UPLOAD

“Chairs Lieber and Kropf, members of the Committee, and colleagues. My name is Mark Harris. I’m an educator, therapist, SUD treatment provider, member of the. Press, and an activist-advocate. I work for HIV Alliance in Eugene, and I participate in Lane County BHRN 2. This year I celebrated 50 years in the field, 40 of them in Oregon. I went to Portugal the three main takeaways were these:

1. SUD Problems are a medical problem, and science based medical solutions are the most effective long term, though they take time to work.

2. Like any disease, there are stages, that must be dealt with using the appropriate infrastructure. The more infrastructure you have, the faster the problems are resolved. Oregon has always lacked the medical infrastructure, which M110 had begun to address 18 months ago.

3. Unlike Portugal’s socialized medicine environment, Oregon still has a segregated treatment environment, where de-facto decriminalization and immediate access to medicalized treatment was available to non-minority populations, and no treatment, or ineffective treatment was offered to ethnic minorities ”most affected by the war on drugs”.

To the last point, from the beginning of my career in Oregon, I have made the correct diagnostic referral, (Of voluntary and motivated patients of color) to adolescent, juvenile justice, or adult in-patient or long-term residential treatment; only to see them be discharged for appropriately revealing their racial trauma which was a driver for their SUD. This pattern of untreated SUD, remained untreated by the criminal justice system. M110 funded culturally specific services, which have been successful, because they are trauma informed, and focus on producing successful citizens, out of those difficult populations. They are difficult only because their medical problems have been criminalized, and treated with mainstream ineffective treatment.
MOTS data disaggregated for Lane County African-American’s showed that 29 out of 113 African-American SUD patients were treated successfully. 75% were not. What other disease would we tolerate a 75% failure rate, without investigation and quality improvement?

This is not something the criminal justice system is oriented, or capable of doing. I have long requested efficacy and outcome data from them and been refused, which is a statement in itself. This is why I oppose HB 4002, which despite some funding of MAT services, I see as a criminal justice money grab, and recriminalization. “Deflection” is not the Portuguese Dissuasion Commission. Deflection is an unnecessary detour and delay of effective treatment. There needs to be an infrastructure of low barrier treatment, sobering stations, shelters, entry level treatment and housing, for law enforcement to take people to. It has been estimated by OHA that, a necessary system would take $500 Million and 5 years to build and staff. Far more than a cannabis sin tax can fund. Diverting any monies to law enforcement, or counties will not directly address the problem, as they haven’t addressed the. Problem in 50 plus years of drug wars.
There are effective medical and evidence-based ways to address the problems that caused this house bill 4002 into existence.
In 40 years I have watched at least 6 (Depending on how you count) epidemic waves of opiate and methamphetamine abuse. Fentanyl, for nearly a decade. Chinese, Russian, Mexican, Israeli, Italian, International drug Cartels don’t care about drug laws, and they weren’t waiting for decriminalization in Oregon, to suddenly flood our cities. It still demands a medical response, particularly when our jails and prisons are also flooded with drugs. That is a topic for another day. Please stay the medical course.

Thank you for your attention. Mark Harris MA CADC I, MAC