IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

MILAN PUSKAR HEALTH RIGHT, LAWSON KOEPPEL, ALINA LEMIRE, and CARRIE WARE,

Plaintiffs,

v.

BILL J. CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources, JOLYNN MARRA, in her official capacity as Interim Inspector General and Director of the Office of Health Facility Licensure and Certification, and STEVE HARRISON, in his official capacity as Clerk of the House of Delegates and Keeper of the Rolls,

Defendants.

Civil Action No: 3:21-cv-00370

Hon. Robert C. Chambers

BRIEF OF AMICI CURIAE OF THE NETWORK FOR PUBLIC HEALTH LAW, MOUNTAIN STATE JUSTICE, MARCH OF DIMES, CABIN CREEK HEALTH SYSTEMS, AND WEST VIRGINIA HEALTH AND PUBLIC HEALTH EXPERTS IN SUPPORT OF PLAINTIFFS' MOTION FOR INJUNCTIVE RELIEF

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I. Interest of Amici Curiae

The **Network for Public Health Law** (Network) provides visionary leadership in the use of law to protect, promote, and improve health and health equity. The Network provides non-partisan legal technical assistance and resources, collaborating with a broad set of partners to expand and enhance the use of practical legal and policy solutions. The Network is committed to using public health law and policy to improve the conditions, as well as strengthen the services and systems, that make our communities safer, healthier, stronger and more equitable. The views expressed in this brief are solely those of Network staff and may not represent those of any affiliated individuals or institutions, including funders and constituents.[1]

Mountain State Justice is a non-profit legal services firm dedicated to redressing entrenched and emerging systemic social, political, and economic imbalances of power for underserved West Virginians through legal advocacy and community empowerment. Through class actions, individual cases, and policy advocacy, Mountain State Justice has assisted thousands of individuals fighting to protect their families, their homes, their health and safety, and their livelihoods.

March of Dimes is the nonprofit organization leading the fight for the health of all moms and babies. March of Dimes began that fight more than 80 years ago as an organization dedicated to eradicating polio in the U.S., a goal that they achieved. March of Dimes continues that fight today, working to address some of the biggest threats to moms and babies, such as premature birth and maternal mortality, through research, education, programs and advocacy.

Cabin Creek Health Systems is a Federal Qualified Health Center in Kanawha County, West Virginia, focused on promoting the health and well-being of all people, especially the most

[1] No party, party's counsel, individual or organization other than *amici* authored any part of this brief or contributed funds for its preparation or submission.

vulnerable, through health care that is guided by science, compassion and respect and to contribute to the education of skilled and caring health professionals. In addition to primary care and dental care services, CCHS provides behavioral health counseling and medication assisted treatment for individuals with opioid use disorder.

Judith Feinberg, MD, is the Dr. E.B. Flink Vice Chair of Medicine for Research, Professor of Behavioral Medicine & Psychiatry, and Professor of Medicine/Infectious Diseases at the West Virginia University School of Medicine. She is a national expert on the connection between injection drug use and its medical and infectious disease complications and serves as an expert in this area for the ongoing opioid abatement trial in federal court in the southern district of West Virginia. She is also a principal investigator in a study of the fentanyl test strip use on drug user behaviors, the vertical transmission of hepatitis C from mother to newborns, integrating treatment for opioid use disorder with care for drug use-associated infections, and the Appalachian Node of National Institute on Drug Abuse Clinical Trials Network.

Robert H. Hansen, **MS,** served as Director of the West Virginia Office of Drug Control Policy from 2018 to 2020. His career in behavioral health spans 45 years, including 22 years as the Chief Executive Officer of Prestera Center, the state's largest non-profit comprehensive behavioral health center.

Daniel J. Lauffer, PA-C, FACHE is the Chief Executive Officer of Thomas Health, a 383-bed hospital system with 1,812 employees and an estimated 450 physicians. He has been a certified Physician Assistant since 1982 and has held numerous health care management positions in his career, all in the state of West Virginia. He currently serves on the HIV Task Force Committee of the Kanawha Charleston Health Department.

Craig Robinson, MPH, is the Executive Director of Cabin Creek Health Systems, which provides medical services in West Virginia, including treatment for addiction. Mr. Robinson has been recognized as an expert in the field of opioid use disorder.

Catherine Slemp, MD, MPH served as Commissioner and State Health Officer for the West Virginia Bureau for Public Health from 2018 to 2020, and previously served as the Acting State Health Officer and Preparedness Director. Dr. Slemp was actively engaged in addressing Cabell County's HIV Outbreak, early identification of Kanawha's HIV outbreak, initial COVID-19 response, and multiple other infectious disease and substance use related issues. With others, she helped shape the WV 2020-2022 Substance Use Response Plan which includes the role of evidence-based harm reduction and syringe services programs.

Christine Teague, PharmD, MPH, AAHIVP is the Director for the Charleston Area Medical Center's Ryan White Part C HIV Program. The Program provides comprehensive medical and support services for more than 400 adults with HIV in Kanawha County as well as 18 other counties in the Southern part of West Virginia. Dr. Teague anticipates that nearly all the individuals involved in the current outbreak (now well over 70 cases since January 2019) will be managed by the program.

II. Argument

West Virginia is experiencing an unprecedented epidemic of drug-related harm, most notably opioid-related overdose and infections related to the use of non-sterile syringes. Syringe services programs ("SSPs") help reduce the spread of bloodborne infections, decrease syringe litter, connect people who inject drugs to treatment, and save lives.

Amid a surging number of West Virginians experiencing opioid-related overdose and contracting injection-related illness, Senate Bill 334 imposes new requirements for SSPs that

threaten the continued operation of existing programs and would make it extremely difficult if not impossible for new programs to begin operations. The closure of SSPs would have immediate and devastating effects on the health of West Virginians, including increases in opioid overdose, HIV and hepatitis infections, and preventable deaths.

A. There is a Pressing Need for Syringe Services Programs in West Virginia

Approximately eighteen SSPs currently operate in West Virginia. These SSPs received 35,770 visits, connected 1,277 participants to treatment services, performed 3,846 HIV tests and 2,885 hepatitis C tests, and dispensed around 100,000 syringes each month in 2019. Bureau for Pub. Health, W. Va. Dep't of Health & Human Res., *Harm Reduction Program Statewide Report January to December 2019*, https://bit.ly/3dqxWlT (last visited June 26, 2021). Among people who use drugs in Cabell County, nearly two-thirds reported obtaining syringes from an SSP in the previous six months. Sean T. Allen et al., *Factors Associated with Likelihood of Initiating Others into Injection Drug Use Among People Who Inject Drugs in West Virginia*, AIDS & Behavior (2021). According to the West Virginia Department of Health and Human Resources ("DHHR"), SSPs are "playing a key role across West Virginia in fighting the opioid crisis and ensuring state residents can access treatment while reducing the likelihood of a significant and costly infectious disease outbreak." Bureau for Pub. Health, W. Va. Dep't of Health & Human Res., *The Need for Harm Reduction Programs in West Virginia* (Nov. 6, 2017), https://bit.ly/2U3WHxv. They provide a myriad of evidence-based harm reduction services, including syringe distribution and disposal, naloxone and naloxone training, screenings for bloodborne infections, and linkage to medical care. Bureau for Pub. Health, W. Va. Dep't of Health & Human Res., *West Virginia Harm Reduction Programs At-A-Glance*, https://bit.ly/3w0zNnX (last visited June 26, 2021).

Still, the opioid epidemic has had devastating effects in West Virginia. In 2019, the state had the highest overdose death rate in the country. Ctrs. for Disease Control & Prevention, *Drug Overdose Mortality by State*, https://bit.ly/3x5C42H (last reviewed Feb. 12, 2021). Preliminary data from DHHR shows there were 1,275 confirmed fatal drug overdoses in 2020—up from 878 in 2019. W. Va. Dep't of Health & Human Res., *West Virginia Experiences Increase in Overdose Deaths; Health Officials Emphasize Resources* (Apr. 23, 2021), https://bit.ly/3jjASoi. New HIV infections linked to injection drug use increased over five-fold from 2014 to 2019. Catherine Slemp, *Health Advisory #162*, W. Va. Dep't of Health & Human Res. (Oct. 9, 2019), https://bit.ly/3heMLcz. Kanawha County is currently experiencing what a federal government official described as the "most concerning" outbreak of HIV in the country. Lauren Peace, *The CDC says Kanawha County's HIV outbreak is the most concerning in the United States*, Mountain State Spotlight (Feb. 11, 2021), https://bit.ly/3w4BAIw. In 2017, West Virginia also had the highest incidence rate of acute hepatitis C in the country, with injection drug use cited as the most common risk factor for infection. Loretta E. Haddy et al., *West Virginia Viral Hepatitis Epidemiologic Profile 2017*, W. Va. Dep't of Health & Human Res., 13-14 (Aug. 16, 2017), https://bit.ly/3qzxU0v. Hospitalizations for infective endocarditis have skyrocketed along with rates of injection drug use; the number of patients admitted to the largest tertiary care center in southern West Virginia for infective endocarditis and drug use increased by more than 250% from 2008 to 2015. Mark C. Bates et al., *Increasing incidence of IV-drug use associated endocarditis in southern West Virginia and potential economic impact*, 42 Clinical Cardiology 432 (2019).

In addition to the immeasurable human costs associated with this dramatic increase in opioid-related harm, the financial cost of these preventable infections is enormous. The lifetime

cost of treatment is around $450,000 for HIV and $64,490 for hepatitis C. Jill Kriesky, *The High Cost Of Losing Harm Reduction in Kanawha County*, W. Va. Ctr. on Budget & Policy (Nov. 18, 2020), https://bit.ly/3dre16x. In Kanawha County alone, the estimated lifetime cost to treat the new cases of HIV and hepatitis C diagnosed in 2019 is $47,251,150. *Id*. From 2008 to 2015, the total hospital charges to treat infective endocarditis associated with illicit drug use at a tertiary care center in southern West Virginia were $17,306,464, 78% of which was never paid, resulting in a hospital deficit of over $13,476,763. *See* Bates, *supra*. Similarly, an analysis of endocarditis operations performed at West Virginia University confirmed that "providing care for patients with IVDA [IV drug–associated] endocarditis represents a major unsustainable financial burden to the healthcare system." Chris C. Cook et al., *The opioid epidemic and intravenous drug–associated endocarditis*, 159 J. of Thoracic and Cardiovascular Surgery 1273, 1275 (2019). The West Virginia Medicaid program paid approximately $4.4 million for hepatitis A-related costs for people with substance use disorder from January 2018 through July 2019 alone. Samantha J. Batdorf et al., *Estimated Medicaid Costs Associated with Hepatitis A During an Outbreak — West Virginia, 2018–2019*, 70 Morbidity & Mortality Wkly Rep. 269, 271 (2021). Most of these injection-related harms can be avoided by providing easy access to sterile injection supplies and other harm reduction tools and services.

The consequences of eliminating access to sterile syringes and other harm reduction interventions are already evident. The recent spike in West Virginia's HIV rate has been attributed in part to the suspension of the Kanawha-Charleston Health Department's SSP in March 2018. John Raby, *CDC: West Virginia HIV wave could be 'tip of the iceberg'*, Associated Press (Mar. 17, 2021), https://bit.ly/3y02HGj. The county went from 17 new cases with five from intravenous drug use in 2018, to 29 new cases with 15 from intravenous drug use in 2019,

to 45 new cases with 37 from intravenous drug use in 2020. Anna Saunders, *CDC agents working in Kanawha to help task force address 'most concerning' HIV outbreak*, WCHS (May 10, 2021), https://bit.ly/3h0T6Jy. Interviews conducted with residents of Kanawha County who had injected illicit drugs in the previous 30 days revealed that the scarcity of sterile injection equipment had led to high-risk injection drug use practices, including injecting with used syringes. Sean T. Allen et al., *Understanding the public health consequences of suspending a rural syringe services program: a qualitative study of the experiences of people who inject drugs*, 16 Harm Reduction J. (2019). Similarly, an outbreak of HIV in Cabell County was associated with the implementation of stricter requirements to access the county's SSP, Amy Atkins et al., *Outbreak of Human Immunodeficiency Virus Infection Among Persons Who Inject Drugs — Cabell County, West Virginia*, *2018–2019*, 69 Morbidity & Mortality Wkly Rep. 499, 499 (2020), which resulted in the number of new participants dropping by 80% and a 50% reduction in the number of returning clients. Bridget M. Kuehn, *Restrictive Policies Threaten Efforts to Stop 2 West Virginia HIV Outbreaks*, 325 J. of the Am. Med. Ass'n 2238 (2021). These tragic consequences will only increase with the closure of more SSPs.

B. Syringe Services Programs Protect Against Bloodborne Disease Infection, Connect Participants with Substance Use Disorder Treatment, Decrease Syringe Litter, Prevent Overdose, Reduce Costs and Do Not Increase Crime

The benefits of SSPs have been apparent for decades. In 1995, an expert panel of the National Research Council and the Institute of Medicine found that "needle exchange programs can be effective in preventing the spread of HIV and do not increase the use of illegal drugs." *Preventing HIV Transmission: The role of sterile needles and bleach* 6 (Nat'l Rsch. Council and Inst. of Med. et al. eds., 1995). In 1998, then-Secretary of Health and Human Services Donna Shalala declared 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 illegal drugs." U.S. Dep't of Health & Human Servs., *Research Shows Needle Exchange Programs Reduce HIV Infections without Increasing Drug Use* (Apr 20, 1998), https://bit.ly/3gZxhu2. The Centers for Disease Control and Prevention summarizes the evidence for SSPs as follows:

> Nearly 30 years of research has shown that comprehensive SSPs are safe, effective, and cost-saving, do not increase illegal drug use or crime, and play an important role in reducing the transmission of viral hepatitis, HIV and other infections.

Ctrs. for Disease Control & Prevention, *Summary of Information on The Safety and Effectiveness of Syringe Services Programs (SSPs)*, https://bit.ly/3qvY0kW (last reviewed May 23, 2019).

1. SSPs Protect Against Bloodborne Disease Infection

Because sharing needles and other injection equipment is an extremely efficient mode for HIV and hepatitis C transmission, SSPs play a critical role in lowering disease incidence. For example, following the establishment of an SSP during an HIV outbreak in 2015, Scott County, Indiana saw a "rapid reduction" in syringe sharing and other injection-related HIV risk behaviors. Monita R. Patel et al., *Reduction of Injection-Related Risk Behaviors After Emergency Implementation of a Syringe Services Program During an HIV Outbreak*, 77 J. of Acquired Immune Deficiency Syndromes 373 (2018). A 2014 meta-analysis found that SSPs were associated with reductions in HIV transmission among people who inject drugs. Esther J. Aspinal et al., *Are needle and syringe programmes associated with a reduction in HIV transmission among people who inject drugs: a systematic review and meta-analysis*, 43 Int'l J. of Epidemiology 235 (2014). Likewise, a 2014 review found that SSPs reduce injection risk behavior and likely reduce HIV transmission. Georgina J. MacArthur et al., *Interventions to*

prevent HIV and Hepatitis C in people who inject drugs, 25 Int'l J. of Drug Pol'y 34 (2014). A more recent analysis of three studies involving 3,241 participants found that the combination of SSPs and medication-assisted treatment was associated with a 74% reduction in the risk of hepatitis C acquisition. Lucy Platt et al., *Needle syringe programmes and opioid substitution therapy for preventing hepatitis C transmission in people who inject drugs – An overview of systematic reviews*, 9 Cochrane Database of Systematic Revs. 9 (2017). In 2017, an overview of systematic reviews found that "the overall results of the included systematic reviews are supportive of the effectiveness of [SSPs] in reducing HIV transmission and [injecting risk behaviors] among [people who inject drugs], as well as in reducing HCV infection…" Ricardo M. Fernandes et al., *Effectiveness of needle and syringe Programmes in people who inject drugs – An overview of systematic reviews*, 17 BMC Pub. Health 309 (2017).

2. SSPs Connect Participants with Substance Use Disorder Treatment

In addition to minimizing the negative effects of ongoing risky drug use, SSPs also significantly increase the likelihood that participants' drug use will be reduced or stopped altogether. Likely because participants develop trusted relationships with SSP employees and volunteers, SSPs are often extremely effective at connecting them with drug treatment. One study found that people who frequented SSPs were five times more likely to start drug treatment than those who did not, and that former SSP participants were more likely to remain in treatment and report substantially reducing or ceasing drug injection. H. Hagan et al., *Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors*, 19 J. of Substance Abuse Treatment 247 (2000). Another described SSPs as an "important bridge" to substance use treatment after finding that use of such programs was independently associated with entering detoxification. Steffanie A. Strathdee et

al., *Needle-Exchange Attendance and Health Care Utilization Promote Entry into Detoxification*, 76 J. Urb. Health 448, 448 (1999). Similarly, an analysis of an SSP in New Haven, Connecticut concluded:

> [The program] has also acted as a conduit to bring injectors and noninjectors alike into substance abuse treatment programs. Past criticism of SEPs included the contention that they encourage or condone illicit drug use. This report shows that SEPs can accomplish the opposite, decreasing the community-wide use of addictive and illicit drugs. *However, it must also be concluded that such gains are easily lost through the imposition of impediments to the implementation of a complete harm reduction program*.

Robert Heimer, *Can Syringe Exchange Serve as a Conduit to Substance Use Treatment?*, J. Substance Abuse Treatment 183, 190 (1998) (emphasis added).

3. SSPs Decrease Syringe Litter in Communities

SSPs protect communities from syringe litter and the threat of needlestick injury. A study completed in 2008 and 2009 compared syringe litter in a city with SSPs (San Francisco) and a city without such programs (Miami) and found eight times as many improperly disposed syringes in the city without. Hansel E. Tookes et al., *A Comparison of Syringe Disposal Practices Among Injection Drug Users in A City with Versus A City without Needle and Syringe Programs*, 123 Drug & Alcohol Dependence 255, 258 (2011). Among people using injection drugs in San Francisco, obtaining syringes from an SSP was "protective against improper disposal[.]" Lynn D. Wenger et al., S*yringe Disposal Among Injection Drug Users in San Francisco*, 101 Am. J. Pub. Health 484, 484 (2011). Similar results were obtained in Los Angeles, where researchers found that "[h]aving received sterile syringes from [an SSP] was independently associated with lower odds of improper syringe disposal." Brendan Quinn et al., *Syringe Disposal Among People Who Inject Drugs in Los Angeles: The Role of Sterile Syringe Source*, 25 Int. J. Drug Policy 905, 905 (2014). Moreover, following the implementation of Florida's first SSP in 2016, researchers reported a "significant decrease in the number of

improperly discarded syringes in public...” Harry Levine et al., *Syringe Disposal Among People Who Inject Drugs before and after the Implementation of a Syringe Service Program*, 202 Drug & Alcohol Dependence 13, 13 (2019). The reduction of syringe litter is an important public safety measure, particularly for law enforcement officers and other individuals who might otherwise be at risk of needle-stick injury. *See generally* John Lorentz et al., *Occupational Needlestick Injuries in a Metropolitan Police Force*, 18 Am. J. Preventative Med. 146 (2000).

4. SSPs Prevent Overdose Deaths

Nearly all SSPs distribute the overdose reversal drug naloxone, which is extremely effective at preventing deaths from opioid overdose. In 2019, SSPs distributed over 700,000 doses of this life-saving medication. Barrot H. Lambdin, *Overdose Education and Naloxone Distribution within Syringe Service Programs — United States, 2019*, 69 Morbidity & Mortality Wkly Rep. 1117, 1118 (2020). A study of naloxone distribution to participants in an SSP in New York found that 82% reported feeling comfortable to very comfortable using naloxone if indicated and that naloxone had been administered 82 times with at least 68 of those overdose victims surviving. Tinka Markham Piper et al., *Evaluation of a Naloxone Distribution and Administration Program in New York City*, 43 Substance Use & Misuse 858, 862 (2008). Another study revealed that of 399 overdose events, 83% were successfully reversed using naloxone by study participants who had received training and naloxone to administer at sites throughout San Francisco. Lauren Enteen et al., *Overdose Prevention & Naloxone Prescription for Opioid Users in San Francisco*, 87 J. Urb. Health 931, 936 (2010). A study of people who inject drugs in Cabell County, West Virginia found that having recently accessed an SSP was associated with accessing naloxone. Sean T. Allen et al., *Take-home Naloxone Possession*

Among People Who Inject Drugs in Rural West Virginia, Drug & Alcohol Dependence, Nov. 2019, at. 5.

5. SSPs Are Cost Effective and Do Not Increase Criminal Activity

SSPs are extremely cost-effective, with one study showing that for every dollar invested in SSPs, at least 6 dollars are saved in averted costs associated with HIV. Trang Quynh Nguyen, *Syringe Exchange in the United States: A National Level Economic Evaluation of Hypothetical Increases in Investment,* 18 AIDS & Behav. 2144, 2150 (2014). Another study assessing hepatitis C prevention found that SSPs had an incremental cost savings of $363,821 for each case avoided per 100 people using opioid drugs—the highest out of the intervention strategies analyzed. Stephen C Ijioma et al., *Cost-Effectiveness of Syringe Service Programs, Medications for Opioid Use Disorder, and Combination Programs in Hepatitis C Harm Reduction among Opioid Injection Drug Users: A Public Payer Perspective Using a Decision Tree*, 27 J. Managed Care & Specialty Pharmacy 137, 141 (2021). Further, SSPs are not associated with increased criminality or increased drug use. For example, researchers found "[n]o significant differences in arrest trends" following the introduction of a needle exchange program in Baltimore. Melissa A. Marx et al., *Trends in Crime and the Introduction of a Needle Exchange Program*, J. Pub. Health 1933, 1933 (2000). Similarly, a study in New York found no consistent association between living near an SSP and incidence of robbery or violence. Galea Sandro et al., *Needle Exchange Programs and Experience of Violence in an Inner City Neighborhood*, 28 J. of Acquired Immune Deficiency Syndromes 282, 286–87 (2001).

C. Senate Bill 334's Requirements Will Force SSPs to Close

The requirements of SB334 are so onerous that many currently operating SSPs may be forced to close, and it will be very difficult for new ones to open. After SB334 was enacted,

Plaintiff Carrie Ware stopped providing syringes to low income and marginalized people in Huntington, citing "fear of substantial financial penalties or the threat of an injunction." *See* Declaration of Carrie Ware, submitted with Complaint. Similarly, Plaintiffs Lawson Koeppel and Alina Lemire ceased syringe distribution due to SB334, which they worry will make the current outbreak of HIV and hepatitis C in West Virginia "far worse than it already is." *See* Joint Declaration of Lawson Koeppel and Alina Lemire, submitted with Complaint. The co-founder of Solutions Oriented Addiction Response (SOAR), an SSP operating in Charleston, where HIV rates are spiking, has also stated that the legislation could shut down the SSP there. Associated Press, *CDC Inquiry Sought on HIV Outbreak in WVa's Largest County*, US News (Apr. 5, 2021), https://bit.ly/3qxrHlG. Another SSP, in Marion County, has also announced that it will cease operations because of the new law. JoAnn Snoderly, *Marion County Harm Reduction Program to Close, Taylor County's under Review after Passage of W.Va. Syringe Exchange Bill* (Apr. 18, 2021), https://bit.ly/3dqcjlF. When reporters reached out to sixteen SSPs in the state, out of nine that responded only a single one was confident that it would be able to continue operating if SB334 goes into effect. Lauren Peace, *WV Health Experts Worry New Law Will Ignite 'Powder Kegs' Amid HIV Outbreak*, Mountain State Spotlight (June 9, 2021), https://bit.ly/3doaBBr. These closures will be disastrous for the people of West Virginia. Several requirements in particular will be difficult to impossible for many programs to meet and are inimical to the health goals of SSPs.

1. Many SSPs Can Not Provide a Qualified Licensed Health Care Provider at Every Visit

SB334 requires that each syringe services program "offer services, at every visit, from a qualified licensed health care provider." S.B. 344, 85th Leg., Reg. Sess. § 16-6-3(b)(1) (W. Va. 2021). This requirement will be difficult if not impossible for many SSPs to meet, as it would

require either a paid employee or volunteer medical professional to be always onsite at each SSP location. Mobile SSPs, which can provide services to people without transportations in rural areas, would be particularly impacted, as a provider would need to be detailed specifically to the SSP vehicle. Even SSPs that operate out of health care facilities or health departments would likely have to curtail their activities to operate only during normal business hours. Lack of ability to meet this requirement is exacerbated by SB334's prohibition on Medicaid reimbursement for "syringe exchange services." *Id.* at § 16-63-10(c).

2. Local Authorization Will Be Impossible in Some Jurisdictions

SB334 requires that each SSP submit a written statement of support from "a majority of the members of the county commission and a majority of the members of a governing body of a municipality in which it is located or is proposing to locate." *Id.* at § 16-63-2(b)(9). This requirement makes what should be a public health decision a political one, and likely drastically reduces the probability that SSPs will operate in a jurisdiction. The requirement that each SSP obtain a written statement of support from two bodies of elected officials will sound the death knell for many programs, especially where elected officials may be generally supportive of harm reduction but unwilling to proactively go on the record in support of an SSP in their jurisdiction. The requirement may also make it nearly impossible for mobile SSPs to operate in multiple counties or municipalities, since doing so may require explicit authorization from the governing bodies in each.

3. Identification Requirement Will Make It Impossible for Some Participants to Access SSP Services

SB334 also requires that each participant provide "proof of West Virginia identification" as a condition of receiving syringes from the SSP. *Id.* at § 16-63-2(b)(7). This requirement ignores the fact that drug-related harm does not know boundaries. Some SSPs in border cities

have reported that they often service participants without permanent residence in the state or who commute over state lines. *See* Peace, *supra*. Many participants, such as lower-income individuals and those without homes, will likely be disenfranchised by this requirement. A 2018 study of people in Cabell County who reported having injected drugs in the past six months found that a majority reported being homeless. Allen et al., *Factors Associated with Likelihood of Initiating Others into Injection Drug Use Among People Who Inject Drugs in West Virginia, supra*, at 4. People without homes, as well as those who are Black and Latino, are much less likely to have state-issued identification, and researchers believe it is important to "ensure that institutions provisioned with promoting the public's health do not require government-issued IDs to access their services and resources." Alana M. W. LeBrón, *Restrictive ID Policies: Implications for Health Equity*, 20 J. Immigr. Minor Health 255, 258 (2018). Plaintiff Ware's outreach work in Huntington previously included providing sterile syringes to low income and marginalized people, most of whom "do not have IDs" and would therefore be unable to utilize any SSP under SB334. *See* Declaration of Carrie Ware, submitted with Complaint. As explained by Plaintiff Laura Jones, the executive director of a free health care clinic that provides sterile syringes in Morgantown, the identification requirement "create[s] barriers that will make it less likely for people to come to us for help." *See* Declaration of Laura Jones, submitted with Complaint.

Additionally, due to social stigma against people who use drugs, even participants who have identification may be wary of identifying themselves to receive sterile syringes, which could lead them to avoid SSPs altogether. Fear of being targeted by law enforcement simply for participating in an SSP may cause some individuals to forgo such programs and the many other services they provide in addition to syringe distribution. If participants are unwilling to access SSP services due to identification requirements, the community harm that would ensue would be

equivalent to not having an SSP in the community at all.

4. SSP Operations Will be Impacted by Unique Syringe Requirement

SB334 requires that each SSP "ensure a syringe is unique to the syringe services program." S.B. 344, 85th Leg., Reg. Sess. § 16-6-3(b)(3) (W. Va. 2021). We are aware of no way for this to be accomplished other than opening up individual packages of syringes and marking or otherwise labeling each one. Especially at SSPs that distribute many hundreds or thousands of syringes, this is an extremely burdensome and completely unnecessary requirement. Further, opening the packages in which syringes are provided may contaminate them, eliminating the benefits of a "sterile" syringe. Even if the syringes were able to be individually marked without contamination, the time and cost involved would likely be insurmountable for SSPs, which are often run on shoestring budgets.

III. CONCLUSION

Individuals and communities across West Virginia are in the midst of an historic epidemic of drug-related harm. Syringe services programs have been conclusively shown to reduce that harm. The requirements of SB334 make it virtually impossible for SSPs to operate in the state, and will almost certainly lead to immediate, irreparable, and preventable harm in the form of increased bloodborne disease infection, increased costs to the taxpayer, and overdose deaths.

For the foregoing reasons, amici—a collection of public health and medical experts—respectfully request that Plaintiffs' motion for a preliminary injunction be granted.

Respectfully submitted,

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