of the total HIV/AIDS cases, as well about half of the nearly 100,000 persons living with HCV.¹⁷ Public health authorities agree that lack of access to clean syringes is a primary cause of these skyrocketing transmission rates.¹⁸

¹² See Richard Garfein et al., *Viral Infections in Short-term Injection Drug Users: The Prevalence of Hepatitis C, Hepatitis B, Human Immunodeficiency, and Human T-lymphotrophic Viruses*, 86 Am. J. Pub. Health 655-661 (1996).

¹³ See, *Evidence-Based Findings*, *supra*, note 11.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ See Massachusetts Medical Society, *Syringe Prescriptions for Injection Drug Users – Vital Signs* (Jan 28, 2002) at <http://www2.mms.org/vitalsigns/feb02/ph1.html>.

¹⁸ See R. Broadhead et al., *Risk Associated With Closing A Needle Exchange Program*, 46 Social Problems 48-66 (1999).

B. The Public Health Challenge Of Stemming The Tide Of Injection Drug-Related Disease Transmission.

Stemming the tide of injection drug-related disease transmission poses a unique public health challenge. Preventing substance abuse and facilitating entry of those with addictions into treatment are critical goals.¹⁹ Indeed, addiction is a treatable biomedical and psychological disease.²⁰ Public health officials and medical professionals, however, agree that curing addiction is a challenging societal problem. As the CDC has concluded, “[m]any drug users are not currently in substance abuse treatment programs because of multiple factors including the limited availability of these programs and the lack of readiness or willingness of some drug users to enter substance abuse treatment.”²¹ At the same time, injection drug users are a “population at extremely high risk that is not engaged in appropriate [disease prevention] interventions through traditional mechanisms of outreach and referral.”²²

Needle exchange programs are based on a simple principle: HIV, HCV, and HBV are preventable diseases. Needle exchange programs save lives by permitting intravenous drug users to obtain sterile needles and return dirty injection equipment, “engage active ... drug users in prevention strategies that will protect them, their partners

¹⁹ See *Evidence-Based Findings*, *supra*, note 11.

²⁰ See CDC, *New Attitudes & Strategies*, *supra*, note 6.

²¹ See CDC, *HIV Prevention Bulletin: Medical Advice For Persons Who Inject Illicit Drugs* (May 1997) at http://www.cdc.gov/idu/pubs/hiv_prev.htm. See also American Medical News, *Negating The Stigma Associated With Certain Diseases* (Nov. 5, 2001) at http://www.ama-assn.org/sci-pubs/amnews/pick_01/hlsb1105.htm (“[t]he shame of ... drug addiction ... means they have put off seeking treatment as long as possible.”)

²² See *Evidence-Based Findings*, *supra*, note 11.

and families from exposure to HIV,” and refer those who might previously have had little or no contact with the public health system to drug treatment or other services.²³

C. The Consensus In The Scientific Community That Needle Exchange Helps Control Injection Drug-Related Disease Transmission Without Increasing Drug Use.

There is a consensus in the federal agencies, as well as the scientific and medical communities, that needle exchange helps control the spread of HIV, HCV and HBV, and does not increase substance abuse. In an extensive review of all of the scientific literature on needle exchange in March 2000, the United States Secretary for Health and Human Services and the Surgeon General declared that there is “conclusive scientific evidence” that needle exchange programs: (1) decrease new HIV infections; (2) increase the numbers of injection drug users referred to and retained in substance abuse treatment; and (3) play a unique role in reaching and serving the most disenfranchised populations at high risk for HIV infection and engaging these populations in meaningful prevention interventions and medical care.²⁴ Similarly, the National Institutes of Health concluded in 1997 that “legislative restriction on needle exchange programs must be lifted because such legislation constitutes a major barrier to realizing the potential of a powerful approach and exposes millions of people to unnecessary risk.”²⁵ A 1995 study from the National Research Council and Institute of Medicine commissioned by Congress concluded that: “For injection drug users who cannot or will not stop injecting drugs, the

²³ *Id.*

²⁴ *Id.*

²⁵ See National Institutes of Health, *Interventions to Prevent HIV Risk Behaviors, NIH Consensus Statement Online* (Feb 11-13, 1997) at http://consensus.nih.gov/cons/104/104_statement.htm.

once-only use of sterile needles and syringes remains the safest, most effective approach for limiting HIV transmission ... Needle exchange programs should be regarded as an effective component of a comprehensive strategy to prevent infectious disease.”²⁶ That report also found that there is “no credible evidence” that drug use is increased among needle exchange participants.²⁷ The CDC, the nation’s preeminent public health authority, recommends the “one-time only use of sterile syringes from a reliable source as a central risk reduction strategy for [intravenous drug users] who cannot or will not stop injecting.”²⁸ Finally, as early as 1991, the National Commission on AIDS recommended the “removal of legal barriers to the purchase and possession of injection equipment” as part of a strategy for reducing the spread of HIV among IDUs.²⁹

Major medical and public health associations concur. The American Medical Association recommended in 1995 that physicians encourage patients to “have their own personal injection equipment that is never shared,” and characterized as “urgent” the need

²⁶ See National Research Council and Institute of Medicine, *Preventing HIV Transmission: The Role of Sterile Needles and Bleach*, 2-4 (Jacques Normand et al., eds.1995).

²⁷ *Id.* at 4.

²⁸ See CDC, *New Attitudes & Strategies*, *supra*, note 6. See also CDC, *HIV Prevention Bulletin*, *supra*, note 21 (“persons who inject drugs should use sterile syringes to prevent transmission of HIV and other blood-borne infectious diseases.”).

²⁹ See National Commission on Acquired Immune Deficiency Syndrome, *The Twin Epidemics of Substance Use and HIV*, at 3 (1991), available at <http://www.dogwoodcenter.org/references/studies91F.html>.

for the “extensive application of needle and syringe exchange programs.”³⁰ In 1994, the American Academy of Pediatrics concluded that “programs that provide access to sterile injection equipment” and “a reassessment of laws regarding the possession of needles, syringes and bleach” were required to combat the spread of HIV infection to infants, children and adolescents.³¹ Major organizations of government officials have also recognized the public health imperative of needle exchange programs. In 1997, both the National Black Caucus of State Legislators and the U.S. Conference of Mayors issued resolutions supporting needle exchange.³²

II. AN INDIVIDUAL WHO OBTAINS STERILE NEEDLES THROUGH A PROGRAM IMPLEMENTED BY THE DEPARTMENT OF PUBLIC HEALTH UNDER G.L. C. 111, § 215 MAY LAWFULLY POSSESS THOSE NEEDLES ANYWHERE IN THE COMMONWEALTH.

When the Legislature first authorized a pilot needle exchange program in 1993, its indisputable goal was the compelling public health need to provide

³⁰ See American Medical Association, *Resolution 435- Needle and Syringe Exchange Programs* (1997) at <http://www.sfaf.org/prevention/needleexchange/statements.html>.

³¹ See American Academy of Pediatrics, *Reducing the Risk of Human Immunodeficiency Virus Infection Associated With Illicit Drug Use*, 94(6) *Pediatrics* 945-947 (December 1994), available at <http://www.aap.org/policy/00509.html>. See also Association of State and Territorial Health Officials, *Policy Position Statement* (2000) at <http://www.astho.org/about/policy/policy.html> (recommending removal of barriers to distribution or possession of clean needles and syringes); American Public Health Association, *Resolution 9415, Syringe and Needle Exchange and HIV Disease* (1994) (urging federal, state and local governments to improve drug users’ access to clean injection equipment).

³² See U.S. Conference of Mayors, *Resolution No. 26* (1997) and National Black Caucus of State Legislators, *Resolution No. 97-09* (1997), both available at <http://www.sfaf.org/prevention/needleexchange/statements.html>.

injection drug users with access to clean needles.³³ That law, St. 1993, c. 110, § 148, codified as G.L. c. 111, § 215, provides, in relevant part:

The department of public health is hereby authorized to promulgate rules and regulations for the implementation of a pilot program for the exchange of needles in cities and towns within the commonwealth upon nomination by the Department. Local approval shall be obtained prior to the implementation of the pilot program in any city or town.

G.L. c. 111, § 215.³⁴ The Legislature simultaneously passed an amendment to the law regulating possession of hypodermic needles or syringes, which provided:

Notwithstanding any general or special law to the contrary, needles and syringes may be distributed or possessed as part of a pilot program approved by the department of public health in accordance with section two hundred and fifteen of chapter one hundred and eleven and any such distribution or exchange of said needles or syringes shall not be a crime.

The department of public health shall ensure that individuals participating in a pilot needle exchange program will be encouraged to

³³ See Richard A. Knox, *Encouraged By Flaherty, Panel OK's Needle Bill*, Boston Globe, February 11, 1992 (describing unanimous approval by Legislature's joint Health Care Committee of bill authorizing state sponsored pilot program to offer drug addicts clean hypodermic needles and referring to "needle exchange projects in New Haven, Washington State and Europe [which] have shown that providing sterile needles does not encourage drug abuse, does decrease sharing of contaminated needles among drug users and draws about one in four participants into drug treatment programs."). Indeed, by 1993, the success of needle exchange programs was well known. See, e.g., National Commission on Acquired Immune Deficiency Syndrome (1991), *supra*, note 29 at 7 (recommending the removal of legal barriers to the purchase and possession of syringes as part of strategy to reduce spread of HIV among injection drug users and noting that "[t]hese programs have demonstrated the ability to get substance abusers to change injection practices and lead substantial numbers of substance users to seek treatment."); *The Public Health Impact of Needle Exchange Programs In the United States and Abroad*, prepared by the University of California, Berkeley, for U.S. Centers for Disease Control and Prevention (1993) (concluding that there is "clear evidence of decreases in HIV drug risk behavior among needle exchange program clients).

³⁴ In 1995, the statute was amended to authorize the implementation of "not more than ten pilot programs." See St. 1995, c. 38, § 128. The legislature did not otherwise change the operative language of the statute.

seek and will be placed in contact with substance abuse treatment and health care.

St. 1993, c. 110, § 142, codified at G.L. c. 94C, § 27(f). Based on the plain and unambiguous language of these two statutes, once a person lawfully obtains needles from a program implemented by DPH under G.L. c.111, § 215, G.L. c. 94C, § 27(f) plainly provides that possession of those needles “shall not be a crime,” without any geographical restriction or requirement that the person exclusively remain in the city or town in which the program is sited.

A. The Unambiguous Language Of G.L. C. 111, § 215 And G.L. C. 94C, § 27(f) Demonstrates That It Is Not A Crime For An Enrollee In A Needle Exchange Program In A Particular City Or Town To Possess Needles Or Syringes In Another City Or Town That Has Not Granted Local Approval For The Siting Of A Needle Exchange Program.

It is a settled rule of statutory construction that a statute “must be interpreted according to the intent of the Legislature ascertained from all its words construed by the ordinary and approved usage of the language, considered in connection with the cause of its enactment, the mischief or imperfection to be remedied and the main object to be accomplished ...” Commonwealth v. Smith, 431 Mass. 417, 421 (2000). As the Supreme Judicial Court has repeatedly emphasized, “the statutory language itself is the principal source of insight into the legislative purpose.” *Id.* at 421 (quoting Registrar of Motor Vehicles v. Board of Appeal on Motor Vehicle Liability Policies & Bonds, 382 Mass. 580, 585 (1981)). “Where ... the language of a statute is clear and unambiguous, it is conclusive as to the intent of the Legislature.” Ciardi v. F. Hoffman-La Roche, Ltd., 436 Mass. 53, 60-61 (2002). Moreover, two statutes relating to the same subject “clearly are to be construed harmoniously so as to give full effect to all of their provisions and give rise to a consistent body of law.” *Id.* at 62.

Looking first at § 215, the statute does two things: (1) It authorizes DPH to establish rules for “the implementation” of a needle exchange program; and (2) It makes that “implementation” dependent upon initial approval by the city or town where the program would be located. The verb “to implement” means “to provide a definite plan or procedure to ensure the fulfillment of.” American Heritage Dictionary of the English Language (1981). This dictionary definition is the best indicator of the plain and ordinary meaning of the word “implement.” See Town of Boylston v. Commissioner of Revenue, 434 Mass. 398, 405 (2001). Section 215 is thus *solely* concerned with matters relating to the establishment of the needle exchange program itself, such as the siting and operation of the program in a city or town. The statute further provides that “local approval” is a prerequisite to “implementation” of the program. There is no other reference to “local approval” in § 215 or elsewhere in the needle exchange statutory scheme. The words “local approval,” therefore, are plainly linked and limited to permission to place a program in the city or town.

Turning to the second, interrelated statute, G.L. c. 94C, § 27(f), it amends the pre-existing § 27, which limits lawful possession of hypodermic needles and related paraphernalia to specified classes or categories of persons. Section 27(f) provides that “needles and syringes may be distributed or possessed as part of a pilot program ... and any such distribution or exchange of said needles *shall not be a crime.*” (emphasis added). Nothing in the plain language of this statute suggests any geographical limitation. Where § 27(f) provides that needles may be possessed “as part of a pilot program,” the phrase “as part of” is broad, general language which simply means, “in connection with” or “through participation in.” Thus, “as part of a pilot program” means

nothing more than that the person obtained the needles through an authorized needle exchange program. There is no textual basis to import into § 27(f) from § 215 the words “local approval,” which relate only to permission to “implement” or set up the program itself.³⁵

B. The Plain Meaning Of § 215 And § 27(f) Is Reinforced By Several Rules Of Statutory Construction.

Several established rules of statutory construction reinforce the conclusion that the lawful possession of needles obtained through an authorized program is of statewide application. First, to the extent that the Court finds ambiguity in the meaning of the words “as part of a pilot program,” or as to the importation of the words “local approval” into §27(f), any ambiguity in a criminal statute must be resolved in favor of the defendant.

See Commonwealth v. Valiton, 432 Mass. 647, 649 (2000); Commonwealth v. Hammond, 50 Mass. App. Ct. 171, 176 (2000). Moreover, as a statute enacted for the protection of the public health, § 215 must be liberally construed in order to fulfill the legislature’s clear goal of providing injection drug users with access to clean needles. *See* Sutherland Stat. Const. § 71.02 (5th ed.) (“For some time courts have been committed to give statutes which are enacted for the protection and preservation of the public health an

³⁵ The district attorney may argue that the lack of parallelism between the words “may be distributed or possessed as part of a pilot program” and “any such distribution or exchange ... shall not be a crime” means that the words “shall not be a crime” were not intended to include “possession.” That assertion fails for two reasons. First, the use of the words “any such” clearly indicates that “distribution or exchange” refers back to “distributed or possessed.” Indeed, the concepts of “distribution or exchange” presume possession by the recipient. Second, such a construction defies logic. If the word “possessed” is not linked to the phrase “shall not be a crime,” then possession would not even be lawful within the city or town in which the needle exchange program is sited. Even the district attorney would acknowledge the error of that assertion.

extremely liberal construction in order to accomplish and maximize their beneficial objectives.”). *See also Deas v. Dempsey*, 403 Mass. 468, 470 (1988). Taken together with the Legislature’s use of the clear words “shall not be a crime,” these principles require the conclusion that needle exchange participants may lawfully possess needles throughout the Commonwealth.

Second, neither § 27(f) nor § 215 places *any* geographical restriction on the lawful possession of a hypodermic needle obtained as part of a needle exchange program. This Court should not infer or supply conditions or restrictions which do not appear in the statute. *See Commissioner of Revenue v. Cargill, Inc.*, 429 Mass. 79, 82 (1999) (refusing to add requirement not set out in text of statute, and stating that “where ... the language of the statute is clear, it is the function of the judiciary to apply it, not amend it.”); *King v. Viscoloid Co.*, 219 Mass. 420, 425 (1914) (“we have no right to ... read into the statute a provision which the Legislature did not see fit to put there”).

Third, the language and structure of § 27 demonstrate that the Legislature specifically did *not* intend to place a geographical limitation on lawful possession under § 27(f). In the immediately preceding section of the statute, § 27(e), the Legislature provided that certain licenses issued by local boards of health “shall be valid only in a particular city or town.” As this Court has stated, where “the Legislature has carefully employed specific language in one paragraph of a statute ... but not in others which treat the same topic ... the language should not be implied where it is not present.” *See Hallett*

v. Contributory Retirement Appeal Board, 431 Mass. 66, 69 (2000) (quoting First Nat'l Bank v. Judge Baker Guidance Ctr., 13 Mass. App. Ct. 144, 153 (1982)).³⁶

Fourth, importing a “local approval” requirement into § 27(f) would create absurd and irrational results. For example, there is nothing in § 215 which restricts the use of a needle exchange program to residents of the city or town in which the program is sited. Yet, importing the “local approval” requirement into § 27(f) would mean that individuals could lawfully obtain and possess needles at a pilot program, and then be prohibited from leaving that city or town and returning to their homes. Further, even participants who reside where the program is sited would be prohibited from leaving that city or town with needles in their possession. Clearly, the very nature of addiction means that people must often carry needles with them wherever they go. In passing a public health statute with the clear goal of reducing disease transmission among persons addicted to intravenous drugs, the Legislature could not have intended to quarantine individuals within the city or town in which the program is sited. This court should not adopt such an illogical interpretation, which has no basis in the statutory language and which would unquestionably undermine the public health goals by deterring all people from accessing pilot programs. See Manning v. Boston Redevelopment Authority, 400 Mass. 444, 453 (1987) (“A statute or ordinance should not be construed in a way that produces absurd or unreasonable results when a sensible construction is readily available.”); Board of

³⁶ Moreover, the Legislature has demonstrated that it knows how to specify detailed restrictions and limitations on lawful possession of syringes. For example, § 27(c) requires that a prescription for a hypodermic needle must be in a container with a label bearing the name and address of the pharmacy, the name and address of the patient, and the name of the physician. The complete absence of any restrictions, specifications, or conditions in § 27(f) compels the conclusion that the Legislature intended none, as long as the needles were obtained through an authorized needle exchange program.

Appeals of Hanover v. Housing Appeals Committee, 363 Mass. 339, 355 (1973) (“[W]e must avoid a construction of statutory language which produces irrational results.”). *See also* Sutherland, *supra* at p. 16 (liberal construction given to public health law).

Fifth, this Court must construe § 215 and § 27(f) in a way that avoids the constitutional question of whether restricting lawful possession of needles to the city in which the program is sited unduly burdens the constitutional right to travel and move freely within the Commonwealth. Courts have long held that statutes should be construed to avoid constitutional problems unless such construction is plainly contrary to the intent of the Legislature. Edward J. DeBartolo Corp. v. Florida Gulf Coast Bldg. and Const. Trades Council, 485 U.S. 568 (1988). A statute must be construed “so as to avoid not only the conclusion that it is unconstitutional but also grave doubts upon that score.” United States v. Jin Fuey Moy, 241 U.S. 394, 401 (1916); Globe Newspaper Co. v. Superior Court, 379 Mass. 846, 853 (1980). As the Supreme Judicial Court has stated, “traditionally, we have regarded the presence of a serious constitutional question under one interpretation of a statute to be a strong indication that a different possible interpretation of that statute should be adopted, if the constitutional issue can be avoided thereby.” Baird v. Attorney General, 371 Mass. 741, 745 (1977).

A construction of § 215 and § 27(f) that immunized conduct from criminal liability in some parts of the Commonwealth, but criminalized the *very same conduct* in other parts of the state, would unduly burden the right to intrastate travel and movement.³⁷ Many federal courts have recognized the right to intrastate movement. For

³⁷ Both the U.S. Supreme Court and the Supreme Judicial Court of Massachusetts have long recognized a right to interstate travel. *See, e.g., Shapiro v. Thompson*, 394 U.S. 618, 630 (1969); Commonwealth v. Pike, 428 Mass. 393, 402 (1998). Although the Supreme

example, in Lutz v. City of York, Pa., 899 F.2d 255 (3rd Cir. 1990), the Court invalidated an anti-cruising law, which sought to ban repetitive driving around a city's downtown strip. The Court concluded that "the right to move freely about one's neighborhood or town ... is indeed 'implicit in the concept of ordered liberty' and 'deeply rooted in the Nation's history.'" *Id.* at 268. Similarly, the Second Circuit has stated that "it would be meaningless to describe the right to travel between states as a fundamental precept of personal liberty and not to acknowledge a correlative constitutional right to travel within a state." King v. New Rochelle Mun. Housing Auth., 442 F.2d 646, 648 (2d Cir. 1971). *See also* Pottinger v. City of Miami, 810 F. Supp. 1551, 1580 (S.D. Fla. 1992) (holding that an anti-sleeping ordinance interfered with homeless persons' right to travel); McCollester v. City of Keene, 586 F. Supp. 1381, 1384-1385 (D.N.H. 1984) (juvenile curfew law violated the right to "freedom of movement"); Bykofsky v. Borough of Middletown, 401 F. Supp. 1242, 1254 (M.D. Pa. 1975), aff'd, 535 F.2d 1245 (3rd Cir. 1976) ("rights to locomotion, freedom of movement, to go where one pleases, and to use the public streets in a way that does not interfere with the personal liberty of others are basic values 'implicit in the concept of ordered liberty'").

Statutes that penalize the right to travel are subject to strict scrutiny. *See* Lee v. Commissioner of Revenue, 395 Mass. 527, 530 (1985). There is no question that the force of criminal prosecution and the resultant deprivation of liberty is a penalty. *Id.* at 530-531 (citing cases which find that residency requirements to receive welfare benefits or to exercise the right to vote are penalties). Whether analyzed under a strict scrutiny

Judicial Court has not squarely addressed whether it would find a right to intrastate travel, it has suggested that it may well follow those federal courts which have found such a right. *See* Town of Milton v. Civil Serv. Comm., 365 Mass. 368, 371 n.2 (1974).

standard or even the lesser standard of being reasonably related to a legitimate state purpose, the criminalization of conduct on one side of a city line, but not on the other, is arbitrary and without any apparent justification.³⁸ As such, in order to avoid this constitutional question, this Court should conclude that § 27(f)'s authorization for lawful possession of needles obtained through a DPH pilot program is of statewide application.

III. A PERSON WHO IS ENROLLED IN AN AUTHORIZED NEEDLE EXCHANGE PROGRAM AND PRODUCES A FACIALLY VALID ENROLLMENT CARD CANNOT BE ARRESTED, SUMMONSED, OR CHARGED WITH UNLAWFUL POSSESSION OF NEEDLES.

A. If A Person Falls Within Any Statutory Exemption In § 27, Including As A Participant In A Needle Exchange Program, There Is No Probable Cause To Arrest That Person For A Violation Of G.L. C. 94C.

It is a fundamental principle of the Fourth Amendment to the United States Constitution and article 14 of the Declaration of Rights to the Massachusetts Constitution that there must be probable cause in order for an arrest to be valid. *See Commonwealth v. Santaliz*, 413 Mass. 238, 240 (1992). The standard for probable cause is well established: “[P]robable cause exists where, at the moment of arrest, the facts and circumstances within the knowledge of the police are enough to warrant a prudent person in believing that the individual arrested has committed or was committing an offense.” *Id.* at 241 (quoting *Commonwealth v. Storey*, 378 Mass. 312, 321 (1979)). The police officer must have something “more than a suspicion of criminal involvement, something definite and substantial.” *See Commonwealth v. Bond*, 375 Mass. 201, 210 (1978).

³⁸ Counsel for *amici* is unaware of any Massachusetts statute which can be interpreted to create criminal liability in one city or town, but which does not criminalize the identical conduct under the same circumstances the moment a person steps over the town or city line.

The plain purpose of G.L. c. 94C, § 27 is to create categories or classes of persons who may lawfully possess hypodermic needles or syringes. It defies law and logic to interpret this statute to mean that there is probable cause to arrest a person who squarely falls within that class of persons whom the Legislature explicitly authorized to possess lawfully hypodermic needles or syringes. Moreover, the Legislature used stronger language to provide that possession of needles as part of a needle exchange program is lawful than it did even for the other exemptions in § 27. Where in subsections (a)-(e), the Legislature followed a pattern of simply stating that “no person” who does not fall into the specified category “shall possess a hypodermic needle,” in subsection (f), the Legislature used the clear and unequivocal words “shall not be a crime.” If an act “shall not be a crime,” then it is beyond cavil that the conduct cannot even begin to give rise to probable cause.

The Supreme Judicial Court’s decision in Commonwealth v. Couture, 407 Mass. 178 (1990), squarely states this established principle. In Couture, the police received a telephone call that a man had a small handgun protruding from his pocket. *Id.* at 179. The police stopped the man’s car, searched the vehicle, and found a .38 caliber pistol. *Id.* The Court ruled that the stop was improper under Fourth Amendment principles because “the mere possession of a handgun was not sufficient to give rise to a reasonable suspicion that the defendant was illegally carrying the gun.” *Id.* at 183. The Court noted that “*carrying a .45 caliber revolver is not necessarily a crime.*” *Id.* at 180 (emphasis in original). Rather, “[a] possible crime was carrying a gun without a license to carry

firearms.” *Id.*³⁹ Because the police did not learn that the defendant lacked a firearm identification card until after the search, the court found that at the time of the search “the police had no probable cause to believe that the defendant was or had been engaged in any criminal activity.” *Id.* See also Commonwealth v. Alvarado, 420 Mass. 542, 549 (1995) (“view of an object which may be used for lawful as well as unlawful purposes, even a container of the type commonly used to store controlled substances, is not sufficient to provide the viewing officer with probable cause to seize that object or arrest the individual possessing that object.”).

Commonwealth v. Jefferson, 377 Mass. 716 (1979), Commonwealth v. Jones, 372 Mass. 403 (1977), and similar cases, are distinguishable and not applicable to the reported question before this Court.⁴⁰ Neither Jefferson nor Jones addresses the question of whether there were valid grounds for an arrest in the first instance. The defendants in Jefferson and Jones were arrested without at the time having any license, identification card or other authority which brought them within a statutory exemption to possess methadone or a firearm, respectively. In the absence of a license or other authority that the defendants fell within a statutory exemption, there was probable cause for arrest. Jefferson and Jones addressed the constitutionality of G.L. c. 278, § 7 which provides that: “A defendant in a *criminal prosecution*, relying for his justification upon a license,

³⁹ As the Court observed, the relevant statute provided for the punishment of an individual who, “except as provided by law, carries on his person, or carries on his person or under his control in a vehicle, a firearm, loaded or unloaded.” *Id.* at 181. The Court observed, however, that the statute listed exceptions, including for a person who has a license to carry firearms. *Id.*

⁴⁰ In the Commonwealth’s Application For Direct Appellate Review (p. 11), the district attorney stated his belief that Jefferson and related cases stood for the proposition that a member of a needle exchange program with a facially valid enrollment card should, nonetheless, be arrested, and forced to prove the statutory justification in the courtroom.

appointment, admission to practice as an attorney at law, or authority, shall prove the same; and until so proved, the presumption shall be that he is not so authorized.”

(emphasis supplied). Thus, these cases simply address an evidentiary issue at trial -- presuming a valid arrest has already occurred -- and stand for the proposition that a defendant who is validly arrested may still present evidence at trial ultimately establishing a justification. Importantly, in Couture, the Court rejected the Commonwealth’s assertion that its ruling conflicted with Jones, observing that “[t]he Jones standard does not make an open target of every individual who is lawfully carrying a handgun.” 407 Mass. at 183.

B. Requiring A Full Trial For Every Person Who Lawfully Possesses Needles Under § 27 -- From Doctors To Diabetics -- Would Result In Absurd Consequences, Flood The District Courts With Needless Prosecutions, And Eviscerate The Intended Public Health Goals Of Needle Exchange.

It is inconceivable that the Legislature intended the exemptions in c. 94C, § 27 to create nothing more than categories of persons who can be arrested for illegal possession of hypodermic needles and then subjected to the full extent of the prosecutorial process -- arrest, bail hearing, arraignment, and jury trial. Under such a reading of the statutory language, every diabetic who daily injects insulin and every person with a severe allergy who carries an “epi-pen,”⁴¹ would be subject to arrest and jury trial, even if the person possessed a prescription meeting the requirements of §27(c).⁴² The defendant would then

⁴¹ An “epi-pen” is a hypodermic needle which contains epinephrine used to treat a life-threatening anaphylactic reaction to an allergen, such as nuts or bee stings. It is prescribed by doctors and carried by patients in event of an emergency.

⁴² One-third of the 196,000 diabetics in Massachusetts inject insulin on a daily basis. See Massachusetts Department of Public Health, Bureau of Health Statistics, Research and Evaluation, *Diabetes in Massachusetts: Results From The Behavioral Risk Factor*

be forced to prove the validity and authenticity of the prescription at trial as an affirmative defense. Similarly, if §§ 27(a)-(f) merely give rise to an affirmative defense, then § 27(a) must mean that physicians, dentists, nurses, embalmers, or “manufacturers of or dealers in surgical supplies” are subject to arrest, but must raise their license, registration or other authority under the statute as an affirmative defense at trial. It is unfathomable that the Legislature intended these explicitly protected categories to be so illusory. Nor could the Legislature have reasonably intended that the Commonwealth’s law enforcement personnel, district attorneys, and judicial system expend scarce resources on tens or hundreds of thousands of such potential cases.

There is no sound basis in the language and structure of § 27 to treat § 27(f) differently than §§ 27(a)-(e) with respect to the question of immunity from arrest. Rather, if anything, § 27(f) creates stronger protections, given its exclusive use of the words “shall not be a crime.” Moreover, an interpretation of § 27(f) which permits arrest and public prosecution of individuals possessing needles through a DPH program would make utterly hollow the Legislative intent to reduce the twin epidemics of substance abuse and injection drug-related HIV, HCV and HBV. It is well known that addiction and injection drug use are associated with severe social stigma and shame.⁴³ Indeed, as

Surveillance System 1994-1996, (1998) at <http://www.state.ma.us/dph/bhsre/cdsp/diab3.htm>.

⁴³ See, e.g., Grace E. Macalino et al., *Community-Based Programs for Safe Disposal of Used Needles and Syringes*, 18 (Suppl. 1) *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* S111 at S118 (1998) (“it is important to realize the stigma attached to being identified as an IDU”). See also National Center for HIV, STD and TB Prevention, *Preventing Blood-borne Infections Among Injection Drug Users: A Comprehensive Approach* (2000) at 34 (“If [intravenous drug users] are to be successfully engaged in prevention efforts and if public policy is to move forward, the

DPH has observed, “[I]njection drug users must trust and value a needle exchange program before they will agree to participate ... Some injection drug users may fear that the needle exchange is a cover for a police operation to make drug arrests.”⁴⁴ *See also* Macalino, *supra*, note 43 at S118 (“program options that provide anonymity are more likely to be attractive to users of syringes.”). It is clear that arrest, public disclosure, and prosecution will drive people away from needle exchange programs and thwart the legislative goal to combat the transmission of HIV, HCV and HBV.

C. A Facially Valid Needle Enrollment Card Is Satisfactory Indicia That An Individual Is Protected From Arrest By § 27(f).

For each category of persons specified in § 27(a)-(e), the Legislature has described the indicia or criteria to demonstrate inclusion within the statutory exemption. For example, physicians must be “registered” under the laws of the Commonwealth. *See* § 27(a). A prescription for lawful possession of syringes must meet certain specifications *See* § 27(c). The Legislature, however, took an entirely different approach with respect to needle exchange pilot programs. Because the Legislature was creating a public health program aimed at the population of injection drug users, the Legislature wholly delegated to DPH *all* aspects of the implementation and operation of needle exchange programs. *See* § 215 (“The department shall promulgate rules and regulations for the implementation of [not more than ten] pilot programs ...”). It is notable that the Legislature itself did not specify a single aspect of needle exchange programs. This expansive delegation of authority demonstrates the Legislature’s decision that DPH is

negative attitudes, stereotypes, and stigma attached to injection drug users and their addiction must be recognized and overcome.”).

⁴⁴ *See* Massachusetts Department of Public Health, *Setting Up a Needle Exchange*, (January 1996) at 23.

best suited to design a program to meet the unique public health goals of needle exchange.

This broad delegation to DPH encompasses the methods for identifying program participants. Because DPH recognized that injection drug users were unlikely to participate in a program requiring the disclosure of names, DPH formulated a system of anonymous enrollment in which no names or addresses are collected.⁴⁵ Enrollment in this system, as evidenced by a valid enrollment card, should protect against arrest.

In light of the Legislature's decision to leave implementation of the program to DPH, this Court should not second-guess the operational decisions made by DPH. Moreover, the Legislature has been aware since 1995 of the anonymous enrollment policy and has not taken any steps to change it or alter its delegation of authority to DPH.⁴⁶ There is no basis in the text of § 27 to rule that those persons within § 27(f) can be subject to arrest, but that other classes of persons authorized to possess needles are

⁴⁵ While DPH has not issued formal regulations, it has clearly established anonymous enrollment as a rule and program requirement. *See Final Report, First Year of the Pilot Needle Exchange Program in Massachusetts*, prepared by The Medical Foundation under contract to the Department of Public Health (October 1995) (hereinafter "Final Report") at 20 ("The program provides anonymous enrollment, and no names or addresses are collected. However, in order to track clients, a unique identifier is generated which consists of the first three letters of the mother's first name and the client's birthday. This identifier is used to track each client's participation in the program."). *See also* Report Pursuant to Mass. R. Crim. P. 34 on the Defendant's Motion to Dismiss (p. 2, ¶ 1, A-C, describing anonymous enrollment and card).

⁴⁶ The Final Report, *supra*, note 45, was submitted to the Legislature in response to the directive contained in St. 1993, c. 110, Sec. 148. In addition to the clear description of anonymous enrollment, the Final Report contains a March 7, 1994 Order regarding needle exchange from Boston Police Commissioner Paul Evans to all personnel stating: "Police officers shall not charge intravenous drug users who are enrolled in the Pilot Needle Exchange Program with unlawful possession of hypodermic needles or syringes. Pilot Needle Exchange participants can be distinguished by their Pilot Needle Exchange Program Identification Card." *See Final Report, supra*, note 45, Appendix 1, p. 3.

immune from arrest. This Court should not interfere with DPH's legislatively authorized implementation of needle exchange programs.

IV. THIS COURT SHOULD CONSTRUE § 215 AND § 27(F) CONSISTENT WITH THE LEGISLATURE'S GOAL TO IMPLEMENT THE PUBLIC HEALTH AND SOCIETAL BENEFITS OF NEEDLE EXCHANGE IN RESPONSE TO A PUBLIC HEALTH EMERGENCY.

In addition to the reasons set forth in Arguments I-III, *supra*, the construction urged by the defendant and the *Amici* is consistent with the public health goals of needle exchange programs.

A. Needle Exchange Is A Scientifically Proven Intervention To Reduce The Transmission Of Incurable Diseases And Does Not Increase Drug Use Or Crime.

The success and benefit of needle exchange programs is beyond serious dispute. In 1998, the United States Secretary of Health and Human Services, acting pursuant to the requirements of federal law, announced that: "A meticulous scientific review has now proven that needle exchange programs can reduce the transmission of HIV and save lives without losing ground in the battle against illicit drugs."⁴⁷ Indeed, innumerable studies from authoritative, peer-reviewed medical journals bear out this conclusion. For example, a 1994 study tracking returned needles at the New Haven, Connecticut exchange program concluded that "needle exchange has served to reduce the rate of new HIV infections."⁴⁸

⁴⁷ See Press Release, Department of Health and Human Services, *Research Shows Needle Exchange Programs Reduce HIV Infections Without Increasing Drug Use* (April 20, 1998) at <http://www.hhs.gov/news/press/1998pres/980420a.html>. Under Public Law 105-78, the Secretary was authorized to determine that needle exchange programs reduce HIV transmission and do not encourage the use of illegal drugs, as a pre-requisite to lifting the restriction on federal funding.

Similarly, a 1995 study concluded that after Connecticut loosened restrictions on needle prescription and drug paraphernalia laws, there was a 39% decrease in syringe sharing.⁴⁹ A 1998 study of programs in San Francisco, Chicago, Baltimore, and New Haven concluded that syringe exchange programs were associated with decreases in syringe use by drug injectors and concluded that “[t]hese findings add to earlier studies supporting the role of [syringe exchange programs] in reducing the transmission of syringe-borne infections such HIV and Hepatitis.”⁵⁰ An analysis of these and the many other studies of needle exchange programs conducted by the National Institutes of Health found that needle exchange programs “show a reduction in risk behaviors as high as 80 percent in injecting drug users, with estimates of a 30 percent or greater reduction in HIV.”⁵¹ In an analysis of 81 cities with needle exchange programs throughout the world (with 54% in North America), the prevalence of HIV decreased in cities with needle exchange

⁴⁸ See Edward H. Kaplan, Robert Heimer, *HIV Incidence Among Needle Exchange Participants: Estimates From Syringe Tracking and Testing Data*, 7 *Journal of Acquired Immune Deficiency Syndromes* 182-189 at 186 (1994).

⁴⁹ See Samuel Groseclose et al., *Impact of Increased Legal Access to Needles and Syringes on Practices of Injecting-Drug Users and Police Officers – Connecticut, 1992-1993*, 10 *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* 82-89 (1995).

⁵⁰ See Robert Heimer et al., *Syringe Use and Reuse: Effects of Syringe Exchange Programs in Four Cities* 18 (Suppl. 1) *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* S37-44 (1998).

⁵¹ See National Institutes of Health, *supra*, note 25.

programs and increased in cities without them.⁵² Needle exchange has been equally effective in reducing HCV and HBV.⁵³

Moreover, the early qualms of some that needle exchange would increase drug use and crime have proven to be baseless fears. For example, a 1994 study in the *Journal of the American Medical Association* found that the San Francisco program did not stimulate increased drug use among current users or recruit new or younger users.⁵⁴ Similarly, a study of the syringe exchange program in Baltimore concluded that “needle exchange programs are not associated with an increase in crime rates.”⁵⁵ There is no evidence which suggests that needle exchange increases crime.

B. Needle Exchange Programs Increase Enrollment Of Injection Drug Users In Substance Treatment.

As the Surgeon General has observed, “[r]ecent research studies document the role that effective syringe exchange programs serve as mechanisms to engage very high risk and hard to reach individuals in substance abuse treatment services.” *See Evidence-Based Findings, supra*, note 11. For example, a 1998 study in *Public Health Reports* found that 51% of needle exchange clients referred for substance abuse treatment actually

⁵² See Susan F. Hurley et al., *Effectiveness of Needle Exchange Programmes for Prevention of HIV Infection*, 349 *Lancet* 1797-1800 (1997).

⁵³ See Holly Hagan et al., *Reduced Risk of Hepatitis B and Hepatitis C Among Injection Drug Users in the Tacoma Syringe Exchange Program*, 85 *Am. J. Pub. Health* 1531 (1995) (in study of Tacoma, Washington syringe exchange program, exchange led to significant reduction in hepatitis B and hepatitis C).

⁵⁴ See John K. Watters et al., *Syringe and Needle Exchange as HIV/AIDS Prevention for Injection Drug Users*, 271(2) *JAMA* 115-120 (1994).

⁵⁵ See Melissa A. Marx et al., *Trends in Crime and the Introduction of a Needle Exchange Program*, 90 *Am. J. Pub. Health* 1933 (2000).

entered treatment, with 76% completing the first 13 weeks of treatment.⁵⁶ The Surgeon General observed that these results were achieved despite the fact that these clients had more severe drug use, more HIV risk behaviors, less employment, and greater engagement in illegal activities than clients referred to substance abuse treatment from traditional sources. *See Evidence-Based Findings, supra*, note 11. Similarly, a study of the Seattle needle exchange program found that “[c]ompared to those who had never used an exchange, new exchange users were five times more likely to enter methadone treatment and ex-exchangers were 60% more likely to remain in methadone treatment over the 1-year study period.”⁵⁷

C. Needle Exchange Programs Create A Safer Environment For Police And Other Law Enforcement Personnel And Save Billions In Future Medical Costs.

The legal possession of needles through authorized exchange programs creates safety for police and other law enforcement by eliminating the risk that an officer will be accidentally stuck with a dirty needle. When police stop and search a person, the presence of a dirty needle poses a potential risk to the police officer. It is simply common sense that an injection drug user is less likely to inform the arresting officer of the presence of a dirty needle (e.g., in a jacket, pocket, or purse), and more likely to attempt to hide it, if he or she can be arrested and prosecuted for illegal possession of the needle. Indeed, in this case, the defendant voluntarily informed the police of additional needles in her purse,

⁵⁶ See Robert Brooner et al., *Drug Abuse Treatment Success Among Needle Exchange Participants*, 113 Public Health Reports 129 (1998).

⁵⁷ See Holly Hagan et al., *Reduced Injection Frequency and Increased Entry and Retention in Drug Treatment Associated With Needle Exchange Participation In Seattle Drug Injectors*, 19 Journal of Substance Abuse Treatment 247-252 at 250 (2000).

likely because of her understanding, stated on the back of her needle exchange program card, that she could not be arrested. Moreover, by requiring that dirty needles be returned in exchange for clean needles, needle exchange programs reduce the risk that dirty needles will be carelessly discarded in any public place -- such as a street, park, or garbage bin -- where they pose a health threat to *any* citizen or public worker who may be accidentally stuck. As one study of this problem noted, “[intravenous drug users] are unlikely to save or transport used syringes if they risk arrest and criminal penalties for doing so.”⁵⁸ In fact, after restrictions on the possession of needles were loosened in Connecticut, needlestick injuries among Hartford police officers were lower.⁵⁹

In addition to increased public safety, the reduction in the incidence of severe and incurable diseases will save billions of dollars in future health care costs. One study concluded that for each year without increased access to sterile syringes in the United States, “as many as 12,350 persons will become infected with HIV, leading to an estimated \$1.3 billion in future medical costs for these persons.”⁶⁰ In addition, reduction in the incidence of Hepatitis C will also result in substantial savings, as Hepatitis C is the leading cause of severe liver disease and cirrhosis and the leading indicator for liver transplants in the United States.

⁵⁸ See Macalino et al., *supra*, note 43, at S118.

⁵⁹ See Groseclose et al., *supra*, note 49 at 82.

⁶⁰ See David R. Holtgrave et al., *Cost and Cost-Effectiveness of Increasing Access to Sterile Syringes and Needles as an HIV Prevention Intervention in the United States*, 18 (Suppl.1) *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* S133-138 (1998).

CONCLUSION

For the foregoing reasons, the *Amici* urge this Court to rule that: (1) Once a person lawfully obtains needles from a needle exchange program implemented by the Department of Public Health under G.L. c. 215, § 111, possession of those needles is lawful throughout the Commonwealth; and (2) Persons who have a facially valid enrollment card to possess needles through participation in an authorized needle exchange program are not subject to arrest.

Respectfully Submitted,

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ADDENDUM

DESCRIPTION OF AMICI

AIDS Action Committee of Massachusetts

Founded in 1983, AIDS Action Committee of Massachusetts is New England's leading provider of AIDS services, education, and advocacy. AIDS Action currently provides a wide range of confidential services free of charge to more than 2,100 men, women, and children living with HIV disease. The agency works to stem the spread of the AIDS epidemic through neighborhood-based prevention education efforts. AIDS Action also advocates at the federal, state, and local level for responsible laws and policies affecting people living with HIV and AIDS.

AIDS Project Worcester, Inc.

AIDS Project Worcester, Inc. is a comprehensive HIV/AIDS service organization and the primary provider of non-medical HIV/AIDS services to families and individuals living with HIV disease throughout Central Massachusetts. AIDS Project Worcester provides direct services, volunteer opportunities, education and advocacy within the 68 cities and towns of Central Massachusetts seeking to reach those infected with or at-risk for HIV infection and those impacted by HIV disease.

American Public Health Association

American Public Health Association (APHA) is a national organization devoted to the promotion and protection of personal and environmental health. Founded in 1872, APHA is the largest public health organization in the world, with over 50,000 members. It represents all disciplines and specialties in public health. APHA also publishes a technical report series dealing with various aspects of the HIV epidemic through the American Journal of Public Health, as well as numerous books related to HIV and state-of-the-art research.

Boston Public Health Commission

The Boston Public Health Commission is the city's health department, and its mission is to protect, preserve and promote the health and well-being of all Boston residents, particularly those who are most vulnerable. The prevention of the spread of HIV in the City of Boston is an important part of this mission and the needle exchange program operated by the Commission is a crucial element of the containment of this epidemic. The resolution of the issues before the court will have a critical impact on the continued viability of needle exchange programs and health care options available to some of the most vulnerable populations, not only in the city of Boston but throughout the Commonwealth of Massachusetts.

CAB Health and Recovery Services, Inc.

CAB Health and Recovery Services, Inc. was founded in 1958 to provide information, treatment and referral for the control and prevention of alcoholism. It has since diversified, now providing quality substance abuse and related health treatment and prevention services that strengthen the capacity of all families, businesses and communities to lead satisfying lives.

Cambridge Cares About AIDS

Cambridge Cares About AIDS operates Cambridge's needle exchange program. Incorporated in 1988, the agency was created by the City of Cambridge's AIDS Task Force to coordinate a response to the service needs of the community's most hard-to-reach constituency of persons living with HIV. The mission of Cambridge Cares About AIDS has been to develop a comprehensive approach to the AIDS epidemic that is sensitive to the diversity of people living with HIV and those at risk of infection. To achieve these goals, the agency has developed comprehensive programs in client services, housing and prevention education.

Cambridge Public Health Department

The Cambridge Public Health Department is the public health unit for the City of Cambridge, Massachusetts. The department provides a range of services, including disease surveillance, community health programs, environmental health monitoring, and regulatory functions. The department is a division of the Cambridge Health Alliance, which operates 3 hospitals and 21 primary care sites. The Alliance operates the Zinberg Clinic, which provides medical services for people with HIV/AIDS, as well as an extensive array of HIV prevention services.

Disability Law Center

The Disability Law Center is a statewide private non-profit organization that is federally mandated to protect and advocate for the rights of individuals with disabilities. Pursuant to the Protection and Advocacy of Individual Rights Program, 29 U.S.C. § 794e, the Disability Law Center represents individuals with disabilities who face discrimination in employment and housing and access to public accommodations. Since 1978 the Law Center has provided a full range of legal assistance to people with disabilities in Massachusetts, including legal representation, regulatory and legislative advocacy, and education and training on the legal rights of people with disabilities.

Fenway Community Health Center

Fenway Community Health Center is a non-profit organization dedicated to enhancing the physical and mental health of the local community, which includes those who are lesbian, gay, bisexual, transgender, people with HIV, and the people who live and work in the neighborhood. The Center provides high quality, comprehensive health

care in a welcoming environment. Fenway Community Health seeks to improve the overall health of the larger community, locally and nationally, through education, advocacy and research.

Health Care of Southeastern Mass., Inc.

The mission of Health Care of Southeastern Mass., Inc. is to improve the health and well-being of individuals, families and communities by providing preventive health and social services to promote health and reduce risks for disease.

Infectious Diseases Society of America

The Infectious Diseases Society of America (IDSA) represents over 6500 physicians, scientists and other health professionals dedicated to excellence in patient care, research and public health disease prevention and education in the field of infectious diseases. Many persons with HIV/AIDS in this country receive their care from infectious diseases physicians. Based on a thorough review of the epidemiological evidence and in the context of the HIV public health emergency, the IDSA strongly supports efforts to: (1) increase injection drug users' access to clean injection equipment; (2) reform and decriminalize syringe possession and paraphernalia laws; (3) legalize over-the-counter syringe access; (4) legalize physician prescribing of sterile syringes to injection drug users; and (5) allow federal and other funding for syringe exchange programs. IDSA believes that all of these activities must be coupled with increased provision and access to drug treatment.

Justice Resource Institute

Justice Resource Institute, Inc. (JRI) is a not-for-profit organization founded in Massachusetts in 1973 by activists who recognized an urgent need to provide health and social services to disenfranchised populations. In 1991, JRI established JRI Health to provide services to people living with HIV disease and AIDS and those at the greatest risk of infection. JRI Health is a multi-service human service organization that provides housing, case management, primary medical and mental health treatment, outreach and other social services. Many JRI Health clients struggle with substance use issues, and access to clean needles is essential to their health and well-being. Additionally, the referral services offered by needle exchange programs result in clients obtaining the treatment they need to overcome addiction.

Latin-American Health Institute

The Latin-American Health Institute is a community-based professional organization that promotes the health of the community, its institutions, families and individuals through effective interventions that are culturally competent and technologically appropriate. The Latin-American Health Institute effectively advocates on behalf of Latin-American residents of Massachusetts, New England and the Nation on

public health issues, in close contact and collaboration with other health and human services organizations.

Lynn Health Task Force

The Lynn Health Task Force is an organization focused on empowering consumers and those lacking access to care to bring about fundamental health care reform. It believes that quality affordable health care is a right of all people and thus supports a health care system that is universal, comprehensive, efficient and equitable. Substance abuse prevention and treatment programs have been a major part of the Task Force's advocacy for many years. The Task Force wholeheartedly supports any efforts to increase and facilitate harm reduction strategies in the community.

Massachusetts Asian AIDS Prevention Project

Founded in 1993, the Massachusetts Asian AIDS Prevention Project (MAAPP) is an Asian Pacific Islander community based organization that promotes health, HIV and sexuality awareness, and access to health care through education, advocacy and technical assistance. MAAPP offers a culturally relevant combination of HIV prevention services that include health education, training, community outreach and advocacy.

Massachusetts Nurses Association

The Massachusetts Nurses Association (MNA), consisting of approximately 20,000 registered nurses, is the largest organization of registered nurses within Massachusetts. It is also the single largest collective bargaining agent for registered nurses in New England. Although its primary mission is to preserve the identity, integrity, and continuity of nursing, MNA is a multi-purpose organization whose goals include improving access to and the quality of health care in Massachusetts. As an advocacy organization for nurses and for high quality of patient care, MNA has an important stake in the appropriate implementation of health care practices regulated by law.

Massachusetts Public Health Association

The Massachusetts Public Health Association seeks to improve health status through education, advocacy and coalition building. MPHA educates its members, the public health community, and the general public on health-related issues and promotes action to address public health concerns.

Multicultural AIDS Coalition

The Multicultural AIDS Coalition is the largest agency in New England that is focused specifically on HIV/AIDS in communities of color. Its work includes direct prevention and education service to individuals at high risk of HIV infection and technical assistance and capacity building services to organizations seeking to develop, enhance, or expand HIV/AIDS programming. As one of the leading health promotion

agencies in the state's communities of color, MAC strongly supports the position that a person who obtains a clean needle through a lawful needle exchange program should be exempt from prosecution for possession of a needle, even when outside of the city where it was obtained.

Nantucket AIDS Network

The Nantucket AIDS Network provides services to those affected by and infected with HIV/AIDS in the Nantucket community. It offers a variety of services, including HIV testing and counseling, prevention education workshops, and referral for medical, legal, and social services.

National Alliance of State and Territorial AIDS Directors

The National Alliance of State and Territorial AIDS Directors (NASTAD) is the only national public health organization in the United States that focuses exclusively on the HIV/AIDS epidemic. Founded in 1992, the organization represents the chief state HIV/AIDS program administrators who are responsible for managing federally-funded and state-funded HIV/AIDS prevention, health and housing programs in every state. As an organization whose focus is on preventing the occurrence of HIV, NASTAD supports the creation and maintenance of needle exchange programs and the decriminalization of possession of hypodermic syringes. NASTAD believes that needle exchange programs are needed to reduce the spread of blood borne infections, such as HIV, and that for needle exchange programs to be effective, participants in the programs must be assured they will not be criminally prosecuted for possession of a syringe resulting from their participation in the program.

Neighborhood Legal Services

Neighborhood Legal Services is a non-federally funded provider of civil legal services to low income residents of Essex County, Massachusetts. Much of its work involves health related issues. Neighborhood Legal Services also runs a referral service for people with HIV infection. A significant number of clients suffer from addiction as one of their disabling conditions. Neighborhood Legal Services strongly believes that punishing drug users who attempt to control their disabling addiction and who strive to maintain their fragile health will adversely affect the organization's efforts to assist them.

New England Prevention Alliance

The New England Prevention Alliance (NEPA) is a group of activists, drug users and service providers dedicated to increasing injection drug users' access to sterile syringes and other harm reduction materials.

North Shore AIDS Collaborative

The North Shore AIDS Collaborative is a group of service providers, community organizations and people affected by HIV/AIDS committed to advocacy, prevention, education, access to services and securing a more compassionate community. They work together to help people with HIV and AIDS in Lynn, Salem, Peabody and surrounding towns to cope with HIV and to live full lives. Close to 50 percent of those they serve contracted HIV/AIDS through injecting drug use, a number that has remained steady or increased slightly for many years.

North Shore AIDS Health Project

The North Shore AIDS Health Project, a non-profit corporation, was founded in 1988 by a group of men and women in health care from Cape Ann. The mission of the health project is to promote wellness in people with HIV/AIDS by providing free holistic health care, support services, information, and outreach in a safe, caring and confidential environment.

Provincetown AIDS Support Group

Provincetown AIDS Support Group operates the needle exchange program for Provincetown. PASG's mission is to provide services to persons with HIV/AIDS that maintain and enhance their quality of life, in Provincetown and the neighboring towns of Truro, Wellfleet, Eastham, and Orleans, and to educate individuals and the community within Barnstable County with timely and accurate information about HIV.

Strongest Link AIDS Services

Strongest Link AIDS Services, Inc. is a non-profit social service agency providing support services to people infected and affected by HIV/AIDS throughout Essex County. Since its inception in 1988, Strongest Link has provided case management services to over 1,400 people with HIV/AIDS. In addition to case management services, Strongest Link provides support groups, information and referral services, transportation resources, a holiday program, and HIV prevention and education programs.

Tapestry Health

Tapestry Health is a multi-service health and human service agency serving four counties of Western Massachusetts. Its programs include reproductive health services, HIV/AIDS prevention and education services, and several other initiatives, all designed to educate and give people the tools to prevent disease and promote well-being. Tapestry Health operates the needle exchange program in Western Massachusetts. The program, which is located in Northampton, serves clients who live in Hampshire, Hampden, Franklin and Berkshire Counties. Tapestry Health believes that the ruling in this case will have an enormous impact on the ability of needle exchange programs to reduce HIV and hepatitis C infection.

Treatment on Demand

Treatment on Demand, Inc. (TOD), a non-profit organization, was founded by two recovering addicts and an HIV educational nurse in 1989. TOD believes in the possibility and necessity of overcoming addiction and AIDS based on the essential worth of all human beings. TOD focuses on the prevention and education of substance abuse and HIV/AIDS, and other related issues. TOD strives to educate, organize, and empower those who disproportionately bear the brunt of substance abuse and AIDS.

Victory Programs

Founded in 1975 as a private non-profit organization, Victory Programs' mission is to promote the successful integration of individuals into their community through the achievement of long-term sobriety, the rebuilding of family systems, and the accessing of such stabilizing factors as housing, holistic health care, employment, and community affiliations. Victory Programs provides innovative services to individuals and their families who are affected by alcoholism and addiction, and who have psychiatric and medical problems, especially AIDS and HIV disease. Victory Programs is New England's largest residential alcoholism and addiction treatment agency, and annually serves over 2,000 individuals and families who are often diagnosed with severe and complicated co-existing medical and psychiatric conditions in addition to their alcoholism and addiction.