March 20, 2019

Senate Committee on Healthcare
900 Court St. NE - HR A
Salem, Oregon 97301

Re: SB 910- Relating to drug treatment

Chair Monnes-Anderson, Vice-Chair Linthicum, and members of the Committee, my name is Paul Lewis and I serve as the Multnomah County Health Officer and I have been a practicing pediatrician for over thirty years. I first want to thank this body for its ongoing commitment to addressing substance misuse and overdose prevention. Second, I want to explain how I became aware of some unintended barriers to reducing drug harms and preventing overdose. Finally, I will describe the components of SB 910-1 and explain how this bill eliminates these barriers and improves the odds of survival and recovery.

I began to pivot from my career in pediatrics and infectious diseases in 2014 when I reviewed a regional health assessment that identified overdose as a leading cause of early death. My first experience in wrestling with opioid misuse was in quiet conference rooms with physicians and pharmacists developing safe opioid prescribing guidelines. Since then I have learned a great deal about the less tidy medical, social, racial, and economic consequences of substance misuse. On this journey I have received innumerable suggestions but no magical solutions to this persistent and troubling problem. Among the ideas I hear, those that resonate most strongly eliminate barriers to the already difficult path to recovery. This bill makes a small but important contribution for the patients that walk this road.

Section 1 of this bill deletes a brief phrase in existing law (ORS 430.560) that allows medication-assisted opioid use disorder treatment for a justice-involved client only with the written approval by a probation or parole officer. Substance-use disorder, and opioid-use disorder specifically, is common in the jail and prison populations. In Multnomah County we estimate that 50% of those booked into our jail carry one or both of these medical diagnoses. The Interim Director of the Multnomah County Department of Community Justice, Erika Preuitt, and her colleagues statewide acknowledge that medication assisted opioid use disorder treatment has a significant impact on the

supervision process. However as she explained to me, decisions to approve or deny treatment are out of the sphere of a probation/parole officer's expertise and that these decisions are appropriately placed with healthcare and treatment providers.

Sections 2 and 3 are minor amendments to Oregon's Prescription Drug Monitoring Program (PDMP) statute. These sections allows the Oregon Health Authority to add other drugs to the PDMP by rule. This addition is to provide future flexibility to track emerging trends in prescription drug misuse without requiring statutory changes. A current example of a prescription drug that falls outside of the current law is gabapentin which is misused in combination with other legal and illegal substances.

Section 4 further expands Oregon's effective naloxone law to enhance widespread distribution. In Oregon, we have reached an opioid overdose fatality stalemate; our state's opioid deaths peaked in 2011 and, after a slight decrease, plateaued at over twice the rate in the year 2000. Naloxone distribution is a foundational part of expanding substance misuse harm reduction efforts across the state. Naloxone is safe, rapidly acting opioid overdose antidote that can be injected or sprayed in the nose by lay people. Naloxone has no psychoactive properties, is not a drug of abuse, and has been considered for 'over-the-counter' status by the FDA. Over 5500 unique individuals trained to use naloxone by Outside In and Multnomah County have reported nearly 4000 rescues and deserve our praise for limiting the deaths from opioid overdose. Much of the training and distribution of naloxone occurs in conjunction with syringe exchange and we are concerned that we are not reaching other opioid users who do not inject or do not visit syringe exchange. This section of the bill will specifically allow distribution of more than one naloxone kit to individuals or social service agencies with the intention of increasing the availability of naloxone in the community.

Section 5 amends the Resident and Landlord Tenant Act to exclude licensed programs and facilities involved in substance use disorders.

Finally Section 6 eliminates the 'thousand foot rule' that prohibits an opioid treatment program from operating within several blocks of facilities such as schools and childcare centers. One specific implication of the current law is the unintended consequence of making methadone treatment in the downtown Multnomah County jail so cumbersome as to be nearly impossible to implement for more than a single individual at a time. As you can imagine, the downtown Portland jail is one of the most secure facilities in the entire city; as described above the jail also has the greatest single concentration of individuals needing opioid use disorder treatment in our region. As county jails and the state department of corrections move toward providing more comprehensive substance use disorder treatment, elimination of this barrier will allow for modern evidence-based

treatment to start and continue regardless of incarceration status. In addition, the current law is stigmatizing and can unintentionally prevent our state's much needed expansion of medication assisted treatment

Thank you for addressing the many details of this important issue.

Paul Lewis, MD, MPH
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