Dear **Joint Interim Committee On Addiction and Community Safety Response ,**

I have been an SUD practitioner since 1974 in Los Angeles, working with minority youth. I have been practicing in Oregon since 1984 to the present day. I have been a workforce state, and Federal trainer and educator, as well as consultant to SUD practitioners and law enforcement.

In that time the US illegal drug using population has grown to 30 Million, with over 353K being incarcerated for substance related crimes. The vast majority of illegal drug users, are white, housed, employed, and their drug use, while known and detectable by law enforcement, remains untouched. The populations that are "low hanging fruit", are poor, white, and ethnic minority, often unhoused street users, and street dealers, who continue to supply a wealthy consumer market. driving substance use, that remains untouched by law enforcement efforts.

Being a treatment provider, I prefer to be effective where a medical approach is more potent. Get people into the treatment continuum, especially where harm and trauma have been increased through racialized criminalization. To be blunt White people get treatment and not jail, Black people got jail and no treatment, even when arrested at the same time for the same drug related offense. Multiply those trends over decades, then M110 with its services to "populations most affected by the war on drugs"...is an attempt to apply medical solutions to all.

Part of my current efforts with BHRN-Lane County, is doing outreach harm reduction and treatment access services to minority populations. These populations have long gone untreated for Mental Health, SUD, viral infections, and medical neglect and other health disparities. All compounding problems which the criminal justice system was never designed to resolve effectively, thus they go untreated.

As SUD is a chronic, progressive, relapsing disease, the most effective treatment is NOT within the criminal justice system, but outside of it, in the community, an approach utilized to great effect in Portugal.

I'm currently working with BHRN providers in OBBIAC (Oregon Black Brown Indigenous Advocacy Coalition) to train workforce practitioners of color, and increase the efficacy of the Oregon system.

I have been engaged in workforce training among communities of color which are doing effective M110 funded work, getting people into productive lives, employed, and engaged in reducing the problems which concern your committee.

Recriminalization to any degree further compounds the problem, because like cancer, the cosmetic skin cancer is removed, leaving the brain, heart, and muscular tumors untouched and growing.

I was part of a fact finding delegation to Portugal. Their comprehensive (More than 70 elements) fully funded efforts began seeing reductions after 5 years, by treating it as the patient centered medical problem that it is.

By contrast Oregon's M110 implemented a handful of reforms, essentially a year and a half ago. Surges in visible addiction problems, have occurred my entire 40 year career in Oregon. These surges are independent of legalization efforts. Decriminalization through M110 did not cause these surges either.

Though the problems are far larger than a cannabis sin tax can fund. The legislature should find other sources of funding from substance producers whose activities generate more problems than cannabis alone.

Thank you for your attention to this matter.
Sincerely,

Mark Harris MA, CADC I, MAC
HIV Alliance Consultat BHRN2 - Lane County
OBBIAC