February 5, 2026

Chair Reynolds and members of the committee: my name is Sarah Lochner; I'm the Executive Director of the Oregon Coalition of Local Health Officials, representing local public health departments across the state.

I want to start by acknowledging the issue. Children should not have to witness people openly using drugs or streets littered with used needles on their walk to school. Witnessing people in this state is shocking, tragic, and very uncomfortable. I empathize with the concerned parents and with the children.

I also want to thank Leader Drazan for meeting with us to hear our concerns and sending us the LC draft in advance of bills being posted online. That said, the provisions in this bill are not our suggestions. We have a number of concerns.

As written, the provisions in SB 1573 create significant operational challenges for public health programs. Regarding the work you and your colleagues are trying to do this session – namely, cut costs in the healthcare system, this bill, as written, will do the opposite - it will increase costs.

On its face, the bill does two things:

1. Establishes a 2000-foot zone around any school or day care in which no mobile syringe programs may operate.
2. Allows anyone to bring a lawsuit against anyone for leaving behind medical waste within that 2000-foot zone.

The "unintended consequences" however are significant. First, I'll address the 2000-foot buffer zone.

First, 2000 feet is nowhere else in statute. 1000 feet is the current standard for citing both retail cannabis stores and methadone clinics.

Second, the large buffer zone and inclusion of career schools and licensed childcare facilities dramatically expand restricted areas in ways that are difficult to verify and comply with. Many childcare facilities are home-based, intermittently operating, or licensed but not actively serving children, and there is no real-time public system to confirm their status. Including these facilities introduces compliance uncertainty and legal risk for public health programs acting in good faith.

As written, this bill would limit public health emergency response (HIV or hepatitis C outbreaks at a homeless camp, for example). In the case of this type of outbreak, mobile syringe programs that offer more than syringe distribution could likely be called

in to do direct, on the ground, work to address a PH emergency with rapid testing and treatment. If this happens to be within the 2000 ft. of a school/childcare facility, the program would not be able to provide timely services to address the emergency without running afoul of these provisions.

The logical result of this 2000-foot buffer zone is that it will significantly reduce access to harm reduction services.

As a result, we will see increases in disease transmission: Extensive evidence shows that comprehensive SSPs or Syringe Service Programs, reduce HIV and Hepatitis C transmission without increasing drug use or crime. **This will increase costs to the healthcare system** as more people will show up in emergency rooms seeking treatment for advanced stage communicable diseases.

CDC summarizes that SSPs are associated with a 50% reduction in HIV and Hep C incidence among people who inject drugs and substantially increase linkage to treatment and prevention services. Global guidance from the WHO provides similar findings.

Further, SSPs that distribute naloxone and provide overdose education **reduce fatal overdoses.** The evidence base includes program findings summarized by CDC as well as long-standing evaluations showing significant decreases in overdose deaths in communities implementing naloxone distribution, which is typically part of harm reduction services that accompany syringe programs.

The way this bill is written, the **broad definition of a "syringe service program"** would likely apply also to services that only collect syringes, but don't distribute. It would include people on foot and tabling at health fairs. It would likely also include mobile diabetes care services.

Second, for the issue of lawsuits and liability: SB 1573 creates a punitive enforcement framework that enables unfair targeting of SSPs and people who use the services. It establishes liability risk for counties contracting with SSP providers. In addition, the presumption of liability invites misuse and does not reflect how syringe litter actually occurs.

As written, Section 1(3)(b) contradicts current state law and typical civil lawsuit precedent.

- The bill levies a **minimum penalty of $5,000 and attorney fees** for any syringes found in the prescribed radius, and presumes the cause of the syringe is **only** a result of a mobile SSP.

- There is no limitation on who can file the lawsuit, it can be someone from out of the county or even out of state.
- The burden of proof is reversed in this bill, **whereupon the SSP would need to prove their non-culpability**. In a typical civil lawsuit, it's the plaintiff - not the defendant - that has the burden of proof.

The presumption that syringes found within 2,000 feet came from a syringe services provider is problematic and incorrect. If anything, **syringe services programs help keep the community safer by removing used needles.**

Studies show that implementation of well-operated SSPs result in substantial reductions in improperly discarded syringes, improving public safety and reducing needlestick hazards. For example, in Miami, after establishment of a legal SSP, observed public syringe litter dropped by 49%.

Further, making syringe service programs a nuisance (with lawsuits and penalties) rather than a public health solution **reinforces stigma** which will make it harder to build community partnerships and trust for harm reduction services. **All of this conflicts with evidence-based public health practice.**

There has to be a better way that both protects school children and allows evidence-based public health practices to continue. As such, we are willing to talk about amendments that will both preserve public health services and make improvements to the experience of minors. Thank you.

Data Sources:

- Centers for Disease Control and Prevention (CDC):
  CDC. (2020). *Strengthening Syringe Services Programs (SSPs)*
  https://www.cdc.gov/hepatitis-syringe-services/php/about/index.html
- World Health Organization (WHO):
  WHO. (2012). *Guide to Starting and Managing Needle and Syringe Programmes*.
  https://www.who.int/publications/i/item/guide-to-starting-and-managing-needle-and-syringe-programmes
- BMJ: Walley et al. (2013), *Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis.* BMJ. 2013;346:f174.
  https://doi.org/10.1136/bmj.f174
- Levine H, Bartholomew TS. *Syringe disposal among people who inject drugs before and after the implementation of a syringe services program. Drug Alcohol Depend.* 2019 Sep 1;202:13-17. doi: 10.1016/j.drugalcdep.2019.04.025. Epub 2019 Jun 29. PMID: 31280002; PMCID: PMC6854527.