MEMORANDUM

TO: Clackamas County Board of County Commissioners (BCC)

FROM: Cindy Becker, Project Coordinator
County Administration

RE: Issues: Recovery-Oriented System of Care Panel and Summit Report

DATE: October 31, 2023

REQUEST: For information and discussion only. Staff will review with the Board the recommendations in the Recovery-Oriented System of Care Summit Report (attached).

BACKGROUND: In April, 2023, the Board asked the County Administrator to schedule a Recovery Summit where a panel of experts and others in the field would convene to discuss issues related to addiction and recovery.

While initially starting as a general housing discussion, the Board determined that the County was best served by hosting a Summit focusing on people with substance abuse challenges who impact - and are impacted by - the availability of services to meet their needs. The invited panelists were subject-matter experts who traveled to Clackamas County from Texas, California, Canada as well as other Oregon counties and engaged in a robust discussion about how the county can act and oversee programs to immediately help those in need.

An Addictions Recovery Summit was held over two days in September, and the panelists engaged with County staff, the Board, and community stakeholders. Discussions were held with the panelists before and after the Summit.

The attached report provides a context for the work, summarizes the current services and gaps in the County, and articulates a set of recommendations and additional thoughts from the panelists.

Attachments: Addictions Recovery Summit Report

Addictions Recovery Oriented System of Care Report

October, 2023

Introduction

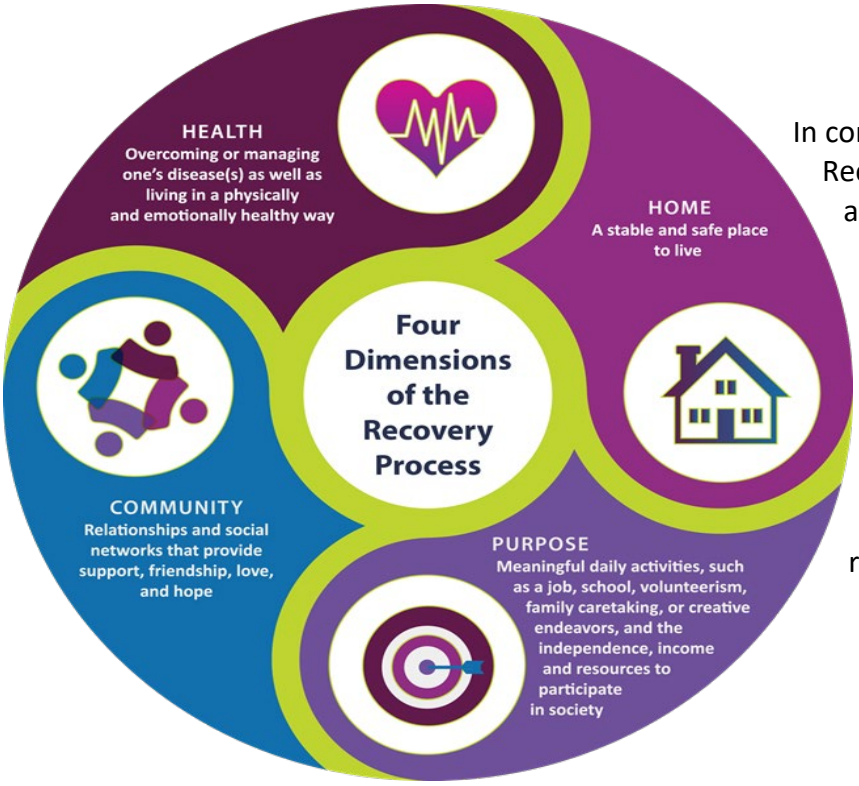
In April, 2023 the Clackamas County Board of County Commissioners passed a resolution to guide County actions regarding individuals living with substance abuse or mental illness who are houseless.

> "NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF CLACKAMAS COUNTY that all efforts to address homelessness in which the County and its employees engage must be concentrated on helping all residents participate in realizing their full human potential, by ensuring shelter, psychiatric, behavioral health and addiction care for all who need it, and by protecting public spaces for the use of the entire community."

This framework, along with the alarming rise in the use of fentanyl and other dangerous drugs in the county, was the Board's call to action to prioritize the creation of a **Recovery-Oriented System of Care (ROSC)** defined by the federal Substance Abuse Mental Health Administration as:

> A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

Below are the Four Major Dimensions of Recovery and are the foundation for a ROSC:



In contrast to acute interventions, Recovery-Oriented Systems of Care address the chronic nature of addictions by focusing on improvements in many aspects of life, supporting a community led response and closing gaps for those entering treatment and maintaining recovery. Like chronic illnesses such as diabetes or coronary artery disease, substance abuse typically requires long-term management.

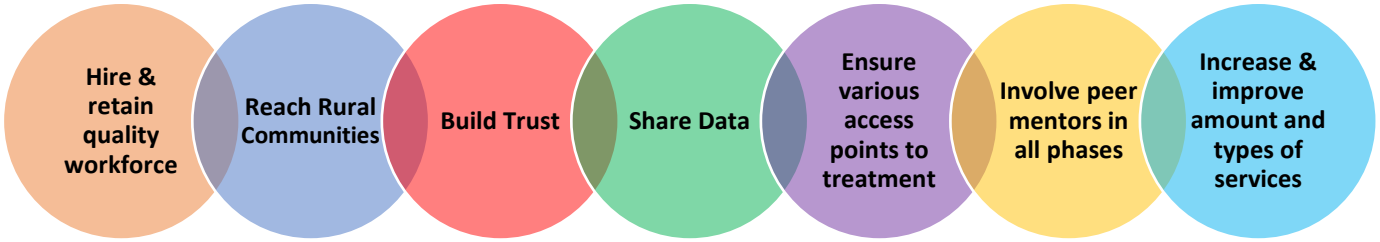
Addictions Recovery Summit

To further its commitment to addressing the addictions crisis, the Board convened a two day Summit of expert panelists, county staff, and community stakeholders focused on creating a Recovery Oriented System of Care (ROSC) across the County. The expert panel included:

- Rick Armstrong, Exec. Director, Our Collective Journey
- Sheldon Bailey, former Advisor to Alberta's Minister of Mental Health & Addictions
- Dr. Robert Marbut, Consultant, former ED of US Interagency Council on Homelessness and founding President/CEO of Haven for Hope
- Dr. Andrew Mendenhall, President and CEO of Central City Concern
- Ana Rausch, Vice President of Program Operations for the Coalition for the Homeless
- Dr. Rob Tanguay, Psychiatrist and Clinical Assistant Professor, University of Calgary
- Tom Wolfe, Director West Coast Initiatives, Foundation for Drug Policy Solutions
- Jennifer Worth, Operations Director, Great Recovery Circle, Confederated Tribes of the Grand Ronde

The purpose of the Summit was to learn more about evidence-based programs, best practices and lessons learned to expand and build upon the services and investments in Clackamas County today. It also provided an opportunity to dialogue with local elected officials, providers, people with lived experience, businesses, public safety, community-based organizations, and the faith community to address these critical issues and challenges together.

The community stakeholders' session elicited a range of themes about developing a system of care including:



Current Landscape in the County

Assets:

The County has successfully braided funding from a variety of federal, state, and local sources to create an array of services including crisis services (site based and mobile), care coordination, prevention, integrated clinics, outpatient treatment, overdose prevention, and residential treatment.

The County has strong relationships with the Coordinated Care Organizations who fund the majority of services.

The County's new Health Center's Behavior Health Clinic is significantly expanding its capacity.

The County is developing a new Crisis-Stabilization Center through a partnership with the Sheriff's Office and the Behavioral Health Division.

The County has been a leader in hiring and contracting with Peer Based Services.

Long term, productive working relationships exist among County Behavioral Health staff, Fire and EMS, Public Safety (Sheriff, District Attorney, and Local Police), and Providers.

Gaps

- There are waiting lists for all levels of care; lack of service slots
- Lack of the right kinds of services, or limited services, to serve the need – withdrawal management (detox), transitional services, supported employment, housing, and prevention education
- Services are not necessarily built around a continuum of care or based on individual needs; rather they reflect available funds.
- Lack of services in rural communities
- Lack of residential beds for youth and adults
- Transportation is challenging

Panelists' Recommendations

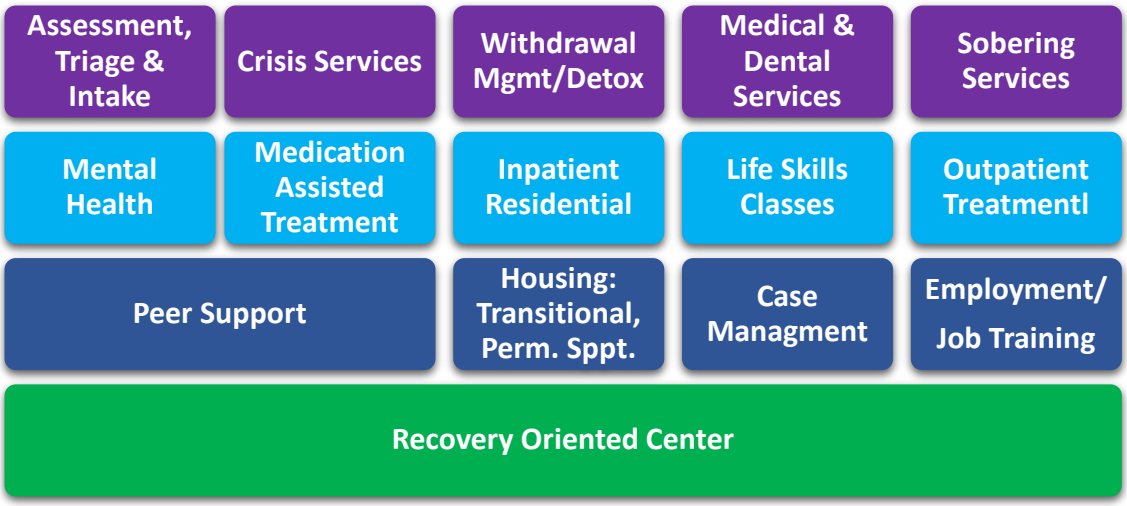
Staff met with the panelists before, during, and after the Summit to discuss current services and gaps. Based on their experiences and expertise, review of the service landscape, and discussions during the Summit, the panelist have made a series of recommendations to the Board. (Many of these recommendations can be done on parallel tracks; that is, they are not intended to be sequential.)

1. Come to agreement on desired outcomes and the **definition of success**.

> ***"Regardless of people's agendas, getting agreement on what success looks like is critical to implementing systems change, " Dr. Marbut***

2. **Analyze data** to understand the needs of the individuals to be served and the corresponding types of services needed
    - Review existing service capacity, types of services, and waiting lists.
    - Identify gaps.
    - Understand by sub-demographic groups of chronicity.
    - Conduct studies/surveys of people experiencing street-level homelessness.

3. **Create a Recovery-Oriented Center/Campus** that includes the full continuum of care: assessment, withdrawal management (detox), crisis stabilization, residential, outpatient treatment, and employment opportunities. Peers would be embedded throughout the continuum of services.
    - Identify potential location(s).
    - After comprehensive analysis of newly gathered and existing data, Identify all potential services to be provided at the site or through contractual arrangements and, based on the data, determine how much of each. Services could include, but are not limited to:



- Convene providers and peers early in the process to help with design of the building.
- Ensure that client, staff and community safety is built into the design.
- Bring law enforcement and emergency responders to the table to identify needed supports to avoid unnecessary jail and emergency room trips.
- Develop entry and exist processes throughout the continuum to ensure multiple pathways into receiving services and transitional support as people move back into the community.
- Develop a budget covering one-time and ongoing resources needed; convene current and potential public and private funders to create a funding plan.

> ***"Training is important, but actually employing people is key. Involve business leaders early on. " Sheldon Bailey***

- Keep Talking! Provide venues (conferences, Town Halls…) for continued engagement with communities including elected leaders, businesses, providers, people with lived experience, medical leaders, faith community, public safety and emergency response.
- Appoint an Operations Committee to develop a detailed plan to implement these activities.

4. **Bolster the existing array of services and** programs to provide rapid access to multiple levels of care:
    - Work with providers to add capacity in areas indicated by the data analysis.
    - Meet with the business community to expand employment and supported employment opportunities.
    - "Double Down" on programs that are working such as Law Enforcement Assisted Diversion (LEAD) that connects low level offenders to community based services instead of jail.
    - Work with state and federal partners to address workforce pay issues across the system.

> ***"The answer isn't Housing or Services, it's Housing AND Services."***
> ***Ana Rausch***

5. **Beef up Prevention Efforts**
    - Engage the media, schools, and other stakeholders to enhance prevention education and awareness.

In addition to the above recommendations, the panelists offer the following thoughts:

⇨Change the language: Multiple stakeholders — from policymakers to physicians — need to re-conceptualize recovery and better understand the role of recovery support services in treating substance use disorders.

⇨The introduction of fentanyl and other dangerous opioids along with the acuity of people entering the system are game changers. In other words, what might have worked in the past may not work any longer. The newness of these drugs means there isn't long term outcome data. As such, the system needs to be flexible and prepared to adapt as needed.

> ***"People are searching out fentanyl. The medical interventions we thought we were good at are useless. We're learning from pockets of excellence."***
> ***Dr. Tanguay***

- Fentanyl is a synthetic opioid that's 50 to 100 times stronger than morphine, according to the Centers for Disease Control and Prevention.
- In 2019, a federal drug task force that operates in Oregon and Idaho seized 43 doses of fentanyl. Just three years later — in 2022 — they seized more than 32 million doses.

> ***"The most important thing we can do is look at addictions as a chronic health condition."***
> ***Jennifer Worth***

⇨Don't think about substance abuse treatment as an acute episode of care. People need long term treatment. They will also need a system of ongoing transition services and warm hand-offs to re-integrate into their communities.

⇨It's critical to pay attention to implement appropriate training and clinical supervision of peers. At the end of the day, peers are great, but they're still recovery from addiction.

⇨Avoid cookie-cutter approaches – the systems and services need to wrap around the individual and their needs, not require them to fit into a prescribed course of treatment.

⇨Because there is no major city in Clackamas County, the County has an opportunity to model the use of a Hub and Spoke model to efficiently and effectively provide services in smaller cities and rural communities.

"Most addicts will tell you they wished someone had intervened earlier."
Tom Wolfe

⇨Intervention isn't a dirty word –Waiting for a person to choose treatment for a disease that affects rational thought can be catastrophic, now more than ever. The lethality of street drugs such as fentanyl means that many people with substance use disorders are in grave and imminent danger, and most cannot simply quit on their own.

⇨Regardless of where you are in the political spectrum, human life is worth saving.

"There will be blow back from the community, but please put people first."
Rick Armstrong

⇨Time is of the essence….

"We have people waiting. Substance use disorder is a condition where if people wait, people die. And even if they don't die immediately, people who don't get help when they are ready for it, may no longer be ready when the help finally does arrive." Dr. Mendenhall

ATTACHMENTS

Board Resolution

Homeless Population Demographics

Substance Abuse Impacts:
Emergency Department Visits
Jail

Current Substance Abuse Services

Health Share Members with Substance Use-Related Claims

BOARD OF COUNTY COMMISSIONER'S RESOLUTION

WHEREAS, Clackamas County has identified drugs, crime, and untreated mental illness, of which homeless encampments are a symptom, as top threats to the health, safety and flourishing of all of its residents; and

WHEREAS, Clackamas County believes in the dignity and worth of its residents, and the communal good that is achieved when residents are on a path toward the realization of their full potential; and

WHEREAS, Clackamas County acknowledges that a significant and consequential portion of both those struggling with homelessness in the greater Portland area and throughout North America also contend with the complex diseases of mental illness and or addiction, whether a precursor to or a result of homelessness; and

WHEREAS, the U.S. Surgeon General specifically describes addiction as a brain disorder disease that results in reduced brain function, that inhibits an individual's ability to make decisions and regulate his or her actions, emotions, and impulses, and furthermore, that changes in the brain persist long after substance use stops and recognizes that addiction to alcohol or drugs is a chronic brain disease that has the potential for recurrence and recovery; and

WHEREAS, Clackamas County recognizes that housing alone cannot cure mental illness or addiction, and the nature of addiction and serious mental illness can make sufferers unable to recognize their own illnesses or seek help willingly and benefit from a well-coordinated continuum of care to help them get the supports they need; and

WHEREAS, Clackamas County agrees that open air drug scenes create violence that is incompatible with clean and vibrant public spaces, and make recovery from addiction more difficult; and

WHEREAS, Clackamas County believes that harm reduction services, when not antithetical to a recovery-oriented system of care, can be effective in saving lives. Moreover, they must exist within a full continuum of compassionate care that includes prevention, intervention, treatment, and recovery for those suffering from addiction; and

WHEREAS, Clackamas County identifies other contributing factors to homelessness, including domestic violence, experience in the child welfare system, economic and health crises, and physical and mental health conditions and is identifying strategies to address these factors; and

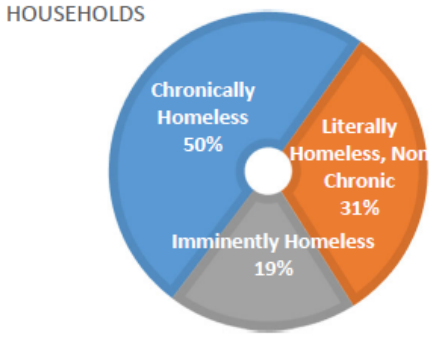
WHEREAS, Clackamas County believes that all people have a right to clean and vibrant public spaces, as well as safe emergency and transitional shelter when needed;

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF CLACKAMAS COUNTY that all efforts to address homelessness in which the County and its employees engage must be concentrated on helping all residents participate in realizing their full human potential, by ensuring shelter, psychiatric, behavioral health and addiction care for all who need it, and by protecting public spaces for the use of the entire community.

CLACKAMAS HOMELESS POPULATION INFORMATION

Clackamas County Coordinated Housing Access (CHA)
2023 Waitlist Analysis

Overall Households in CHA	1,569
Approximate Number of People	2,105



Households	**1,569**
Chronically Homeless	778
Literally Homeless, Non Chronic	489
Imminently Homeless	302

Families with Children	**224**	
Chronically Homeless	83	37%
Literally Homeless, Non Chronic	79	35%
Imminently Homeless	62	28%
Average household size: 2.90		

Adult Only	**1,276**	
Chronically Homeless	682	53%
Literally Homeless, Non Chronic	394	31%
Imminently Homeless	200	16%
Average household size: 1.22		

Subpopulations:

Youth Households Under Age 25	**105**	
Chronically Homeless	22	21%
Literally Homeless, Non Chronic	30	29%
Imminently Homeless	53	50%

Adults Age 62+	**255**	
Chronically Homeless	111	44%
Literally Homeless, Non Chronic	93	36%
Imminently Homeless	51	20%

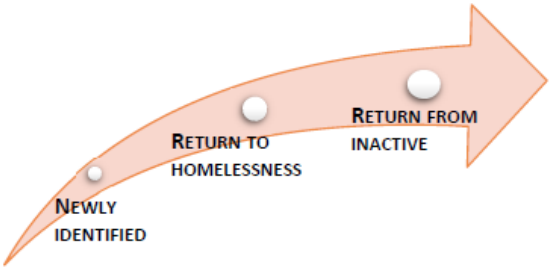
Survivors of Domestic Violence	**458**	
Chronically Homeless	187	41%
Literally Homeless, Non Chronic	167	36%
Imminently Homeless	104	23%

Veteran Households	**120**	
Chronically Homeless	46	38%
Literally Homeless, Non Chronic	45	38%
Imminently Homeless	29	24%

CHA Waitlist Movement January 2021 - December 2022

Inflow

1307 Households Added



Outflow

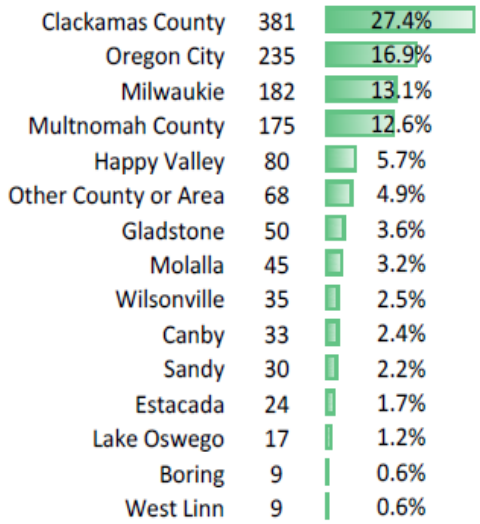
1405 Households Exited

Left for Other Housing Opportunity	51.1%
Missing Data	19.7%
Housing Program Placement	13.2%
Disappeared, Unknown, Moved out of Area	8.4%
Returned to Homelessness	7.4%
Institutional Setting (Jail, Psychiatric Hospital)	0.2%

Definitions

Coordinated Housing Access (CHA)	The system created to allow people experiencing a housing crisis to access, through a single point of contact, all homelessness prevention and housing programs.
Imminently Homeless	Must be out of current residence within 14 days, with no subsequent nighttime residence identified and lacking resources to obtain subsequent residence.
Literally Homeless	Sleeping in either an emergency shelter, transitional housing program, or place not meant for habitation (car, tent, street, barn, abandoned building, garage, etc.).
Chronically Homeless	Sleeping in emergency shelter or place not meant for habitation, have slept in such a location for at least 12 months of the past 3 years, and have a diagnosed disability.
Household	A group of people who are either currently staying together or who plan to stay together once adequate residence is identified. Can include those with or without children.
Youth Household	Household where no member is over the age of 24. Can include those with or without children.

Top Areas Where People Have Been Staying



Head of Household Demographics

Overall Households in CHA **1,569**

Many of the categories on this page display missing data. The majority of missing data comes from participants screened through a domestic violence service provider. In accordance with statutory requirements, not all of their demographic data is recorded in our database. 160 households were screened through a domestic violence service provider.

Race

American Indian or Alaska Native	52	3.3%
Asian	7	0.4%
Black or African American	83	5.3%
Native Hawaiian/Pacific Islander	21	1.3%
White	1195	76.2%
Multiple Races	109	6.9%
Don't Know/Refused	46	2.9%
Missing	56	3.3%

Ethnicity

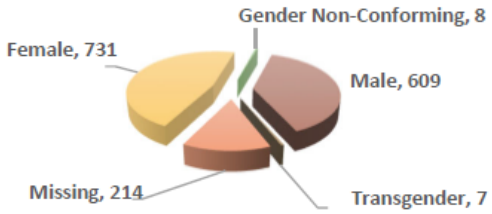
Hispanic/ Latino	139	8.9%
Non Hispanic/Latino	1349	86.0%
Dont Know/Refused	15	1.0%
Missing	61	3.9%

Under Age 18	Age 18-24	Age 25-61	Age 62+	Missing Age
4	98	1062	255	150

71%

REPORTED A DISABILITY IN THE HOUSEHOLD

Gender

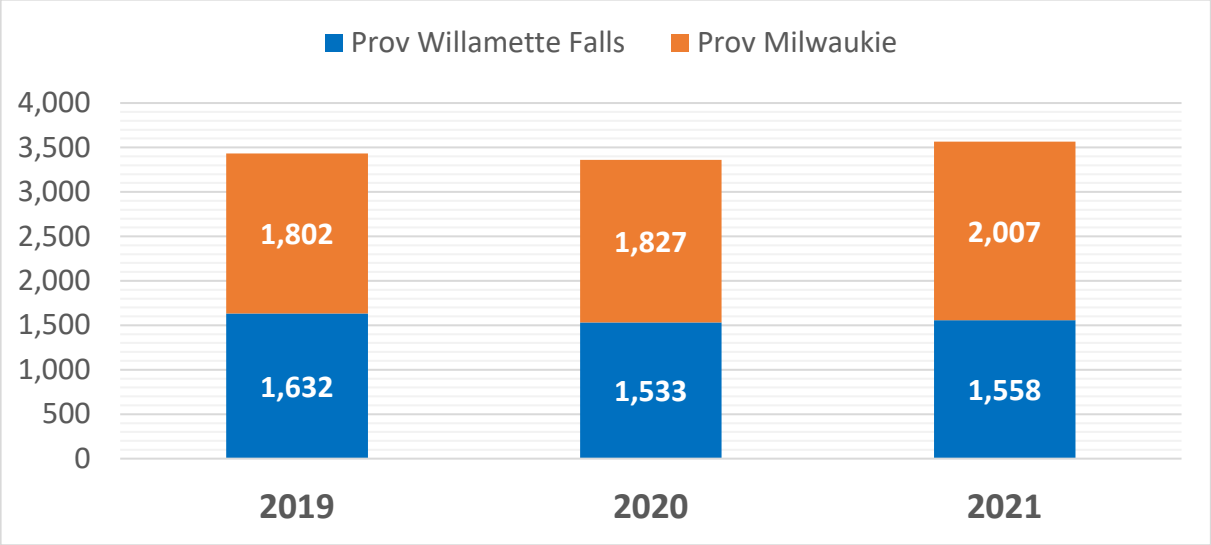


Household Type

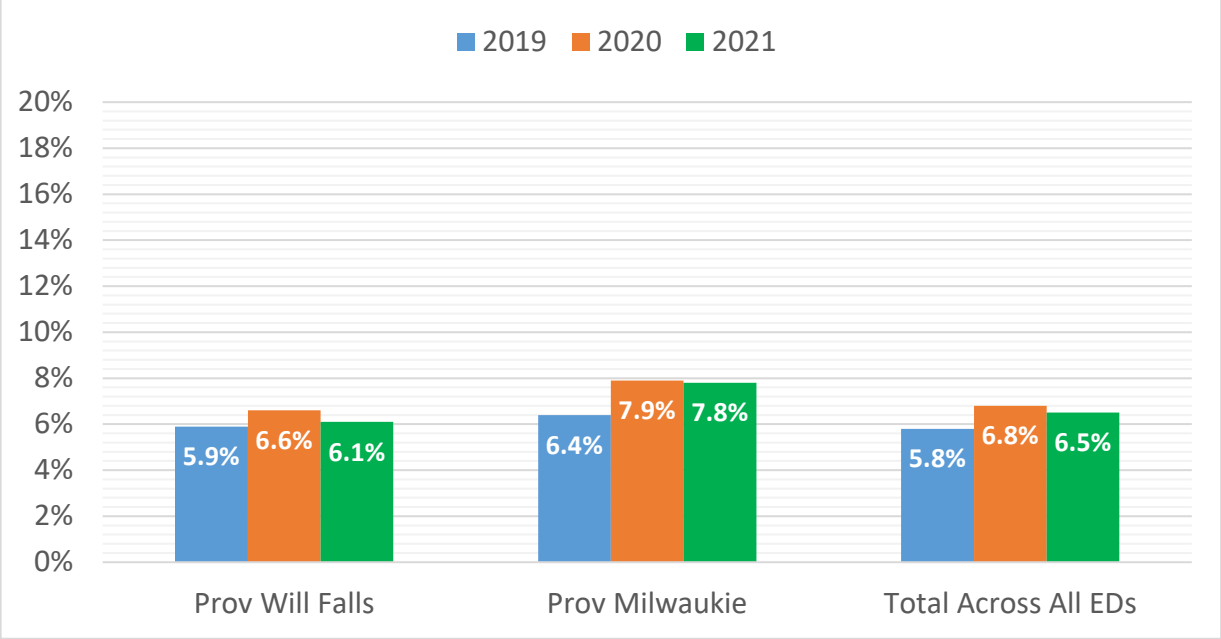
Adult Only	Household with Children	Youth - Parenting	Youth - Unaccompanied
81%	14%	2%	3%

IMPACT OF SUBSTANCE ABUSE IN PROVIDENCE EMERGERGENCY DEPARTMENTS

SUD-Related Emergency Department Visits

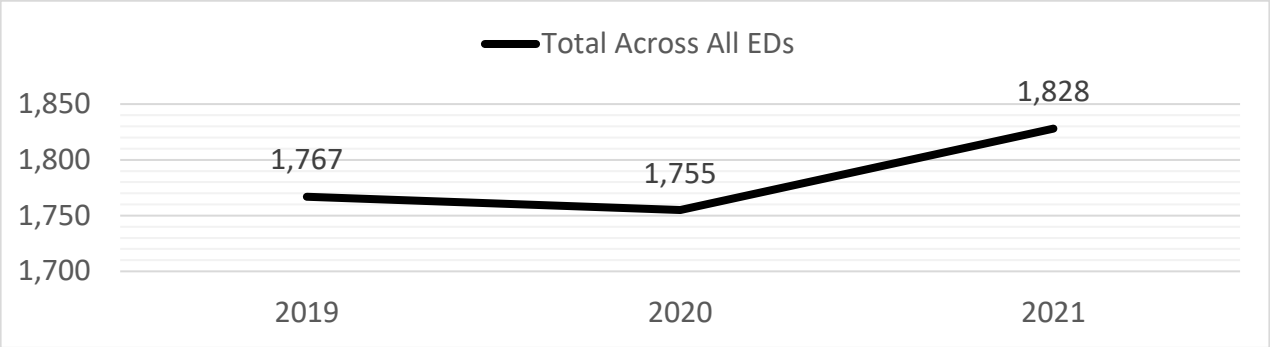


Percent of ALL ED Visits that are SUD-related by ED (2019-2021)

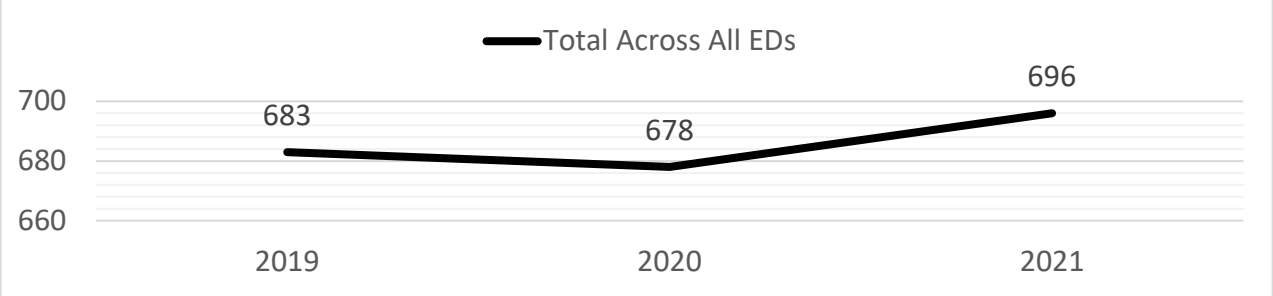


IMPACT OF SUBSTANCE ABUSE IN PROVIDENCE EMERGERGENCY DEPARTMENTS

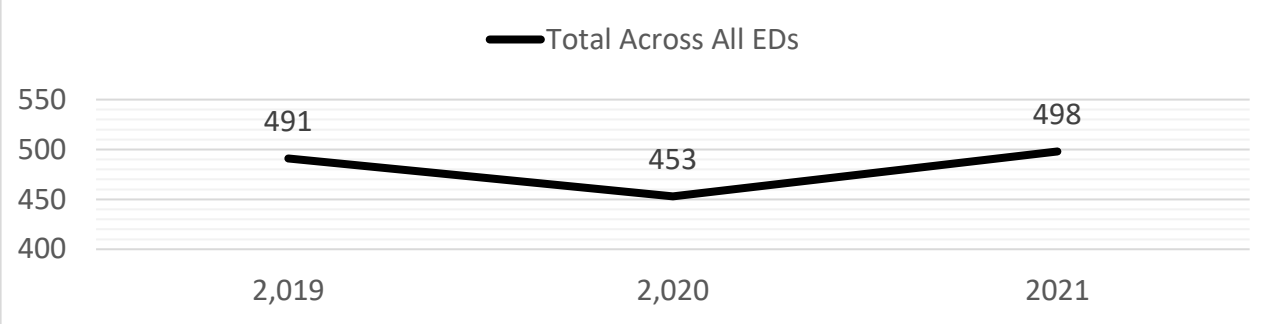
Alcohol-related ED Visit Volumes by ED and Year (2019-2021)



Methamphetamine-related ED Visits and Year (2019-2021)

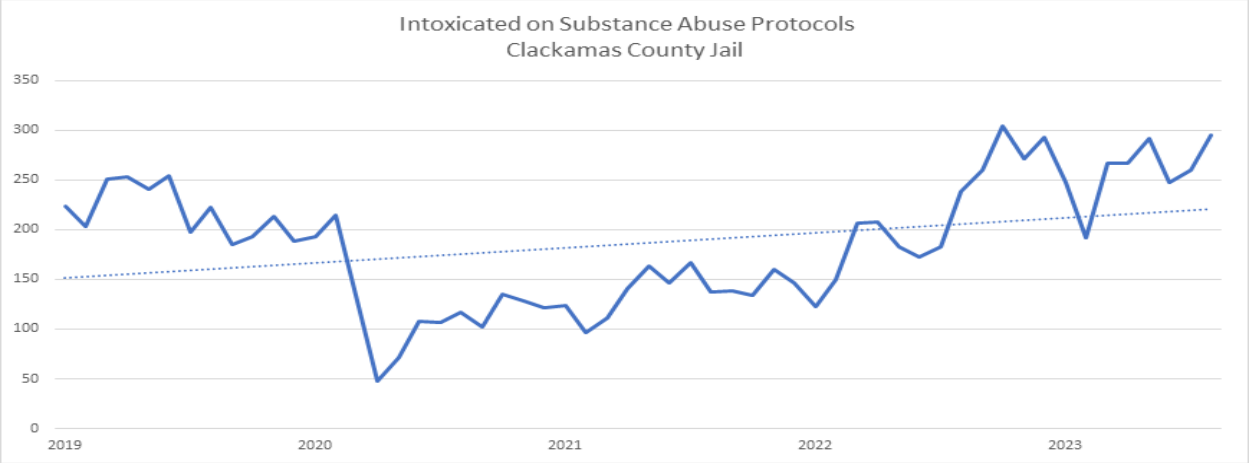


Opioid-related ED Visit Volumes by ED and Year (2019-2021)

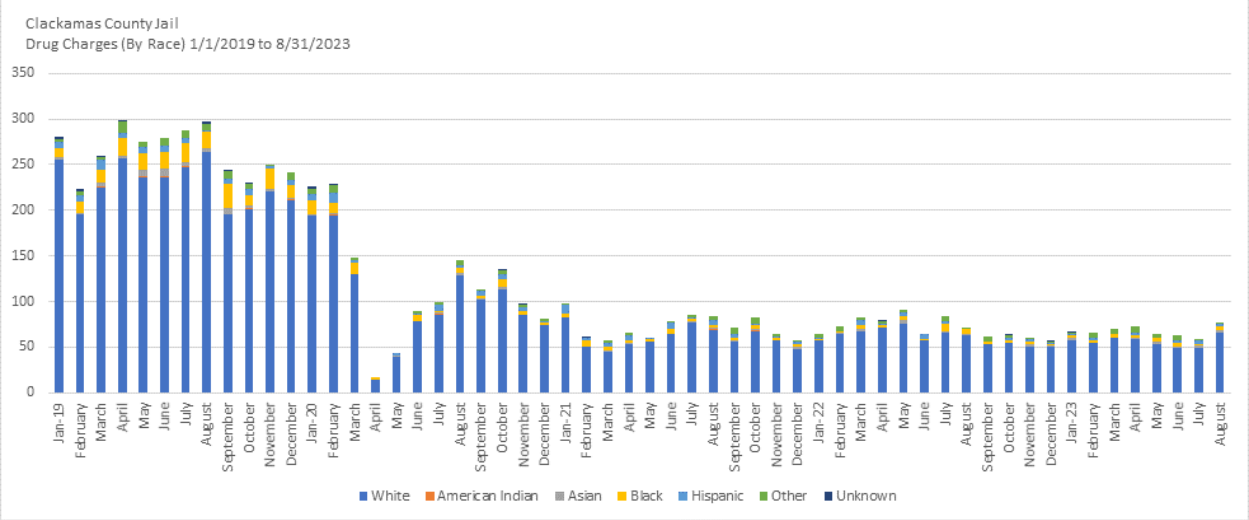


IMPACT OF SUBSTANCE ABUSE IN CLACKAMAS COUNTY JAIL

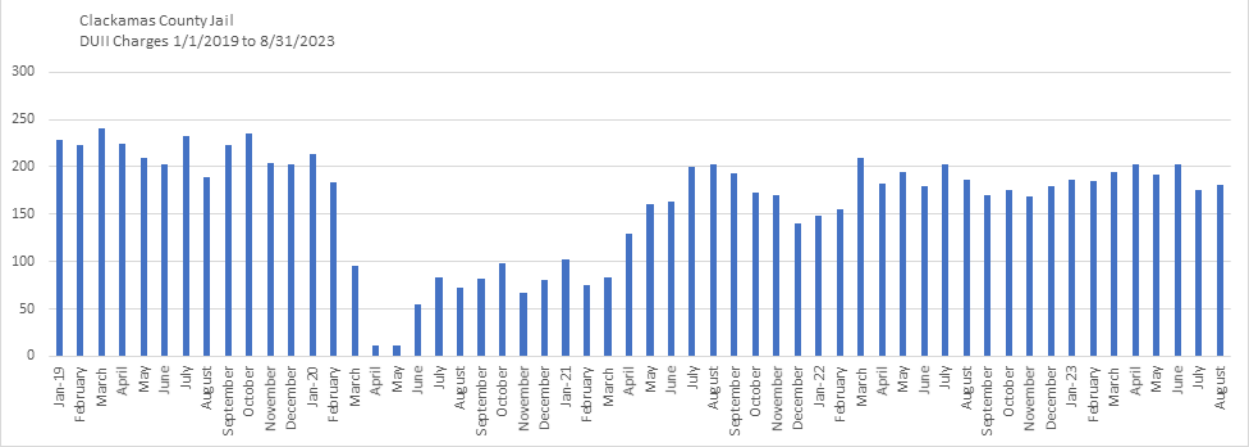
On any given day, 19 Adults in Custody are on substance abuse protocols



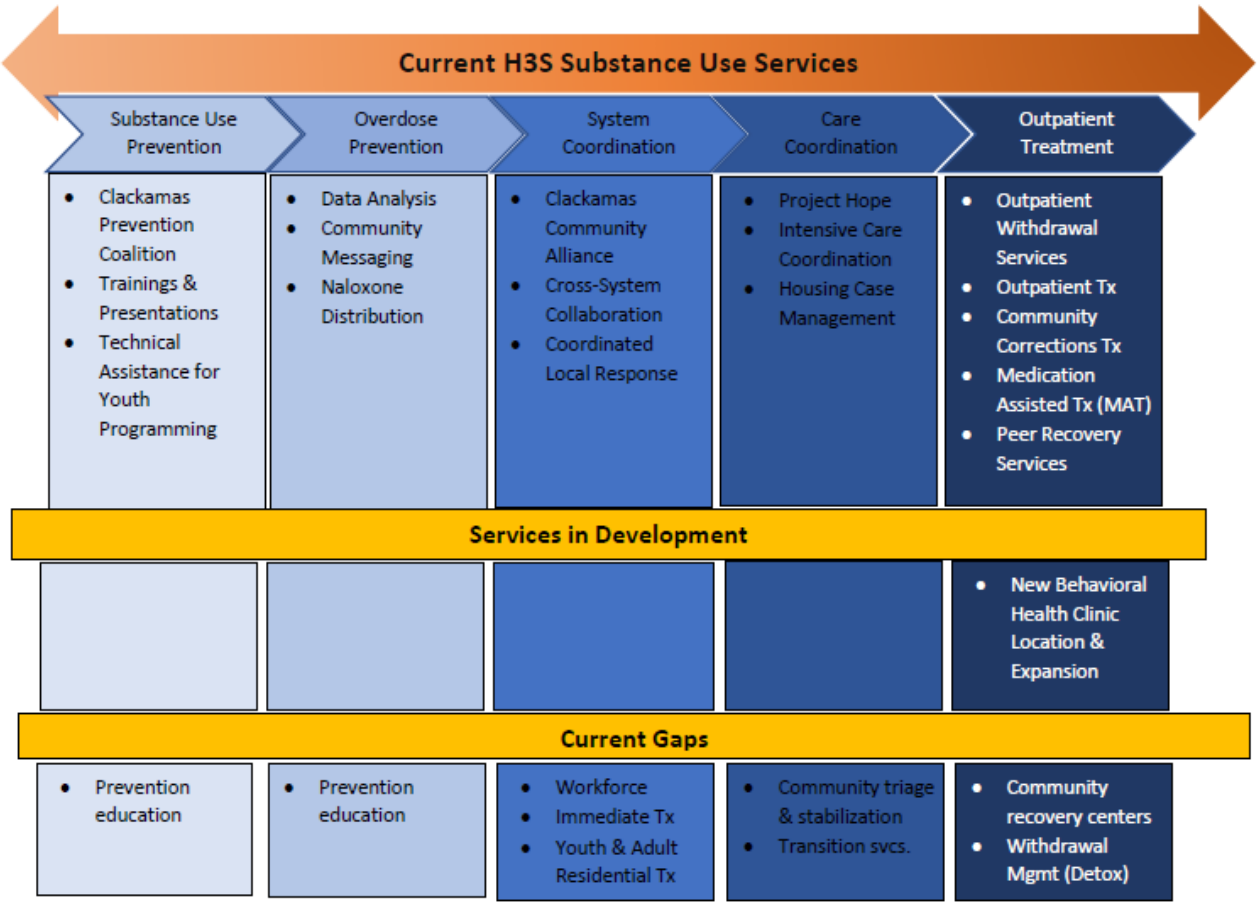
Drug Charges by Race



DUI Charges



CURRENT CLACKAMS COUNTY SUBSTANCE USE SERVICES



HEALTH SHARE DEMOGRAPHICS: CLAIMS BASED DATA