September 21, 2022 Testimony of Professor Todd Korthuis to the Oregon Senate Committee on Judiciary and Ballot Measure 100 Implementation

Chair Prozanski, Vice-Chair Thatcher, and Senators Dembrow, Gelser-Blouin, Heard, Linthicum, and Manning, thank you for the opportunity to speak with you today. My name is Todd Korthuis. I'm head of addiction medicine at Oregon Health & Science University where I work as an addiction medicine physician, professor, and researcher.

My goals today are to update you on recent trends in drug use and its treatment in Oregon and suggest ways to address current gaps in the treatment system.

Oregonians are experiencing an increase in drug use and its consequences. The 2020 National Survey on Drug Use and Health found that Oregon has the **highest** rate of past-year drug use in the United States (9.04% compared to U.S. average of 6.64%). In the same survey, Oregon ranked **last** in access to treatment: 18.08% of people who thought they needed treatment say they didn't receive it (compared to U.S. average of 13.89%).

The consequences of drug use continue to worsen, driven by an influx of illicit fentanyl into the state in the past 2 years. By "illicit" I mean fentanyl and related compounds that are made illegally to look like pharmaceutical pills, but are different from fentanyl that's used to relieve pain in medical care. Illegal fentanyl tablets are easier to get, cheaper, and 50-100 times more potent than heroin. Fentanyl and methamphetamine, which is often contaminated with fentanyl, are now the most common illegal drugs that people use in Oregon. This is leading to a health crisis that is worsening before our eyes. Here are just a few of the consequences:

- In the year ending April 2022, **1,114** Oregonians died of an overdose, an 18.5% increase over the previous year (compared to a 6.9% increase, nationally), or about double the number of Oregonians who died in motor vehicle accidents.
- Fentanyl has become a gateway to addiction for teenagers. This has resulted in a **tripling** of teen overdose deaths in Oregon since 2019 (10 to 31 vs. US doubled 865 to 1784 from 2019-2021; CDC Wonder Provisional data), **some of whom** are experimenting with counterfeit pills for the first time. Those who survive experimentation can quickly become addicted.
- Hospitalizations for serious bacterial infections related to injection drug use in the past 10 year increased over 6-fold, accounting for 6,265 hospitalizations and 8.46% of all patients, costing more than $150 million per year.

Despite the best efforts and good intentions of many, our addiction treatment system has been outpaced by these trends. In a soon to be released report by the Oregon Health Authority and the Oregon Alcohol and Drug Policy Commission, Dr. Liz Waddell and Katie Lenahan documented that over half (54%) of Oregon specialty addiction treatment programs said that their capacity does not meet the demand for treatment. The leading causes of treatment gaps were inadequate staffing and lack of funding. I'm especially concerned about the limited treatment options for Oregon adolescents. Currently, only 4 residential facilities accept teenagers under 18 and ***none*** offer life-saving medications like buprenorphine to treat fentanyl addiction, which is rapidly becoming the leading reason for needing treatment in this age group.

As intended, Measure 110 decreased drug-related arrests by 87%. But so far it has not improved treatment engagement. This is mainly due to delays in BHRN implementation and administrative challenges. The original plan to ticket people who use drugs and have them call a treatment hotline has not worked. Of the 3,169 tickets issued as of August 2022, the hotline

received 137 calls for treatment screening most of whom didn't want treatment. Only 1% of those issued a ticket for drug possession (36 people) requested information about treatment resources. In my discussions with addiction treatment leaders around the state, not one knows of any person who has entered treatment as a result of these tickets.

Addressing these historic increases in substance use and its consequences requires a coordinated response that leverages all of our community strengths.

First, we need to invest in prevention and awareness campaigns directed at middle school and high school students and their families. Small investments in awareness campaigns like the **Fake and Fatal** program in Beaverton School District can make a big difference quickly. Community-based organizations like *Song for Charlie*, which developed this program, can advocate with local school districts for practical ways to keep our kids safe. The OHA and Oregon Department of Education's **Fentanyl and Opioid Response Toolkit for Schools** has resources for local school districts and counselors that can keep our kids and their families safe from fentanyl overdose and decrease the pipeline of people entering adulthood with serious addictions. We could also incentivize pediatricians and primary care providers to integrate screening and prevention messages into well child visits and annual Sports Physicals for this age group.

Second, The *Save Lives Oregon Clearinghouse* provides free naloxone to community-based organizations serving people at risk of overdose. Direct distribution of naloxone kits to community members most in need resulted in more than 1,000 overdose reversals in the past year. We must continue to fund this bright spot in the Oregon Health Authority response.

Third, people who have lived experience with recovery, also called "peers," are highly effective at engaging people who use drugs in treatment. Our Oregon HOPE peer engagement outreach intervention in rural counties lead to about 20% of people engaging in treatment within

6 months of their first peer encounter. The Oregon Health Authority has scaled up this program, now called PRIME+, to other counties and documented decreased client drug use and ER visits at 30 days. One essential key to success is developing clear partnerships between peer outreach and addiction **treatment** services. Strengthening links between Measure 110 peer outreach and addiction treatment services is likely to be a powerful tool for increasing treatment engagement when implemented.

Fourth, we must take steps to decrease the drug supply. The illicit fentanyl and methamphetamine challenges require sophisticated approaches to slow the inflow of drugs into Oregon. We can't compete with a rapidly changing drug supply chain without law enforcement. Coexistence of supply reduction, demand reduction, and harm reduction efforts is possible and required to save lives.

Finally, we must create addiction prevention and treatment infrastructure that is efficiently administered and sustainable. Measure 110 and other funding sources such as the Opioid Settlement Fund can help close our current prevention and treatment gaps if they include professional systems for grant review and administration, content experts who understand the healthcare and addiction treatment systems, and adopt performance and outcomes measures to improve accountability. The most effective funding models will be ones that are sustainable rather than reliant on short-term grants.

I look forward to your questions.