Resolving Homelessness: The Critical Need for a Substance Use Disorder System of Care

A report commissioned by the Homeless Strategies and Solutions Initiative

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Introduction

In September 2022, the Homeless Strategy and Solutions Initiative (HSSI) Behavioral Health Work Group engaged the Technical Assistance Collaborative, Inc. (TAC) — a nonprofit organization dedicated to helping our nation's human services, health care, homelessness and affordable housing systems — to summarize available reports, data, funding, and agencies responsible for meeting the substance use disorder (SUD) treatment, service, and housing needs of people experiencing homelessness in the Portland Metro Area.

This report describes the essential features of an SUD system of care for the three counties of the Portland Metro Area, and provides recommended initial actions to execute cross-system alignment and coordination. The goal of such a system is to ensure that programs are using evidence-based and best practices and improving cost efficiency in order to achieve the best outcomes for people experiencing homelessness and SUDs. It is our contention that while some collaborations do take place between providers and funders, an SUD system of care for people experiencing homelessness does not currently exist. Consistent with TAC's scope of work with HSSI, this report focuses solely on persons with SUDs who are experiencing unsheltered homelessness. Additional analyses of cross-systems alignment between the Portland-Metro Area's mental health, health care, housing, criminal justice and employment systems may be beneficial to creating or enhancing a system of care for other populations experiencing homelessness.

Background

Homeless Landscape

According to the United States Interagency Council on Homelessness, there were nearly 14,700 individuals experiencing homelessness in Oregon on any given day in 2020; of these, nearly 30 percent were experiencing chronic homelessness — the eighth highest percentage of total homelessness of any state.[1] According to the Centers for Disease Control and Prevention (CDC), individuals experiencing homelessness often have co-occurring physical and behavioral health issues, many of them life-threatening, such as HIV infection and SUDs.[2] A recent study by the Multnomah County Health Department and the community-based organization Street Roots found that, on average, individuals experiencing homelessness in Multnomah County die more than three decades earlier than the average U.S. resident.[3]

Addiction Landscape

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH), Oregon has the highest rates of methamphetamine and prescription opioid misuse in the nation.[4, 5] Oregon ranks first in the nation for "percent of the population needing but not receiving treatment for substance use disorders"; second in the nation for "deaths due to drug use"; and sixth in the nation for "deaths due to alcohol."[6] In Multnomah County, approximately 130,670 individuals over the age of 12 are estimated to have had an SUD within the last year. For Clackamas County, this figure is estimated at 66,471 and in Washington County, there are an estimated 93,636 individuals with SUDs. In each of these Portland Metro Area counties, the Oregon Health and Science University (OHSU) reported that cities have nearly the same number of individuals with unmet SUD treatment needs as the number who are estimated to have an SUD.[7] Additional gaps exist in the provision of culturally relevant services, which are necessary to address racial and ethnic disparities in treatment access and outcomes.[8]

Intersection of Homelessness and Addiction

Studies document the range of substance use among those experiencing homelessness from 58 percent to 88 percent.[9] The 2019 point-in-time (PIT) count from the Department of Housing and Urban Development (HUD) found that the rate of substance use disorders (SUDs) in Multnomah County is at 45.6 percent among persons experiencing unsheltered homelessness. The recently released 2022 PIT for Multnomah County found that the rate of SUD among unsheltered individuals was 37 percent, and that the rate of both mental health disorders and SUDs was 21.9 percent.[10] In Clackamas County, the rate of SUD among unsheltered individuals was 39 percent and in Washington County, the rate was 53 percent in 2019.[11] According to the Oregon Health Authority's (OHA) Public Health Division, individuals experiencing homelessness are at the highest risk for unintentional overdose deaths.[12] In Multnomah County, nearly 80 percent of all deaths of individuals experiencing homelessness involved substances.[13] Of these drug-related deaths, roughly half involved methamphetamines.[14] The association between homelessness and drug use is bidirectional. While drug use can lead to homelessness, people

experiencing homelessness may use drugs to cope with the safety risks associated with being unsheltered, for example to stay awake or to sleep in order to cope with the trauma of being homeless.[15]

Inequities for Individuals who are Homeless and Have Substance Use Disorders

HUD's 2019 Annual Homeless Assessment Report (AHAR) noted that "African Americans have remained considerably overrepresented among the homeless population compared to the U.S. population. African Americans accounted for 40 percent of all people experiencing homelessness in 2019 and 52 percent of people experiencing homelessness as members of families with children, despite being 13 percent of the U.S. population. In contrast, 48 percent of all people experiencing homelessness were white compared with 77 percent of the U.S. population. People identifying as Hispanic or Latino (who can be of any race) are about 22 percent of the homeless population but only 18 percent of the population overall."[16] In comparison, African Americans represented 16.1 percent of Multnomah County's homeless population but only 7.2 percent of the general population for the county. American Indians/Alaska Natives (AI/AN) made up 11.6 percent of the PIT homeless population, but were only 2.5 percent of the general population, and Native Hawaiians/Pacific Islanders made up 3 percent of the homeless population but only 1.1 percent of the general population. Conversely, while non-Hispanic white individuals made up 58.4 percent of the homeless population counted, they made up to 70.5 percent of the general population.

While details about the prevalence of SUD by race vary nationally, one study finds that since 2015, overdose deaths have been rising most rapidly among Black and Hispanic and Latino communities.[17] The recent OHSU-Portland State University (PSU) SUD Services Inventory and Gaps Analysis finds differences between the racial/ethnic makeup of the health care workforce and that of the state. Additionally, members of racially marginalized groups are less likely than their white counterparts to engage in treatment, and when they do, are more likely to drop out before completion.[18] A significant body of literature recognizes the importance of providers whose sociodemographic characteristics match those of the patients they are serving and documents the role of this factor in patient outcomes.[19]

Current Systems in the Portland Metro Area

Current Housing and Homeless Services System

A 2020 data scan prepared for Metro found that more than $112 million in public funding was dedicated to Supportive Housing, Rapid Rehousing and Prevention, Emergency Shelter, and Transitional Housing across the Portland Metro Area.[20] Sources of this funding included:

Federal

- HUD: Continuum of Care (CoC), Housing Choice Vouchers, Project Based Vouchers, Community Development Block Grant, Housing Opportunities for Persons with AIDS (HOPWA), Emergency Food and Shelter Program, Emergency Solutions Grant, Family Unification Program Vouchers
- HUD-Veterans Affairs Supportive Housing (HUD-VASH); Department of Veterans Affairs Supportive Services for Veteran Families program
- Health and Human Services: Runaway and Homeless Youth

State

- Oregon Housing and Community Services: Emergency Housing Assistance, State Housing Assistance Program, Elderly Rental Assistance
- Oregon Health Authority: Medicaid, Medicare, State Mental Health Services Fund
- Oregon Department of Human Services
- Oregon Department of Justice

Local:

- County: Multnomah, Washington, and Clackamas County General Funds; Washington County Safety Levy
- City: City of Portland General Fund

Based on data from the 2018-2019 fiscal year, Table 1 below identifies services received by chronically homeless households in the region[21]:

Table 1: Services Received by Chronically Homeless Households in FY 2019

Service Type	Multnomah County	Washington County	Clackamas County	Total
Supportive Housing	1792	175	180	2147
Rapid Rehousing	1285	14	70	1369
Homelessness Prevention	445	5	4	454
Emergency Shelter	1501	26	146	1673
Transitional Housing	360	14	0	374

Notes of caution related to interpretation of this data set:

1) The population categories collected and reported on in the HUD Annual Performance Reports are limited and don't capture the full range of populations served by the region's homeless service systems, as providers that receive no HUD funding are not required to collect this data in the Homeless Management Information System (HMIS).
2) Categories of households served are not mutually exclusive, and individuals and households can be counted in more than one category.
3) More data related to the total population of individuals and families served is available in the cited report, but Table 1 represents only those meeting the "chronically homeless" definition, as TAC expects that many of those unsheltered with untreated SUDs meet this definition.

Data from the Joint Office of Homeless Services shows that in fiscal year 2021-2022, 4,560 unique individuals in Multnomah County were placed into housing and a total of 13,190 unique individuals were in housing during this time. This larger figure includes those newly housed plus those who were living in housing at the beginning of the fiscal year; for comparison, 11,610 unique individuals were housed during fiscal year 2020-2021, and 12,240 were housed during fiscal year 2019-2020.[22]

"Chronically homeless" means:

1. A "homeless individual with a disability," as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability, and:

    - Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
    - Has been homeless continuously for at least 12 months [one year] or on at least 4 separate occasions in the last 3 years where the combined occasions must total at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights. Stays in institutional care facilities for fewer than 90 days will not constitute a break in homelessness.

2. An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Current Substance Use Disorder Treatment and Services System

The Multnomah County Mental Health and Addiction Services Division identifies in its directory 19 addiction treatment provider organizations serving uninsured, underinsured, and undocumented individuals, offering services to a range of youth, families, and adults, including several culturally specific programs that work with African Americans, Latinx, AI/AN, Asian, Burmese, and LGBTQ2S+ populations. Washington County Health and Human Services identified seven addiction treatment and peer service provider organizations in its provider list serving youth, women with children, and adults, including one

provider that is identified as offering Spanish-speaking substance use services. The Clackamas County Behavioral Health Division reports that it offers alcohol and drug treatment services through a network of providers, but does not list who these providers are; a phone number listed on the County's website refers callers to CareOregon.

The recent OHSU-PSU Gaps Analysis report identifies in Appendix B that there are 21 SUD treatment providers, 7 providers of recovery services, and 1 provider of harm reduction services in Clackamas County. Multnomah County is listed as having 44 SUD treatment providers and 15 providers of recovery support services, while Washington County's list includes 15 SUD treatment providers and 9 providers of recovery support services. However, the providers noted in the OHSU-PSU report overlap with those listed in the linked directories above, and greater detail is needed about the availability of SUD treatment providers that accept Medicaid. Additionally, the gaps identified were calculated based on the total population of people with SUD in each county, not the homeless population which is a subset of the populations needing these services. Therefore, the workforce gaps for serving this population are a fraction of the need shown in Table 2 below.

Table 2: Behavioral Health Workforce Gaps Identified by the Calculating for Adequate Systems Tool (CAST)*

Service or Provider Type**	Gap in Clackamas County	Gap in Multnomah County	Gap in Washington County	Gap in Oregon
Peer Support Specialists	52%	Unlisted	64%	28%
Certified Alcohol and Drug Counselors	57%	20%	68%	41%
Inpatient	83%	38%	72%	60%
Outpatient	49%	16%	75%	35%
Qualified Mental Health Associates (QMHAs)	93%	81%	95%	86%
Qualified Mental Health Professionals (QMHPs)	97%	88%	96%	93%
Recovery Housing	42%	6%	78%	55%
Services specific to protected classes (race/ethnicity, sexual orientation)	39%***	33%	39%***	Unlisted
Services in languages other than English	30%***	28%	30%***	Unlisted
Outreach to people experiencing homelessness	40%***	33%	40%***	Unlisted
Overall service gap	68%	42%	75%	49%

** 164 participating organizations completed the survey for each county in which they operate services.*
*** Gap = the percentage of services/staff required that are* missing *in these counties.*
**** These data points are separated by region. Region 1 = Multnomah County, Region 2 = both Clackamas and Washington counties combined, so the figures are the same. Percentages were rounded to nearest whole number.*

In addition to the services listed above, there is a need for psychiatric stabilization unit capacity to address SUD-induced psychotic disorders, a condition of increasing prevalence within Oregon, reflective

of the epidemic of methamphetamine use. This would include capacity to apply time limited mental health holds when necessary.

Funding for Substance Use Disorder Services

Primary sources of funding for Oregon's SUD treatment services include Medicaid, federal block and discretionary grants, beer and wine tax revenue, and as of 2021 the newly created Drug Treatment and Recovery Services Fund from Measure 110.

Individuals insured by the Oregon Health Plan (OHP)/Medicaid in the Portland Metro Area are members of Health Share of Oregon (HSO) or Trillium Community Health Plan. These two Coordinated Care Organizations (CCOs), a network of all types of health care providers who work together in their local communities to serve OHP members, are responsible for the care of 400,000 Medicaid members who reside in this area. In key informant interviews, representatives from HSO were asked how much of HSO's $2 billion annual budget is utilized for SUD-related conditions, but this information was not readily available. However, one interviewee referenced an HSO study which found that SUD was the single highest driver of HSO's costs. A March 2021 HSO-OHA Transformation and Quality Strategy report documented that approximately 50,000 current HSO members have a diagnosed SUD.[23] In 2019, the Report and Findings for Senate Bill 1041 indicated that OHP accounted for 63.5 percent ($298.3M) of the total public expenditure for substance use treatment services in a two-year period. More recent Medicaid SUD treatment expenditures appear to be approximately $170 million per year.[24]

TAC was able to identify several sources of funding that support the SUD treatment continuum. OHA's Behavioral Health Services received $11.9 million SAMHSA State Opioid Response (SOR) funds in 2019 in addition to $20,581,505 from the SAMHSA Substance Abuse Block Grant (SABG). Oregon Liquor and Cannabis Commission (OLCC) revenue targeted to fund SUD treatment in 2019-2020 was $25,750,000, according to an Oregon Legislature report.[25] Counties receive these funds using County Financial Assistance Agreements which include financial, performance, and reporting requirements.

Measure 110 passed in 2020, created a new Drug Treatment and Recovery Services Fund equivalent to over $300,000,000 between 2021 and 2023. Because TAC was unable to interview OHA's Behavioral Health Director, we were unable to confirm that OHA Behavioral Health Services is coordinating its resources with the Medicaid-covered SUD services, though consensus among key informants was that there does not appear to be cross-system alignment between the two entities, or consideration for how to use Measure 110 funds in ways that are complementary with the other sources of funding mentioned above.

The Substance Use Disorder System of Care

According to the 2019 Oregon State Analysis, the publicly funded SUD system of care includes: a) prevention, b) screening and assessment, c) brief interventions, d) detoxification, e) residential treatment, f) intensive outpatient treatment, g) outpatient treatment, h) medication-assisted treatment, i) primary care/hospital-based interventions, j) gambling treatment, and k) recovery and peer-delivered services. The continuum of care for substance use ranges from prevention to recovery and includes all levels of care delineated by the American Society of Addiction Medicine. Services must be woven into each level of care throughout the continuum. Patient-centered care provides the type and amount of service to each individual based on an assessment of need; as that need changes, services are adapted accordingly. Successful transitions between levels of care (e.g., from residential to outpatient treatment) are critical, and a systems (rather than siloed) approach should provide the necessary connections, services, and supports to promote positive outcomes. A system of care should be able to track and provide fluidity of care by utilizing coordinated, community-based case management. A systemic approach to an effective SUD continuum of care should use data to inform need for each level of care to ensure the efficient use of resources to meet the need.

SUD Systems of Care Utilize:

- A cross-sector executive body that implements, maintains, and improves the system of care.
- Coordinated, community-based case management that facilitates access to the system of care.
- Contractual relationships between funders and intra- and cross-sector providers that ensures alignment.
- Intra- and cross-sector data infrastructure, data analysis, and quality improvement capacity.

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State and local systems often fund and implement the array of interventions needed to address unsheltered homelessness and SUDs independently of each other, limiting the availability of comprehensive interventions to address the complex intersection of homelessness and substance use. Modern approaches to building an effective SUD system with access to best practice, evidence-based, and culturally informed interventions require sophisticated cross-agency collaboration, braided funding approaches, and alignment of administrative, reporting, and accountability processes. Cross-agency alignment of resources, guidance, and reporting requirements is necessary to effectively coordinate SUD efforts.

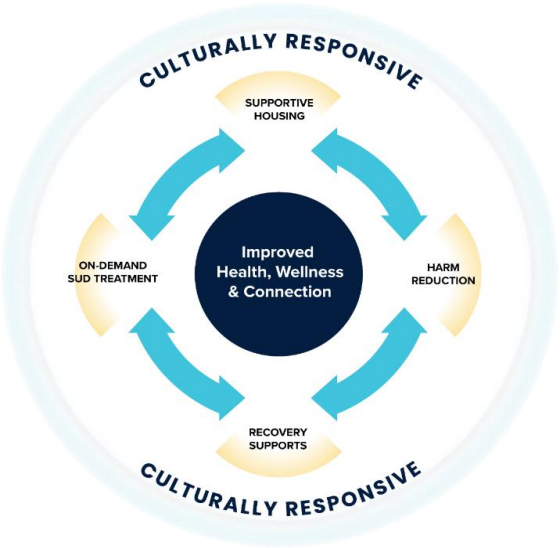
As identified in the "Current Challenges" section, and based solely on nine key informant interviews and a brief scan of available reports, there does not appear to be a mechanism to integrate the various funding sources made available for serving this population to support a comprehensive SUD system of care in the Portland Metro Area. While OHA's Behavioral Health Services is responsible for contracting out Measure 110 and SAMHSA funding and other sources of funds through County Financial Assistance Agreements, there does not appear to be a process to determine how these different sources of funding can be used to complement one another. Nor does there appear to be a process by which these funds are coordinated with OHP billable SUD treatment and service funding at the state or local level, based

on HSO's key informant interview. Similarly, HSO is not currently represented on the HUD Continuum of Care governing board, and there is evidently no coordination between these two entities. Without alignment among funders and resources, treatment gaps, waste, and inefficiencies are unavoidable.

An effective SUD system of care requires capacity to support advanced data exchange and the coordination of multiple federal, state, and local resources. Ideally, an entity would convene a cross-sector executive body that brings together the systems that administer state Medicaid, federal SAMHSA, federal HUD CoC, and available local funding to create a comprehensive continuum matched to the needs of the population being served. Population health analytics can be used to target resources rather than providing a patchwork of treatment, recovery supports, and housing with no coordination of care. This cross-sector executive body would work to create an SUD system of care that is established contractually between funders and the continuum of providers.

To create and operate an executive body that oversees the SUD system of care, locales should determine if a payer (county or CCO) has the capacity and infrastructure necessary to build intentional partnerships that work to integrate investments in a collaborative and coordinated manner. Such a structure needs to build in a process for authentic community engagement which incorporates the voice of persons with lived expertise, as those closest to the problem are often closest to the solution. An SUD system of care continuum serving those who are experiencing unsheltered homelessness will need to bring providers and partners together that offer culturally responsive harm reduction, supportive housing, evidence-based treatment, and recovery support services in coordination, as depicted in Figure 1, to the right. Doing so will require cross-system partnerships and the addressing of regulatory barriers. For more on cross-system alignment strategies, see TAC's recent brief, *Boosting the Power of Harm Reduction: Creating a Comprehensive and Culturally Responsive System of Care Serving People Experiencing Homelessness with Substance Use Disorders*.

Figure 1: Cycle of Culturally Responsive Services



Current Challenges

To gain a clear picture of the challenges facing the SUD continuum in the Portland Metro Area, nine key informant interviews were held with individuals representing agencies responsible for meeting the SUD treatment, service, and housing needs of people experiencing homelessness. These stakeholders included leaders at direct care providers delivering a comprehensive array of services, including health; mental health; SUD; housing; employment; street and shelter outreach; reentry; outpatient; inpatient; recovery; permanent supportive housing (PSH) and other low barrier housing; dissemination of safe-use kits; crisis outreach and mobile response; licensed residential treatment homes; and Psychiatric Security Review Board (PSRB) placements. Additionally, a key informant representing the Portland Mayor's Office as well as one from Health Share Oregon were interviewed. These interviews were scheduled for 60 minutes each. The agencies represented were:

- Bridges to Change
- Cascadia
- Central City Concern
- CODA, Inc.
- Health Share of Oregon
- Portland Mayor's Office
- Miracles Club
- Native American Rehabilitation Association
- New Narrative Integrative Mental Health

All stakeholders were specifically asked their perspectives on the immediate challenges facing their agency or the SUD system in the Portland Metro Area. Their answers are represented in Table 3 below.

Table 3: Challenges Identified by Nine SUD Service System Stakeholders in the Portland Metro Area

Immediate Challenges	Number of Stakeholders who Answered Yes*	Percentage of Stakeholders who Answered Yes
No SUD system of care	8	89%
Insufficient capacity of residential and/or outpatient treatment	8	89%
Insufficient funding	8	89%
Workforce shortage/turnover	9	100%
Unable to engage/treat high acuity populations	9	100%
Insufficient housing to discharge clients	9	100%

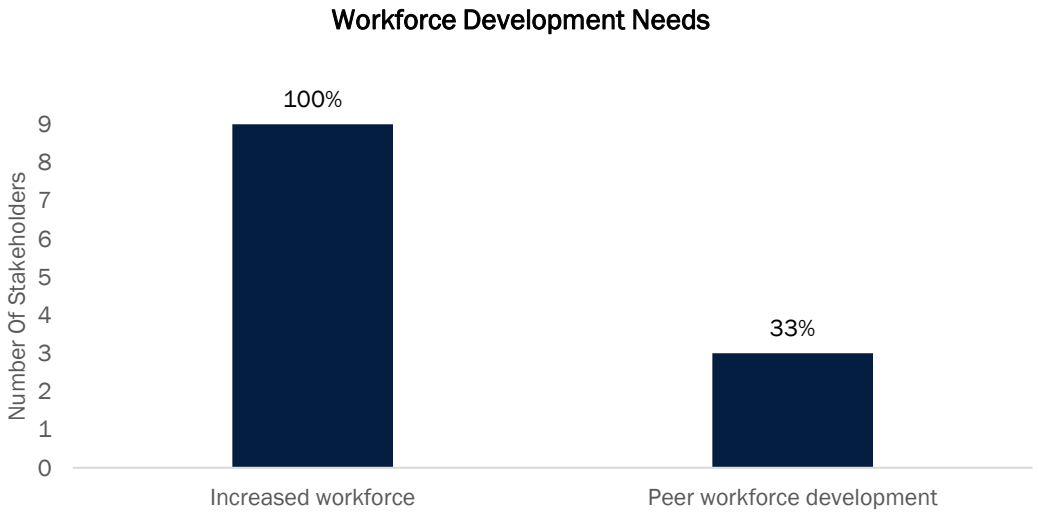
** Not every stakeholder was a treatment provider; therefore, some may have been unable to answer the questions affirmatively.*

Key Themes

In these interviews, respondents shared perspectives that could be grouped into five categories of challenges to be addressed: Workforce development; funding; systems integration; service availability; and cultural and community responsiveness. The sections below describe the challenges by each of these themes and are accompanied by illustrative quotes from respondents.[26]

Workforce Development

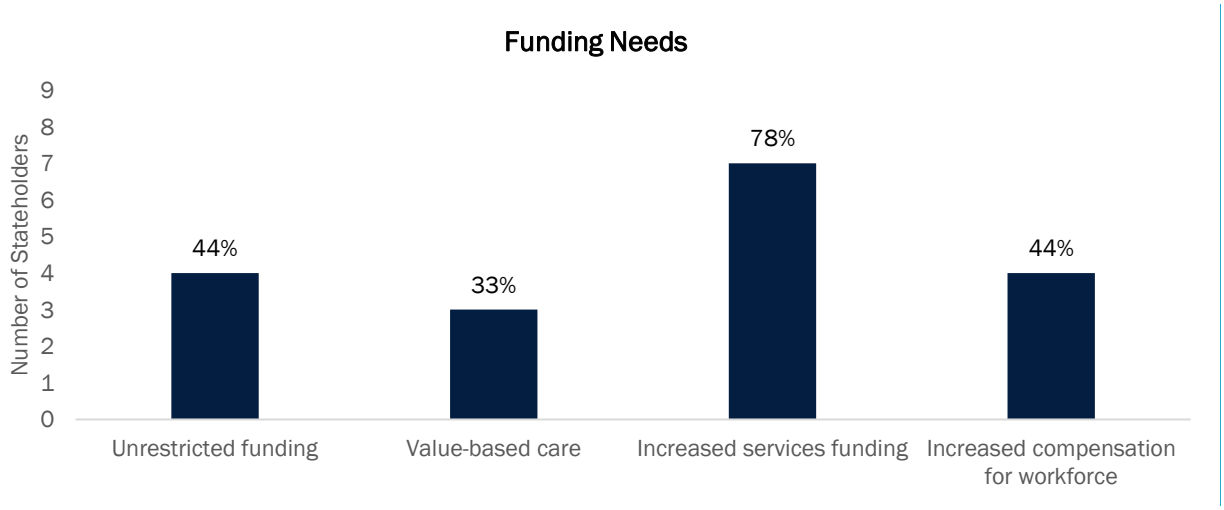
Stakeholders reported a range of workforce issues, with all nine stakeholders (100%) indicating there is an immediate challenge regarding workforce and staff turnover. In addition, three respondents mentioned a need for additional peers in the workforce. Current vacancies by agency ranged from four for the smallest organization up to one hundred and twenty-one for one of the largest agencies.



Workforce Development Needs	Stakeholder Quotes on Workforce Development Challenges
Increased workforce	• "[Insufficient funding] is the most immediate challenge because they keep losing staff due to cost of living and insufficient wages." • "It's a crisis and we need sustainable long-term rates and there needs to be a workforce pipeline development especially with BIPOC providers." • "Need direct funding for workforce housing, loan repayment for workforce who commits to work for agencies for a period of time, tax free rent subsidy for workforce" • "…. these issues are driving workers out of the field." • "We need a training academy to help people get certified as peers, building training for QMHAs, QMHPs and supervision and leadership training."
Peer workforce development	• "Consumer peer wellness specialist providers - need thousands of these." • "Need 200 more Peer Support Specialists/Certified Recovery Mentors."

Funding

Changes to funding came up repeatedly throughout the interviews. These perspectives could be broken into four separate funding needs: the need for unrestricted funding, a desire for value-based purchasing, the need for increased services funding, and the need for increased compensation for the workforce. Seven respondents noted the need for increased services funding; three to four respondents flagged each of the other funding needs.



Funding Needs	Stakeholder Quotes on Funding Challenges
Unrestricted funding	• *"CCOs should have unrestricted funds to pay providers to work with folks whenever and wherever those services are needed 24/7."* • *"We need funding that can be used across all clients, whether insured or not, for things not covered. There are no funds for generalists when folks don't meet specific criteria for an existing program. Need more funding for housing for people who don't fit into a specific housing criterion."*
Value-based purchasing	• *"Would like to see Value Based Payment model with a long glide path to get there"* • *"…move to VBP contracting would be great. It's hard to bill fee-for-service for helping client get a pair of shoes, and documentation is burdensome."*
Increased services funding	• *"Need more funding and need to bring MH and SUD care together because they have to treat them concurrently."* • *"Year to year funding just doesn't work for expanding out a SUD continuum. We need for OHA and CCOs to support 10 years of funding and start up for expansion.* • *"Prior to 2020, SUD treatment programs were already struggling to meet demand. Measure 110 didn't create this mess. The pandemic really shut everything down. The 50 years of the war on drugs and disinvestment in treatment combined with pandemic produces where we are now. New OHSU documents the degree of this capacity gap."*
Increased compensation for workforce	• *"Rates aren't high enough to support a living wage and so people are leaving the area."* • *"…need funding to pay staff adequately. They need parity of funding with health care system. Staff leave to go work for health care."*

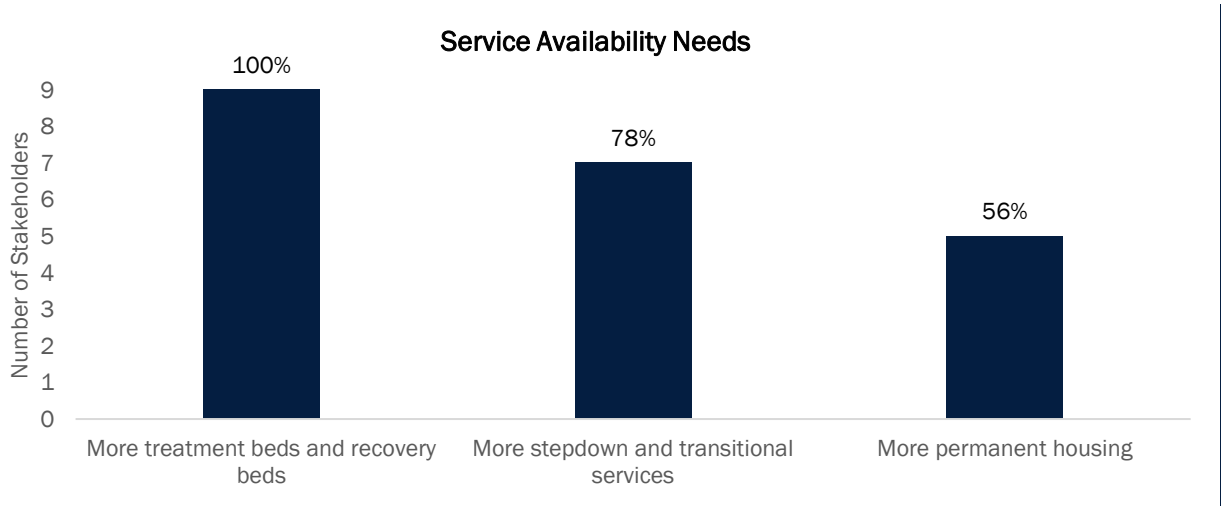
Systems Integration

There was strong agreement among respondents that systems integration is essential. All stakeholders highlighted ideas for systems change, while seven specifically called out a need for better collaboration and coordination both across and within the system.

Systems Integration Needs	Stakeholder Quotes on Systems Integration Challenges
Better collaboration and coordination	• *"The lack of system alignment (across Measure 110 and BECHN and CCO) with funds seems worse than before. The community at large seems to struggle with how to just start if we can't design the perfect system."* • *"There's no cohesive system and no authority that orchestrates integration and contractually obligates collaboration and adherence to this."*
Systems change	• *"Our current environment is a result of a multi-system failure… A SUD System of Care has to be a multi-agency partnership with commitment to resolve the obstacles in system alignment."* • *"Would love to see a governance commission that combines the counties with payer system. It should be payer led."* • *"We have to stop paying for addictions in an episodic way when it is a chronic disease."*

Availability of Services

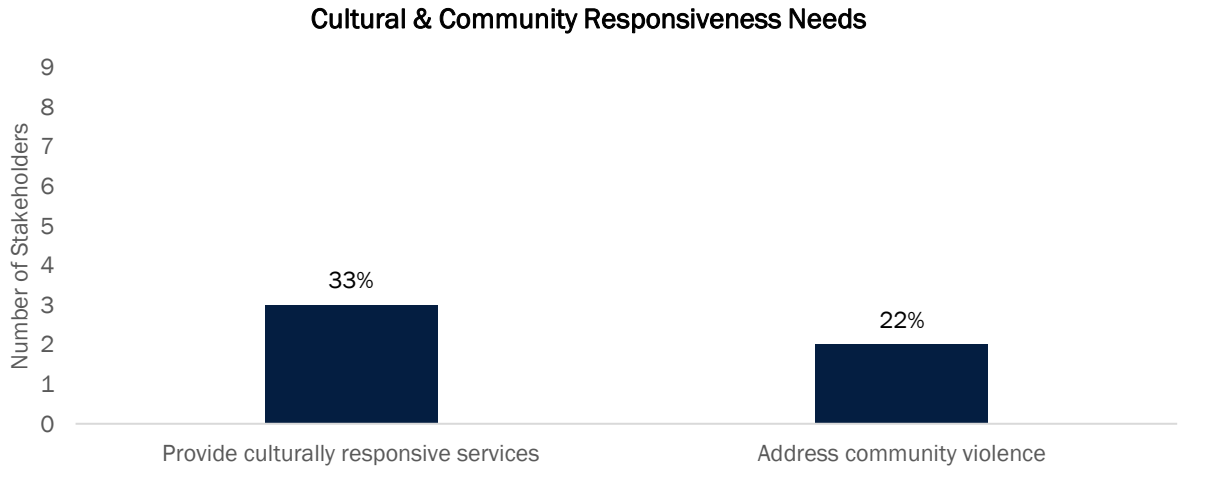
Throughout the interviews, the need for additional services was prevalent. Respondents repeatedly called out the need for more treatment and recovery beds, with 100 percent of stakeholders highlighting this challenge. Other service needs frequently mentioned included more stepdown and transitional housing units as well as more permanent affordable housing.



Service Availability Needs	Stakeholder Quotes on Service Availability Challenges
More treatment beds	• *"There is only 1 Latinx residential treatment program in all of Oregon! Oregon is first for drug use but 49th in access to residential treatment beds. There are no African American residential treatment programs in the entire state."* • *"Need 300-500 secure psychiatric residential facility beds for those using methamphetamine because they are causing safety issues and may need to be committed"*
More stepdown and transitional services	• *"Need 30-40 bed step down units from Hooper to create flow."* • *"Need step down housing. Can't go from residential treatment to your own housing with no support. Need more supportive housing for folks exiting residential treatment."* • *"Need… 1,500 units of transitional Recovery Housing."*
More permanent housing	• *"Need 3,000-4,000 units of PSH."* • *"1,000 more units of recovery housing (singles and families)."* • *"[Agency] could easily use another 800 beds of housing. 40% low barrier/harm reduction housing beds, 20% for family housing environments, 20% permanent recovery housing and 20% PSH."*

Cultural and Community Responsiveness

Some respondents pointed out issues related to cultural and community responsiveness. While these issues were not as commonly cited (three mentioned the need for culturally responsive services and two mentioned the need to address community violence), they were also not specifically asked about in the interviews. Therefore, it is possible that more respondents would agree with these needs if asked directly. In this category, needs were broken down into a need to provide culturally responsive services and a need to address community violence.



Cultural and Community Responsiveness Needs	Stakeholder Quotes on Cultural and Community Responsiveness Challenges
Provide culturally responsive services	• *"Training across the board on cultural humility and responsiveness that addresses all biases. Accountability for racial/ethnic biases. Promotion of those with lived expertise into system redesign."* • *"24/7 fully trained diverse staff representative of the population."* • *"Need training funds for culturally specific services (like those provided by White Bison)."* • *"Conveners should be heads of organizations who have proven to be successful in accomplishing culturally responsive engagement and successful SUDs outcomes. CCOs disregard communities of color."* • *"I would like 20 residential treatment beds for single black women, 20 apartments for black women with children, 20 residential treatment beds for black men with children, and a 20-bed center for black men without children and 40-unit site for black families with children going through onsite outpatient treatment."*
Address community violence	• *"Every other week staff member gets assaulted and have to go to hospital."* • *"Violence in the city is out of control. They have programs located in the middle of gang territory. 24/7 security is unfundable!"*

Recommendations

1) **As the entity that covers 385,000 Medicaid enrollees in the Portland Metro area, HSO should play a central role in convening key stakeholders to create an SUD System of Care Executive Body:** Engage the Governor's Office, OHA, CCOs, and County Behavioral Health Authorities in a conversation that identifies the needs for a payer-driven SUD system of care executive body that will work to align federal, state, and local funding for the continuum of harm reduction services, treatment, supportive housing, and recovery support services required to address the multifaceted population health needs of those experiencing homelessness with active substance use. This will require advanced data exchange that coordinates multiple federal, state, and local information systems.

2) **Engage major payer organizations (OHA and MCOs) to back the planning and engagement of key partners and launch of the executive body:** Securing buy-in from people with lived experience and communities of color will be critically important to the entire process of planning, building and implementing a SUD System of Care, as well as advocating for additional funds to close the gaps identified in this report.

3) **Engage an academic partner and other subject matter experts to evaluate the implementation and efficacy of the SUD system of care utilizing clear metrics and qualitative analyses:** The evaluation should include defined continuous quality improvement processes that would be reported for the first three to five years of implementation. It may be beneficial to engage system alignment subject matter experts, academic and/or technical assistance entities in the planning.

4) **Develop a process to identify barriers to increasing capacity:** Efforts to expand capacity should include both traditional and nontraditional partners. More work needs to be done to understand the challenges to current provider networks in expanding beyond existing capacity as well as engaging nontraditional providers to expand beyond the existing system. An evaluator can document the efficacy of engaging faith-based organizations, BIPOC, and those with lived expertise in the planning and oversight of an SUD system of care.

5) **Create a data infrastructure system:** A cross-system data infrastructure to support an SUD system of care needs to include housing status and homeless services involvement, and would provide actionable data in a timely fashion, guide decision-makers in evaluating impact of efforts, provide real time resource information, and establish a system for tracking referral outcomes. We support current efforts being led by a CCO all-claims analysis of key cohorts at risk of homelessness that will help to understand system capacity and gaps.

In order for a SUD System of Care to be fully successful, we want to emphasize that both the workforce and treatment capacity issues must be resolved. Without adequate capacity, client flow across the system won't occur and the workforce supporting the continuum experiences the moral injury of coordinating care of the most vulnerable clients to nowhere- often to return to homelessness, relapse and harm rather than the potential for recovery, health and wellness.

Endnotes

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[23] Health Share of Oregon Transformation and Quality Strategy, March 2021.

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[26] Some of the challenges were specifically asked during the interviews, and some came up organically throughout the interviews.