I am an addiction medicine physician working at OHSU and OHSU-Hillsboro Medical Center, and I have been the director for 2 years of Oregon's Addiction Medicine ECHO Program – a program focused on addiction care workforce development. I am not sharing any official position of my employer OHSU by writing here as an independent citizen.

I gave testimony on 2/5/24 in support of Rep Marsh's HB 4120 to grant fund MOUD treatment programs in Oregon's jails. I helped develop this bill proposal with Rep Marsh because our jails currently have insufficient programming to treat addiction, despite high rates of adults in custody with substance use disorders, even post-M110. For example, Clackamas Jail reports that about one in four individuals booked to jail have opioid use disorder.

I have watched all the joint committee hearings over the course of the Fall and I am sympathetic to the challenge faced by you and our legislators this session. It is both challenging to understand the current state of affairs in Oregon, and to chart a course forward. I am writing because I am concerned that as you are attempting to promote individual health and recovery, and community well-being, you are at risk of directing Oregon down an unproductive and damaging path with HB 4036, SB 1555, and the re-criminalization provision of HB 4002.

I have 3 important points for you to consider.

1. **The decriminalization aspects of M110 continues to be falsely cited as the cause of increasing overdoses in Oregon.**

Although there has been a strong presence in media such as the New York Times bashing Oregon for our decriminalization, the research community in the past year has clearly stated and published exactly the opposite: that M110's decriminalization aspect is not responsible for Oregon's increasing overdoses and drug crisis.

The first three research teams presenting at the M110 Research Symposium, had each independently come to the same conclusion, through different methods, that it is the arrival of fentanyl to Oregon that is responsible for the worsening outcomes we are seeing. See Panel 1 presentations here: https://www.rti.org/event/oregons-ballot-measure-110-symposium. Oregon is not exceptional in our region with the rise in overdose deaths; the saturation of our West-Coast drug supply with Fentanyl, which was coincident to M110 passing, was a tipping point for us like every state in the U.S.

2. **HB 4036 does not account for the scale of the large systemic investments that were made into administration and services infrastructure by M110, and proposes that we could effectively transfer the administration of these services away from the oversight and accountability council-OHA partnership, and to the Alcohol and Drug Policy Commission (ADCP). This would create an extreme delay if this proposed plan could actually ever be functional at all.**

According to the first Oregon secretary of state audit of M110, the ~20 member volunteer oversight and accountability council was overwhelmed with the task of grant evaluation, and the grant evaluation process eventually had to be salvaged by temporary reassignment of staff from OHA to assist. This resulted in a delay of M110 funding distribution for about 18 months, until late second quarter of 2022. I am under no illusions that this process went well with the first grants. However, the small Alcohol and Drug Policy Commission (ADCP) and its volunteer subcommittee members would face similar or greater challenges to take on the mammoth task of grant administration for the existing M110-service providers, and the ADPC is certainly not poised to effect the immediate beneficial changes that Oregon needs to improve SUD outcomes. Additionally, for the M110 service providers who faithfully waited on their funding, and were promised secure funding streams to offer consistent programming, a changeup in leadership of the grant program could jeopardize currently running services and betray the trust and investment in new infrastructure.

When Oregon is faced with a problem, we optimistically like to build a new system to fix it. Building a new system on top of these already existing systems that were exhausting to implement in the first place— will lead us on a lengthy detour and ultimately be a massive setback and waste of time and resources that could be used to immediately augment our treatment and recovery infrastructure right now.

3. **For any re-criminalization framework adopted, routing more individuals through the criminal-legal system in Oregon will never be able to swing the state towards more treatment and recovery. We must continue investing into medical-evidence proven strategies instead—these have a comparatively large effect size and potential to reach a larger population.**

There continues to be a fictitious concept repeated that jail, community supervision, and treatment courts are somehow highly effective toward incentivizing people to enter recovery and maintain abstinence. In my own personal experience providing medical care to patients with SUD in Washington County as an addiction medicine provider at OHSU-Hillsboro Medical Center, I am frequently seeing patients who are under community supervision by a PO, yet continue to use drugs. The threat of legal consequences is not overriding the powerful immediate lure of substance use. Note that when Community Corrections Director Jeremiah Stromberg presented to the joint interim committee on 11/6/23, he shared no data about rates of recovery or abstinence outcomes promoted by community corrections, and only shared data about enrollment numbers. On his concluding slide, he asks the question “What does Community Supervision need more of?”— and lists first “Treatment Resources”. He is talking about residential treatment beds, detox beds, and recovery housing programs which POs are frequently referring clients to, and I agree.
https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/277616

There is also a prevailing assumption that these small entities within the criminal legal system have the capacity to significantly impact the large population of people with substance use

disorders (SUD) in Oregon. Over the past 3 years I have talked with many jail commanders and come to understand that jail beds are a very limited resource and they prioritize housing individuals who are an immediate threat to community safety— not individuals who are booked for only a possession charge. Community supervision and treatment courts focus on "high risk (for repeat crime), and high needs" populations. Drug courts in particular are an extremely limited expensive resource that have no potential to serve the vast majority of Oregonians with SUD. In PSU-Researcher Dr. Henderson's recent presentation at the Measure 110 Research Symposium, she illustrated graphically that PCS charges prior to M110 were brought against about 7% of Oregon's population of people with SUD. And drug court enrollment was only 5% of that 7%, only 1300 people. Therefore drug courts are effecting less than half a percent of Oregon's population of people with SUD. See slide 9: https://s3.amazonaws.com/assets.cfsecosystem.com/m110/Presentations/Panel+4_Henderson.pdf.

4. **Numerous experts have testified to the need to increase investment in Oregon's behavioral health workforce, inpatient treatment facilities, and primary prevention of SUD with interventions in our schools and communities— we must do this. We can expand law-enforcement interaction with treatment programs by expanding the availability and accessibility of these programs to law-enforcement; not by mandating engagement into treatment when we already don't have enough resources.**

Although HB 4002 proposes deflection programs, these are unlikely to be more successful than the class E violations and there are possibilities for unintended harms. A new system overlaying the CCO behavioral health providers, BHRN services providers, and CJC-certified deflection programs adds an unnecessary level of new expenses and complexity on top of what would otherwise be straightforward delivery of behavioral health services, that is finally up and running with the BHRNs. We can expand law-enforcement interaction with treatment programs by expanding the availability and accessibility of these programs to law-enforcement. For example, there is not a mechanism for police to drop someone off at a detox center with priority for that individual to get in, even in Portland where we have several detox centers. This committee should recall the example of the testimony from Arizona's crisis centers in the Fall, in designing crisis services to be accessible to law-enforcement. Similarly, officers working with Seattle's LEAD program spoke of dropping people off (a warm hand-off) at a referral site for case management services.

Thank you for considering my views on these important issues.

Best,

Dan Hoover, MD
Assistant Professor of Medicine
OHSU Division of General Internal Medicine
Section of Addiction Medicine