COMMONWEALTH OF MASSACHUSETTS

BARNSTABLE, SS **SUPERIOR COURT**
C.A. NO. ____

AIDS SUPPORT GROUP OF CAPE COD, INC.,	)
Plaintiff	)
	)
v.	)
	)
TOWN OF BARNSTABLE, BOARD OF HEALTH OF THE TOWN OF BARNSTABLE, and THOMAS MCKEAN, in his official Capacity as Director of Public Health of the Town of Barnstable,	)
Defendants	)

PLAINTIFF'S MEMORANDUM OF LAW IN SUPPORT OF MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

INTRODUCTION AND SUMMARY OF ARGUMENT

Plaintiff AIDS Support Group of Cape Cod (ASGCC) provides critical services to people living with HIV/AIDS and hepatitis C Virus (HCV) – including medical case management, testing, nutritional support, housing, and referrals to health care and substance abuse treatment – and also works to stem the tide of the devastating and intertwined epidemics of HIV and HCV transmission and fatal opiate overdose. ASGCC's work saves lives. Since 2009, it has provided clients in Hyannis who are intravenous drug users (IDUs) with free clean needles, a practice endorsed by the United States Centers for Disease Control and Prevention and the medical community as the only way to prevent HIV/HCV transmission in this population. It also provides each client with free Narcan, an opioid antagonist used to reverse overdoses. From July, 2014 to September, 2015, there were 282 reported opiate overdose reversals through this program at ASGCC's Hyannis site. ASGCC enhances community safety. It counsels all clients about the

importance of proper syringe disposal and provides them with free bio-hazard sharps containers. During ASGCC's last fiscal year, it had a syringe return rate in Hyannis of 102%.

This is an action for declaratory judgment arising from an unlawful cease and desist order dated September 22, 2015 issued by the Town of Barnstable, its Board of Health, and the Director of Public Health, Thomas McKean (collectively, the "Town" or "defendants") prohibiting ASGCC from distributing needles and syringes at its Hyannis location. *See* Exhibit A (the "Order"). The Order asserts that ASGCC's distribution of needles to its clients violates G.L. c. 111, § 215 and G.L. c. 94C, § 27.[1] No language in these statutes limits the possession, distribution, or exchange of hypodermic needles by ASGCC. The Order contravenes Massachusetts law because the legislature's 2006 amendment to c. 94C, § 27 repealed *all* prohibitions, restrictions and limitations on the possession, distribution and exchange of hypodermic needles by any person in order to address the public health crisis of HIV/HCV transmission. *See* St. 2006, § 172, Exhibit B (An Act Relative to HIV and Hepatitis C Prevention) (the "2006 Act"), repealing the entire preexisting § 27. The text of G.L. c. 94C, § 27 as it existed prior to the 2006 Act is attached as Exhibit C. Thus, while the Department of Public Health may still nominate cities and towns for one of its own pilot programs, Massachusetts law does not otherwise restrict the possession or distribution of needles by any other person or entity, as the legislature repealed the regulation of hypodermic needles in toto. *See* Argument, § I(C)(2), *infra.*

[1] These statutes are set out in Argument, § I, C(2), *infra*. In brief, G.L. c. 111, § 215, passed in 1993, authorizes the Department of Public Health to "promulgate rules and regulations for the implementation of not more than ten pilot programs for the exchange of needles in cities and towns … upon nomination by the department," and requires that "[l]ocal approval shall be obtained." G.L. c. 94C, § 27, as amended in 2006, was enacted to permit the sale of syringes and needles without a prescription, and its single paragraph simply provides that hypodermic needles and syringes may only be "sold" by a pharmacist.

Further, the Town acted without lawful authority or power to issue the Order in the first place. A local board of health's enforcement power is limited to its own validly promulgated health regulations and those areas of enforcement specifically delegated by the legislature. The legislature has not granted local boards of health authority to enforce the statutes cited in the Order, nor does the Order cite any local regulation. *See* Argument, § I, C(1), *infra.*

The irreparable harm that would result without the issuance of immediate relief is evident. Barnstable County has the highest rate of HCV transmission among people aged 15-25 in Massachusetts. IDUs will use dirty needles and contract deadly diseases; the effort to combat the opiate overdose crisis in Massachusetts will be undermined. In light of the catastrophic consequences of stopping ASGCC's drug user health program, the intent of the legislature to combat HIV and HCV, and Governor Baker's prioritization of halting the tragedy of opioid overdoses[2], the balancing of the equities and the public interest weighs heavily in favor of the issuance of a temporary restraining order and preliminary injunction. *See* Argument I, C(3), *infra.* This Court should issue a temporary restraining order and preliminary injunction enjoining enforcement of the Order as set forth in Requests for Relief. Nos. 1 and 3 of the Complaint.

STATEMENT OF FACTS

ASGCC provides comprehensive services to support people living with HIV/AIDS and HCV, and implements programs to reduce the spread of these infections to others. Affidavit of Max Sandusky ("Sandusky Aff.") ¶ 3. Its services include medical case management, peer support, housing, nutritional programs, testing, and risk reduction strategies. *Id.* It has sites in Provincetown and Hyannis. *Id.*

[2] *See* Felice J. Freyer, *Opioid Task Force Says More Beds, Treatment Options Needed*, Boston Globe, June 22, 2015, https://www.bostonglobe.com/metro/2015/06/22/baker-release-findings-state-opioid-crisis/yP4me9jqa4flJSabUDiNuJ/story.html.

A. The HIV and HCV Epidemic Among Intravenous Drug Users and The Established Public Health Practice to Prevent Disease Transmission.

The epidemics of HIV and HCV are a public health crisis in Massachusetts and the country. Sandusky Aff. ¶ 5; Affidavit of Camilla S. Graham, M.D. ("Graham Aff.") ¶¶ 8-10. HIV and HCV are blood-borne infections and the sharing of injection drug equipment is one of the primary sources of their transmission. Sandusky Aff. ¶ 5; Graham Aff. ¶ 7. Recent surveys indicate that approximately one-third of IDUs aged 18-30 are infected with HCV; prevalence among older IDUs is in the 70%-90% range. Graham Aff. ¶ 15. In 2009, 12% of IDUs in the Northeast acquired HIV infection. Graham Aff. ¶ 16. The current opioid crisis has dramatically increased the spread of these infections in Massachusetts, especially in Barnstable County. Sandusky Aff. ¶ 6. Barnstable County leads Massachusetts in the rate of new HCV infections among people aged 15 to 25 according to a 2015 study. Graham Aff. ¶ 10; Sandusky Aff. ¶ 6. For the period of July–September, 2015, 70% of the clients for whom ASGCC made a service referral were positive for HCV. Sandusky Aff. ¶ 5.

The transmission of HIV and HCV causes devastating personal and societal harm. HIV, though no longer fatal if treated, is life altering. It also requires lifelong and expensive medical treatment. Graham Aff. ¶ 12 (lifetime cost of treatment is $379,668). HCV causes end stage liver disease and is the leading cause of liver transplantation in the United States. Graham Aff. ¶ 11. Even after waiting years for a liver, there are numerous risks, such as blood clots in the new liver's blood vessels; immunosuppressive medications to prevent rejection of the new liver can result in diabetes and kidney damage. Graham Aff. ¶ 11. A new breakthrough treatment for HCV that has a high cure rate costs $100,000 for a 12-week treatment. Graham Aff. ¶ 12. A significant percentage of this cost will be paid from public funds. Sandusky Aff. ¶¶ 9, 24.

HIV and HCV are preventable diseases. Providing injection drug users with access to clean needles is essential in preventing the spread of HIV and HCV. Graham Aff. ¶ 6; Sandusky Aff. ¶ 7. When access to needles is limited, the impact can be devastating. This spring in a rural Indiana county, over 150 IDUs contracted HIV after sharing needles. Graham Aff. ¶ 24.

There is a consensus in the governmental, public health, and medical communities that providing access to clean needles prevents the spread of these diseases and does not increase substance abuse. Graham Aff. ¶¶ 20-22. The United States Secretary for Health and Human Services and the Surgeon General have declared that there is "conclusive scientific evidence" that programs that provide access to clean needles decrease infection, increase the number of injection drug users referred to and retained in substance abuse treatment, and play a unique role in reaching the most disenfranchised populations and engaging them in meaningful prevention interventions and medical care. Graham Aff. ¶ 20.

B. ASGCC's Services in Hyannis to Prevent Disease Transmission and Drug Overdoses.

ASGCC employs the standard, effective public health approach to reducing HIV and HCV infection among IDUs known as "harm reduction," a set of strategies aimed at reducing the negative consequences of substance abuse while encouraging and facilitating entry into substance abuse treatment. Sandusky Aff. ¶ 7. Access to clean syringes is an essential aspect of harm reduction. *Id.*

ASGCC's services to IDUs focus on drug user health. Sandusky Aff. ¶ 9. New client engagement starts with an intake process and an assessment of a client's risk behaviors and education about how to prevent disease transmission, including the dangers of sharing needles. *Id.* ASGCC then provides services including testing, assistance with health insurance, linkage to

medical care, and referrals for housing, mental health services, and substance abuse treatment. Sandusky Aff. ¶ 10.

ASGCC has been offering IDU clients access to clean needles and syringes at its Hyannis site since 2009. Sandusky Aff. ¶ 14. The number of syringes it provides to clients at any one time is based on client drug habits and the need to ensure that a clean needle is used each time a person injects. *Id.* ASGCC does not sell, nor has ASGCC ever sold, hypodermic needles or syringes. Sandusky Aff. ¶ 15. The number of new client registrations for clean needles has increased over time with the dramatic increase in the opioid epidemic. Sandusky Aff. ¶ 16 (indicating 183 clients in 2014).

ASGCC also provides clients with free bio-hazard sharps containers and counsels all clients about the importance of proper disposal. During the period July 1, 2014 to June 30, 2015, ASGCC provided its Hyannis clients with 937 bio-hazard sharps containers. Sandusky Aff. ¶ 19. During that same period it distributed 112,604 syringes and collected on return 115,209, for a return rate of 102%. Sandusky Aff. ¶ 20.

In light of the epidemic of opiate drug overdoses in Massachusetts, ASGCC also provides its IDU clients with free Narcan (Naloxone), an opioid antagonist administered by nasal spray used to reverse overdoses. Sandusky Aff. ¶ 17. From 2012 to 2014, the number of confirmed cases of unintentional opioid overdose deaths in Massachusetts rose by 57%. Graham Aff. ¶ 18. In 2014, more than 1,200 people in Massachusetts died from unintentional opioid overdoses, and the problem is worsening. *Id.* During the period July 1, 2014 to June 30, 2015, there were 216 reported overdose reversals as a result of ASGCC's Narcan distribution program. An additional 66 overdose reversals were reported during July–September 2015. Sandusky Aff. ¶ 17.

C. The Cease and Desist Order.

On September 22, 2015, Thomas McKean, Director of Public Health of the Town of Barnstable, handed ASGCC employee Donna Mello a handwritten document. The typewritten words "Warning Notice" on the top were crossed out and the words "cease and desist" were written in hand. The Order stated after the word "Offense": "MGL 111 Sect 215 and Chapter 94C, Section 27." Although the words "Ordinance or Regulation" is typed at the top of the form, no ordinance or regulation was cited. Nor was any opportunity for a hearing, or other remedial step, indicated on the Order. Shortly thereafter, the Town sent a follow-up letter to similar effect. Ex. D.

D. The Immediate Impact of the Order.

If IDUs in Barnstable County are not provided with easy access to clean needles and other equipment, the rates of HIV, HCV, and hepatitis B infections in the County will definitely increase and there will be potential for a catastrophic outbreak. Graham Aff. ¶ 25. It is the assessment of ASGCC's Director of Prevention and Screening Services that a person addicted to drugs will go to any lengths to inject and will not be deterred by lack of access to clean needles. Sandusky Aff. ¶¶ 22, 25. The Hyannis site normally sees 20-30 IDU clients per day. Since the Order, only 2-3 IDU clients appear daily. Sandusky Aff. ¶ 23. These clients lack the financial or other means to obtain clean syringes elsewhere. In addition, the availability of clean syringes is the draw for clients to seek the broad range of ASGCC's health services, including Narcan. Sandusky Aff. ¶ 21. Clients who no longer come for clean needles will not obtain Narcan and will be at greater risk of death by overdose. Sandusky Aff. ¶ 25.

ARGUMENT

I. THIS COURT SHOULD ENJOIN THE DEFENDANTS FROM PROHIBTING OR RESTRICTING THE DISTRIBUTION OF CLEAN NEEDLES BY ASGCC TO ITS CLIENTS.

A. Preliminary Injunction Standard.

The standard for a preliminary injunction is well-established. "A party seeking a preliminary injunction must show that success is likely on the merits; irreparable harm will result from denial of the injunction; and the risk of irreparable harm to the moving party outweighs any similar risk of harm to the opposing party." *Doe v. Superintendent of Schs. of Weston*, 461 Mass. 159, 164 (2011), citing *Packaging Indus. Group, Inc. v. Cheney*, 380 Mass. 609, 616-617. In some cases, it is also "appropriate [] to consider the risk of harm to the public interest that an injunction could pose." *See Landry v. Attorney General*, 429 Mass. 336, 343 (1999).

B. This Case Meets the Requirements for a Declaratory Judgment.

Under G.L. c. 231A, § 1, the Superior Court has jurisdiction to make "binding declarations of right, duty, status and other legal relations sought thereby … in any case in which an actual controversy has arisen…." *See also id.* at § 2 (specifying "determinations" of "construction or validity" of statutes). The provisions of the declaratory judgment statute are to be "liberally construed and administered." *Id.* at § 9. Declaratory judgment is available to challenge the legality of administrative action even where the action concerns neither adjudication nor rule making. *See Villages Dev. Co. v. Secretary of Executive Office of Envtl. Affairs*, 410 Mass. 100, 106 (1991).

In seeking declaratory relief, the plaintiff must show: (1) an actual controversy; (2) standing; (3) necessary parties have been joined; and (4) available administrative remedies have been exhausted. *Id.* This case involves an actual controversy, and ASGCC has standing, because

ASGCC asserts that the Order contravenes Massachusetts law and prevents it from engaging in the critical activities of its mission. There are no other parties to be joined. And, finally, there are no administrative remedies required to be exhausted under the Town Code, nor did the Order apprise ASGCC of any.[3] The Court may enter a preliminary injunction on a claim for declaratory judgment. *See, e.g., Moe v. Sex Offender Registry Bd.*, 467 Mass. 598, 599-600 (2014) (preliminary injunction issued on declaratory judgment claim in trial court); *Velazquez v. Eye Health Associates*, 2014 WL 7466732 (Mass. Super. Ct. Oct. 1, 2014) (issuance of preliminary injunction following request for declaratory judgment).

C. ASGCC Has a Reasonable Likelihood of Success on the Merits of its Claim That the Order is Unlawful.

1. The Board of Health Had No Lawful Authority to Issue the Order.

The Board of Health acted without lawful authority or power to issue the Order because a local board of health's powers of enforcement are limited to its own validly promulgated health regulation, *see* M.G.L. c. 111, § 31, and those sections of G.L. c. 111 in which the legislature specifically delegated enforcement authority to local boards of health. A municipality does not have unrestricted, plenary power to enforce any state statute it wants to outside of these parameters. The Order itself tells the whole story. *See* Ex. A. The Town's form is captioned at the top, "Ordinance or Regulation," with a line below to specify the "Offense." Yet when

[3] In any event, exhaustion is not required where only questions of law are presented, when the decision has public significance, or where irreparable harm would result if judicial action were delayed by the implementation of an administrative process. *See, e.g., Town of Hingham v. Dep't of Hous. & Cmty. Dev.*, 451 Mass. 501, 509 (2008); *Stock v. Mass. Hospital Sch.*, 392 Mass. 205, 213 (1984); *Temple Emanuel v. Mass. Comm'n Against Discrimination*, 2009 Mass. Super. LEXIS 137, 5-6.

completing the form, the Town failed to cite any Ordinance or Regulation that authorizes its drastic actions. This is for good reason; there is none.[4]

Local boards exist because the legislature authorized their creation. *See* G.L. c. 111, § 26. Their authority derives from a delegation of power from the legislature. The legislature authorized boards of health to make "reasonable health regulations." G.L. c. 111, § 31 (requiring public notice). A board of health may not regulate in conflict with state law or in an area where the state prohibits it from regulating. *See Am. Lithuanian Naturalization Club, Athol, Mass., Inc. v. Bd. of Health of Athol*, 446 Mass. 310, 321 (2006) (citing art. 2, § 6 of the Amendments to the Massachusetts Constitution, as amended by art. 89 of the Amendments).The public notice requirement of § 31 allows the public to voice its displeasure with any proposed ordinance and if needed to seek enjoinment of an unlawful regulation before its implementation.

Beyond this general provision, the Board may only act pursuant to, and consistent with the requirements of, one of the specific statutory grants of authority in G.L. c. 111. *See, e.g,* G.L. c. 111, § 31C ("A board of health, or other legal authority constituted for such purpose by vote of the town or city council shall have jurisdiction to regulate and control atmospheric pollution"; authorizing boards, "subject to the approval of the department of environmental protection, … [to] make "reasonable rules and regulations for the control of atmospheric pollution."); G.L. c. 111, §§ 31D-31E (setting forth authority of local boards of health regarding septic tanks and sewage disposal systems); G.L. c. 111, § 127 (the "board of health of a city or town may make and enforce regulations for the public health and safety relative to house drainage"); G.L. c. 111, §§ 127A-127B (setting forth authority of board of health to enforce state sanitary code); G.L. c.

[4] Counsel for ASGCC sent a letter dated October 19, 2015 to the Barnstable Director of Public Health, Thomas McKean, and requested that he identify the "constitutional, statutory, or regulatory authority for issuance of the Order." *See* Ex. E (p. 2, under "second"). In his response, Mr. McKean ignored that request. ***See*** Ex. F.

111, § 198 ("[a]ll local boards of health ... shall enforce [the provisions of the lead poisoning prevention and control statutes] … in the same manner and with the same authority as they may enforce the sanitary code."). *See also Glass v. Town of Marblehead Bd. Of Health*, 2009 Mass. Super. LEXIS 55, 5, 25 Mass. L. Rep. 288 (2009) ("Mass DEP regulation 310 CMR 7.52 specifically empowers boards of health such as Marblehead's to enforce its provisions. Accordingly, the Board was acting pursuant to lawful authority in responding to the complaint").

The legislature has not granted local boards of health or municipalities any enforcement authority with respect to the two statutes cited in the Order, G.L. c.111, § 215 and G.L. c. 94C, § 27. Nor has the Town regulated in any area relevant to this case. Even if it had, the Order would be unlawful because the activities enjoined by the Order would be in conflict with state law. Because the Board had no authority or power to issue the Order, this Court should declare that it was not issued pursuant to lawful authority, is void and of no effect, and enjoin its enforcement.

2. There is No Prohibition, Restriction, or Limitation Anywhere in Massachusetts Law Regarding the Possession, Distribution, or Exchange of Hypodermic Needles by a Private Individual or Entity, Such as ASGCC, Because the Legislature Repealed All Such Restrictions in 2006.

It barely needs mention that an activity not prohibited or restricted by law is entirely lawful. The two statutes cited in the Order, by their plain and unambiguous language, do not prohibit, restrict, or limit the possession, distribution, or exchange of hypodermic needles or syringes by ASGCC. No other statute does so either. First, G.L. c. 111, § 215, provides:

> The department of public health is hereby authorized to promulgate rules and regulations for the implementation of not more than ten pilot programs for the exchange of needles in cities and towns within the commonwealth upon nomination by the department. Local approval shall be obtained prior to implementation of each pilot program in any city or town.

> Not later than one year after the implementation of each pilot program said department shall report the results of said program and any recommendations by filing the same with the joint legislative committees on health care and public safety.[5]

Section 215 on its face does nothing more than authorize the Department of Public Health to set up its own programs. Nothing in the statutory language relates to any other entity.

Second, M.G.L. c. 94C, § 27 provides:

> Hypodermic syringes or hypodermic needles for the administration of controlled substances by injection may be sold in the commonwealth, but only to persons who have attained the age of 18 years and only by a pharmacist or wholesale druggist licensed under the provisions of chapter 112, a manufacturer of or dealer in surgical supplies or a manufacturer of or dealer in embalming supplies. When selling hypodermic syringes or hypodermic needles without a prescription, a pharmacist or wholesale druggist must require proof of identification that validates the individual's age.

Section 27 was enacted to permit the "*sale*" of hypodermic needles without a prescription. It is undisputed that ASGCC does not sell needles or syringes. *See* Sandusky Aff. ¶ 15. This statute does not apply to ASGCC.

The language of §§ 215 and 27 is plain and unambiguous. *See City of Worcester v. College Hill Props., LLC*, 465 Mass. 134, 138 (2013) ("Where the language of a statute is clear and unambiguous, it is conclusive as to legislative intent") (internal quotations omitted); *Cooney v. Compass Group Foodservice*, 69 Mass. App. Ct. 632, 636 (2007) ("primary source of insight into the intent of the Legislature is the language of the statute"). It is not the role of the Court to expand the scope of these statutes by adding restrictions that do not exist. *See Commonwealth v. McLeod*, 437 Mass. 286, 294 (a court must "not add words to a statute that the Legislature did not put there, either by inadvertent omission or by design"); *Commonwealth v. Belliveau*, 76

[5] This statute was originally passed in 1993 and at that time authorized "a pilot program." *See* St. 1993, c. 110, § 148. It was amended in 1995 to add the language "not more than ten pilot programs." *See* St. 1995, c. 38, § 128.

Mass. App. Ct. 830, 842 (2010) ("standards of interpretation forbid courts to add language to the terms chosen by the Legislature.").

The absence in Massachusetts law of any prohibition on the possession, distribution, or exchange of needles or syringes by a private individual or entity is not a result of inadvertent omission or ambiguity. Rather, it is due to the deliberate decision of the legislature in 2006 to repeal all such restrictions in Massachusetts law in the face of the spread of HIV and HCV by injection drug users who shared dirty needles because they did not have access to clean ones. *See* the 2006 Act, Ex. B.

Prior to the passage of the 2006 Act, G.L. c. 94C, § 27, contained ¶¶ (a)-(f) that regulated the possession and exchange of hypodermic needles and syringes. *See* Ex. B. The 2006 Act repealed all of the paragraphs of the then-existing G.L. c. 94C, § 27 and replaced it with the current single paragraph, *supra*, that solely prohibits the sale of syringes by anyone other than a pharmacist. *See* Ex. B, St. 2006, C. 172, § 3 ("Said chapter 94C is hereby further amended by striking out § 27, as so appearing, and inserting in place thereof the following two sections").

An examination of the statutory language repealed by the legislature unmistakably reveals its intent to remove *all* restrictions on the possession, distribution, and exchange of hypodermic needles and syringes by *any* person. It was a wholesale deregulation.

(1) The 2006 Act repealed then-existing G.L. c. 94C, § 27(a) which provided that "[n]o person not being [specifically designated health care providers, embalmers, surgical suppliers, and others] *shall have in his possession a hypodermic syringe, hypodermic needle, or any instrument adapted for the administration of controlled substances by injection.*" *See* Ex. C, ¶ (a) (emphasis supplied).

(2) The 2006 Act repealed then-existing G.L. c. 94C, § 27(b) which provided that "[n]o such syringe, needle, or instrument shall be delivered, or sold to, or *exchanged with, any person except* [specifically designated health care providers and entities]." *See* Ex. C, ¶ (b) (emphasis supplied).

(3) The 2006 Act repealed then-existing G.L. c. 94C, § 27(e) which provided that "[n]o person, except [specifically designated health care providers, and manufacturers or dealers in surgical or embalming supplies] shall sell, offer for sale, *deliver,* or have in possession with intent to sell hypodermic syringes, hypodermic needles, or any instrument adapted for the administration of controlled substances by injection". *See* Ex. C, ¶ (e) (emphasis supplied).[6]

In addition, the 2006 Act removed hypodermic syringes and needles from the definition of "drug paraphernalia" in G.L. c. 94C, § 1. *See* 2006 Act, § 2; c. 94C, § 1, Clause 11, as existing before the 2006 Act, attached as Exhibit G.

Prior to the passage of the 2006 Act, G.L. c. 111, § 215 was the only lawful means to obtain hypodermic needles without a prescription and the distribution or exchange of syringes by non-medical personnel was otherwise prohibited. That was because G.L. c. 94 defined needles as drug paraphernalia, and expressly prohibited their possession or exchange. With the removal of all such provisions, however, there is no basis for any assertion by the defendants that G.L. c. 111, § 215 is the exclusive vehicle for the distribution and exchange of hypodermic needles and syringes under Massachusetts law. While the Department of Public Health continues to have the authority to nominate cities and towns for one of its own pilot programs under G.L. c. 111,

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[6] The previously existing G.L. c. 94C, § 27 ¶¶ (c) and (d) provided that a physician may prescribe hypodermic needles or syringes to a patient under his immediate charge. *See* Ex. C, ¶¶ (c) and (d).

§ 215, Massachusetts law does not otherwise restrict the possession of needles by any other person or entity.

Three aspects of the 2006 repeal remove any doubt that the legislature intended to deregulate possession and exchange of hypodermic needles without limitation. First, when the legislature originally passed G.L. c. 111, § 215, it added a provision to the then-existing G.L. c. 94C, § 27 that:

> 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 [G.L. c. 111, § 215] and any such distribution or exchange of said needles or syringes shall not be a crime.

See Ex. C, ¶ (f). The legislature thus viewed c. 94C, § 27 as being an absolute bar to the possession or exchange of syringes under all circumstances except as it specifically permitted. The 2006 Act, however, repealed this provision. *See* G.L. c. 94C, § 27. It is thus evident that the legislature saw no need to specifically permit possession and exchange via DPH-nominated exchange programs once all such prohibitions were repealed by the 2006 Act. The same is true for any other person or entity who previously could not possess, distribute, or exchange syringes under the prior § 27.

Second, the removal of the explicit wording "exchange" of syringes or needles in the prior language of c. 94C, § 27 makes crystal clear that private entities can now do what only the Department of Public Health was previously authorized to do. *See* Ex. C, ¶ (b). G.L. c. 111, § 215 also uses the word "exchange" in providing for the "exchange of needles in cities and town ... upon nomination by the department." By using the same language in these two related statutes, it is evident that the legislature, by repealing a ban on "exchange" in § 27, intended to

permit private individuals and entities to undertake the very same activity that it permits the Department of Public Health to undertake through its pilot programs under G.L. c. 111, § 215.

Third, the breadth of the legislature's intent to remove all restrictions and limitations on the possession, distribution, and exchange of hypodermic needles is manifest in its consideration, and rejection, of a limit to the number of syringes that a person or entity can purchase at one time. *See, e.g,* Senate Bill No. 1312 (2005-2006 Session), An Act Relative to HIV and Hepatitis C Prevention, § 3, attached as Exhibit H (repealing prior § 27 and authorizing sale of hypodermic needles without prescription, but providing that "[n]o more than 10 such syringes, needles or instruments may be purchased by one person at a time"). Other states enacted such restrictions, but Massachusetts chose not to. *See, e.g.,* N.H. Rev. Stat. § 318:52-c(I) (c) ("A purchaser shall not be sold more than 10 syringes or needles at any single purchase unless such purchaser has a prescription for a bulk purpose"); 720 Ill. Comp. Stat. 635/2(b) ("A pharmacist may sell up to 20 sterile hypodermic syringes or needles to a person who is at least 18 years of age.").

There is no restriction in Massachusetts law on any person or entity purchasing an unlimited number of syringes and distributing them to others. If the legislature had intended to retain any restriction on such activities, it would have indicated so and adopted a more limited, nuanced repeal of c. 94C, § 27. Instead, it enacted a complete deregulation of possession and distribution in order to combat the devastating impact of the HIV and HCV epidemics. In light of the lack of any prohibition in Massachusetts law on the distribution or exchange of needles and syringes, and the legislature's deliberate repeal of such restrictions, it simply does not matter that the legislature left intact the requirement that the Department of Public Health obtain local approval for the implementation of its own pilot programs. It is not for this Court to second-guess the legislature's reasoning or choices.

3. Irreparable Harm Will Result Without the Issuance of the Injunction and the Balancing of the Equities Weighs Heavily in Favor of Immediate Relief.

The affidavits of Max Sandusky and Camilla Graham, M.D., referenced in the Statement of Facts, establish the life or death consequences of the Order. The Order undermines essential efforts to combat in Barnstable County the epidemics of HIV/HCV transmission and opiate overdose, some of the Commonwealth's most severe public health crises. It is hard to imagine any asserted risk of harm to the defendants that could be greater than the increased risk of drug overdoses and transmission of HIV and HCV that will ruin lives and cost the Commonwealth millions of dollars in unnecessary health care costs. Defendants are expected to raise the presence of discarded needles and syringes in public places. The legislature addressed this very issue in the 2006 Act. *See* Ex. B, §3 (adding § 27A to G.L. c. 94C, which was not codified). The legislature was aware that the deregulation of possession and exchange of syringes would necessitate greater efforts by state and local governments towards the "safe, secure and accessible collection and disposal of hypodermic needles," and it added a provision requiring that they implement disposal programs. *See* Ex. B, 2006 Act, § 3. Although ASGCC has no legal obligation to do so, it provides clients with free biohazard containers, accepts the return of syringes, and properly disposes of them. In contrast, an individual who purchases syringes at a local pharmacy does not receive a free biohazard container. And pharmacies do not accept returns of syringes. Yet, the defendants are not taking action against them. The response to any concerns about improperly discarded syringes is the greater availability of biohazard kiosks, as the legislature contemplated, not the unlawful termination of ASGCC's lifesaving programs that ensure drug user health and enhance community safety.

CONCLUSION

For the foregoing reasons, plaintiff AIDS Support Group of Cape Cod respectfully requests that the Court: (1) issue a temporary restraining order enjoining the defendants, and their employees and agents, from enforcing the cease and desist orders dated September 22, 2015 and September 23, 2015, or otherwise prohibiting or restricting the possession, distribution or exchange of hypodermic needles and syringes by plaintiff AIDS Support Group of Cape Cod; and (2) issue a preliminary injunction enjoining the defendants, and their employees and agents, from enforcing the cease and desist orders dated September 22, 2015 and September 23, 2015, or otherwise prohibiting or restricting the possession, distribution or exchange of hypodermic needles and syringes by AIDS Support Group of Cape Cod.

Respectfully submitted,

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