SUBSTANCE USE DISORDER CONTINUUM OF CARE -
VOICES FROM THE FRONT LINE

Suggestions for creating an efficient and effective continuum of care, including a proposed framework and recommended priority investments

Leaders in the SUD continuum share their perspectives on what works, what doesn't, and what policymakers should know as they consider investing hundreds of millions of dollars in building and maintaining an effective SUD system of care.

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Introduction

Behavioral health (comprising substance use disorder (SUD) and mental illness) is a crisis in our region and our state. Fortunately, policy makers have recognized the need for commitment of substantial resources to address the crisis. To optimize these investments, it is critical that there be an effective continuum of care, understanding of barriers in the real-world that prevent success, and a holistic plan for optimizing services and flow through the system as a whole. It is also essential to recognize that the "system" does not represent SUD in isolation, but has intersectionality with serious mental illness, homelessness, and often public safety. Unless we understand system drivers, make connections between disparate parts of the system, match people to the levels of service they actually need, and address real world barriers, no amount of investment will move the dial.

A group of SUD continuum leaders was convened to consider what it would take to create a functional approach to SUD. Participants had backgrounds ranging from personal experience of SUD, leadership and front line work from an array of treatment, recovery, healthcare and homeless service organizations, and advocacy. The charge was to see if consensus could be reached on two items: (1) Developing a framework for a basic continuum of care for SUD; and (2) identifying where major investments could most positively impact the system as a whole. The goal was achieved and is discussed below.

What was truly remarkable was the degree to which this diverse group of leaders agreed - not only on the biggest challenges we face, but on systems-based solutions that can move the dial. Though not a comprehensive formal evaluation, the message from the meeting was clear: We do not need to spend more money, time and energy on more consultants and studying the problem. We need to listen to voices from the real world, and we need to act.

This Report summarizes some of the collective wisdom of the group, including a framework for a basic SUD continuum superimposed on a homelessness to housing framework, recommended priority investments, necessary steps to move forward, and insights that can inform lawmakers as they engage in future policy and funding decisions.

"Our challenges are huge but SOLVABLE!"

> *"Lawmakers have all these meetings and discussions, hire consultants, then take no action. There is little attention to the real barriers and roots of problems. This is a major cause of abuse and waste. But we can address all of this! We know what to do, we need to do it!"*

"It's time for us to ROCK AND ROLL!!!!"

Summary of Key Insights:

- **We need a paradigm shift** from a system organized around illness and crisis to one based on stabilization, wellness and recovery. From a problem and program based system to a person based system.
- **A basic system should be designed before investing in a bunch of one-off projects**, otherwise time, money, and human capital will be wasted.
- **We need centralized and effective leadership** over the continuum as a whole.
- **Much of what leads to current system dysfunction boils down to disconnect and mismatch:**
    - **Disconnect between policies and the real world**, between political goals and human needs, and between different types of service levels; and
    - **Mismatch between individuals in need and the level and types of services they receive**, and between supply and demand for services.
- **Centralize, coordinate and connect!**
    - **Urgently develop effective data systems** - including data collection, management, strategy and sharing.
    - **Create specialized teams to optimize system performance**, such as "inreach teams" for shelters, "transition" and "intensive care" teams that support people through recovery, and "housing retention teams" to optimize people's success in housing.
    - **Focus on flow *throughout the entire system***, rather than from one isolated portion of one system to another.
        - **Detox, treatment, stabilization, and short term housing are not solutions unless there are places other than the streets where people can be discharged to. The most important investment is in long term transitional recovery-based housing!**
- **Until a holistic system is created, invest strategically in a few key areas that will have the greatest impact in the short term while building the functionality of the system over time:** Long term transitional recovery housing, Intensive Outpatient and Partial Hospitalization services, and effective data collection, management, analytics, and information sharing.
- **Fund realistically.** Funding is often orders of magnitude too low to cover the actual cost of services, having a ripple effect of negative impacts.
- **Pick the low hanging fruit!** Optimize what we have that isn't being used.
- **Eliminate technical barriers, streamline contracting.**
- **Build flexibility and fluidity into the system** so people can not only move forward but also step back if needed without losing their place.
- **Acknowledge that some people with the highest needs are not ready for or do not wish to go into housing and help them get what they actually need,** including shelter, until the right services and housing are available for them.
- **Meaningfully include people with lived experience and front line providers in every aspect of this work.**
- **Communicate effectively!**

Recommended Urgent Actions:

1. **Develop a shared framework for a functional SUD Continuum of Care.** A baseline consensus framework is attached as Appendix A.

2. **Prioritize investments in a few key areas that will move the dial and serve as a basis for longer term system expansion, innovation and growth**

    a. **HIGHEST PRIORITY: Invest in available long term recovery housing, at scale, with associated job training and other essential services!**

    b. **EXTREMELY HIGH PRIORITY: Invest in Intensive Outpatient (IOP) and Partial Hospitalization (PH)**, located in proximity to housing**.** IOP and PH are often at least as effective as residential treatment but more cost effective. There is a huge deficit of this level of care in our system.

    c. **Create effective and integrated information sharing systems.** Accurately count people living outside and in shelters and identify their actual needs and barriers. Consolidate survey instruments and data collection.

    d. **Establish a Coordination Hub with centralized leadership and create specialized teams** focusing on shelter inreach, transitions, intensive care, housing retention, analytics, and translation of policy into action. These will connect policies to people and optimize overall system performance.

The following pages provide a more detailed account of the group's key insights and recommendations.

Key Insights - Expanded

1. **There must be a paradigm change from the current system organized around illness and crisis to one based on stabilization, wellness and recovery.** Focus on the person, not the problem, project, or program.

    "We have a problem-based system, not a person-based system."

    "Healing and wellness is almost penalized! The system is set up for illness rather than people and recovery."

    "Looking at the problem from the bottom up provides a very different view than looking at it from the top down."

    "We are doing the best we can in an environment where everything seems to be working against us."

2. **The voices of lived experience and those who are most historically marginalized and have not traditionally had a seat at the table must be incorporated throughout all aspects of this work!** This means more than just last minute or superficial tokenization.

3. **A functional system should be designed before investing in one-off disconnected projects, otherwise massive amounts of time, money, and human capital will be wasted.**

    - **While optimizing investments to address urgent needs, begin the longer process** of understanding and building an effective, person-based, holistic system of care.

4. **The FACTORY/VALUE CHAIN analogy:** If we wanted to produce a bunch of products, say cars, we would need the right systems to build them safely, effectively, and efficiently. We would need to understand demand and supply. We would need the right blueprints and plans. Analogizing our SUD continuum for our car factory:

    - Right now we have many of the parts and some of the personnel needed to make the cars, but the parts are strewn all over the warehouse floor, there is no centralized leadership to provide a vision or direct the work, no accurate inventory of parts or catalog of what's needed to build the cars, no accurate inventory of staff or what's needed to make the factory function, no quality assurance team or Board of Directors overseeing the work, no effective way to measure customer satisfaction among an array

of different and valued customers, little effective coordination of the work, and most of all, no overarching plan.

- It makes no sense to keep buying random parts and continue to throw them onto the floors of randomly distributed warehouses. We need a plan, an inventory of what we have vs. what we need, clear leadership directing the work toward a shared vision, a centralized, effective leadership structure, quality assurance, an approach to customer satisfaction, and a staffing model with an effective pipeline, recruitment and retention.

  "Rather than continuing to say we need more engines, we need to figure out how to build more cars!"

The same is true for systems of recovery-based services. We need a system of care focused on people and recovery, not more individual pieces of the puzzle that are disconnected.

5. **We need clear, effective, and centralized leadership over the system as a whole.** Using the factory analysis, this means someone who has vision, oversight, planning and accountability over the entire production chain.

6. **Much of what leads to current system dysfunction boils down to disconnect and mismatch:**

   a. **Disconnect** between policies and the real world, political goals and human needs, and isolated parts of what should be a cohesive system; and

   b. **Mismatch** between individuals in need and the level and types of services they receive, between the real cost of services and the funding provided, and between supply and demand for services..

      "People must be assessed to receive the level of services they actually need, then funding provided to meet their needs for a realistic duration of time. Our continuum for decades has been unable to provide the level of services people actually need for SUD. With mental health, ACT ("Assertive Community Treatment") teams provide an intensive level of engagement and proactive outreach to people with mental illness. For SUD, we just say "come back when you're ready" and then don't even provide places to go."

7. **Quantify supply/demand mismatch**

   a. **Quantify the actual level of need (demand).** Identify individual needs and barriers through a complete and accurate By Name List. Neither the list nor, to our knowledge, an adequate approach to creating one currently exist.

b. **Catalog currently available services (supply)**

   i. For different levels of service, identify how many physical spaces we have, how many staffed spaces we have that people can actually use, and how many people are actually being served out of the available staffed spaces.

   ii. Include Inpatient Treatment, Secure Residential Treatment, Residential Treatment, Intensive Outpatient, Partial Hospitalization, Detox, Sobering, Shelter, Recovery Stabilization Housing (1-6 months), Recovery Transitional Housing (6 months-2 years), deeply affordable housing connected with recovery-based services, deeply affordable housing with recovery services on site, etc.

   iii. Include sites beyond those contracted with local government.

c. **Create heat maps** showing current need, currently available services, and what is pending.

8. **Centralize, coordinate and connect!** Right now services are fragmented and uncoordinated, providers are disconnected from each other, and no one has control over the system as a whole.

   a. **Urgently establish a centralized and coordinated oversight structure for this work with a clearly identified leader.**

   b. **Create effective and coordinated information sharing and data management systems.**

      i. Create a single integrated data and information-sharing platform. This is an essential technology solution to support navigation for individuals that must bridge homelessness and healthcare/behavioral health systems.

      ii. **Consolidate lists** (Coordinated Access, By Name List, HMIS, PITC, etc.) and vet with a wide range of front line providers and people with lived experience. Piloting with a few small groups is not sufficient.

         1. **Current Coordinated Access creates a domino effect of bad outcomes.** People are often placed in inappropriate housing situations and then met with inadequate services to allow them

to stabilize and be supported. This can lead to a number of negative outcomes, including:

- Failure to retain housing and a return to homelessness;
- Destruction of property;
- Uninsurability for organizations;
- Unsafe living conditions;
- Violence, suffering, harm, and death.

"People who are ready for housing and may have received some services are excluded from getting housing because once they've been stabilized, they go to the bottom of the list!"

"Right now we actively deprioritize service-engaged individuals. There is no transition. Then we don't fund the services they need to be successful where they've been placed. We are dropping the ball TOO EARLY and we're making the system MORE ineffective! Our current process of prioritization and the mismatch that occurs is doing tremendous harm at a huge cost!"

2. **"HMIS is a terrible tool."** Providers do not have access to information, data often has to be double-entered, the system is inefficient and is not designed to help actual people. It is not a By Name List.

   "HMIS is really challenging for providers so we all have our own systems - workarounds, double entry. And the information being collected is about compliance, not people!"

3. **Create a complete, accurate and up to date By Name List maintained in real time.** This should include information identifying people's individual needs and barriers, while maintaining rigorous standards of privacy and security.

4. **The Point In Time Count is a gross undercount and doesn't collect accurate information.** Funding decisions should *not* be based on the PITC.

iii. **Create a meaningful, efficient, user-friendly and effective survey instrument.** Do not roll out a new instrument without extensive involvement of many stakeholders. Piloting with a few groups is not sufficient.

iv. **Create an effective and efficient mechanism for assessing vulnerability in order to get people the services and supports they need.** Same comments as above.

v. **Match people to the services they actually need.** Failure to engage in adequate matching of individuals to the placement and services they need leads to untold human suffering, churn through multiple systems, and wasting of hundreds of millions of dollars. A matching program can optimize investments throughout the system and ensure people are started on the path that is right for them.

vi. **Execute common data sharing agreements.**

vii. **Establish a formal analytic structure to identify and understand disconnects, mismatches, and opportunities, and translate these into operations and action.**

> *"A recent study described 228 evictions that happened in 2023. We need to understand the story behind the numbers. Were the individuals service-engaged or not? How had they intersected with the homelessness and housing system? Did they have healthcare needs that were not being addressed? Without the analysis and deeper understanding, we will not be able to address the root causes of system dysfunction, and we will not be able to effectively match services to needs."*

viii. **Zealously protect individual privacy and security while optimizing the ability to share information aiding in people's treatment and recovery.**

ix. **Establish shared waitlists and create a centralized portal for access to services in real time.**

"Right now case managers and other service providers work the phones for hours trying to find shelter spaces. Each facility has its own waitlist. This is a total burnout issue for staff!"

x. **Overhaul 211.**

c. **Create specialized teams to focus on individual people and their needs and optimize system performance.**

- **Inreach teams** that provide an array of services for shelters and alternative sites.

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    - These teams can provide necessary services more cost-effectively than establishing an array of services at every shelter or alternative location, while establishing relationships over time that can build trust and improve outcomes.

    - Recognizing that length of stay in shelters may be prolonged due to lack of permanent housing or individuals not being ready for or not wanting to go into housing, inreach teams fill a tremendous gap and perform an essential function at the intersection of homelessness and behavioral health.

- **Transition and intensive care teams** that support people through recovery and housing transitions.

  “People need treatment paired with housing AND a transition team that follows them as an individual.”

  “We have ACT teams for mental health, but for people with SUD, we just tell them to come back when they’re ready. And there aren’t even places for them to come back to!”

- **Housing retention teams**.

    - **Retention, health and safety must be front and center.** People need to be placed in the right situation based on their needs, then met with the level of services that will allow them to be successful in their placement and/or transition as needed. The current overemphasis on housing placement as the key measure of success often ends the process of getting the people the services and support they need when really the process should be beginning.

- **Data analytics teams.** Data needs to be interpreted, assessed, and translated into effective policy.

- **Action teams to operationalize recommendations** and tie policy to the real world.

- **Peers must be at the heart of all of these teams.**

d. **Focus on flow *throughout the entire system***, rather than from one isolated portion of one system to another.

- **Detox, treatment, stabilization, and short term transitional housing are not "offramps" unless people have the next place to go.** Right now a substantial number of people accessing even the small number of detox, treatment and short term stabilization slots that exist do not have a place to be discharged to.

- **Without the next place to go, many people going through detox, treatment and stabilization cycle back to homelessness.** There is tremendous human suffering, and massive investments are wasted.

- **Adding more detox, treatment and stabilization capacity will only add to the number of people cycling back to the streets.** More resources will be wasted, and more people will suffer.

- **To increase flow through the system, the single greatest need is the place for people to be discharged to - readily available long term transitional recovery housing!**

9. **Until a holistic system is created, invest strategically in a few key areas that will have the greatest impact in the short term while building the functionality of the system over time.**

   a. **Long term transitional recovery housing**, for reasons already stated.

   b. **Intensive Outpatient (IOP) and Partial Hospitalization (PH) services**

      i. **IOP and PH are often as effective as residential or inpatient treatment, and significantly less costly. Yet there is very little of this level of service in our current system.**

      ii. **We can achieve one of our highest returns on investment by building out these services, located in proximity to long term transitional recovery and/or deeply affordable housing!**

      "There's a huge gap in appropriate services for all levels of care, but especially highest acuity (especially co-occurring) and those in the middle ("Level 2"), where sober living + IOP/day treatment/partial hospitalization can be as effective as residential treatment."

c. **Effective data management, analytics and information sharing** as described throughout this Report..

d. **Centralized navigation and coordination, with clear and defined leadership and specialized teams to optimize system performance**, as shared throughout this report.

10. **Fund services realistically.** Funding is often orders of magnitude too low to cover the actual cost of services and then people are surprised when programs that are drastically underfunded fail.

11. **Pick the low hanging fruit!** A significant number of detox, stabilization, and other spaces exist but are technically unavailable for a variety of reasons, including staffing and other support. This could be targeted to bring existing spaces into service immediately.

12. **Eliminate technical barriers and streamline contracting processes.**

13. **Stop the one-offs!** Lawmakers often overfocus on new high-dollar solutions, while meanwhile basic needs aren't being met and service providers are having to absorb the costs of the most basic functions - shelter, support, community based services and engagement.

14. **Build flexibility and fluidity into the system** so people can not only move forward but also step back if needed without losing their place and having to start from scratch.

15. **We need meaningful stabilization for people as they move *through* the continuum, not just fragmented "stabilization facilities."**

16. **Acknowledge that some people with the highest needs are not ready for or do not wish to go into housing and help them get what they actually need.** Allow them to be in an SRV or other shelter setting that meets their needs until the right services and housing are available for them. Stay with them through transitions so that they can be successful and stabilize wherever they are.

17. **Meaningfully include people with lived experience and front line providers throughout every aspect of this work!**

18. **Communicate effectively** - with providers, the public, and each other. Proactively and regularly reach out and engage with those on the front line. We truly are all in this together.

Conclusion:

The mental health and addiction crisis affects virtually every sector of government and impacts virtually every resident in our region and our state. People who are vulnerable and/or have been historically marginalized suffer disproportionate impacts of the failure to have an effective, trauma-informed system of behavioral healthcare. And the crisis of homelessness is inextricably linked to the deficits of our behavioral health system, leading to a compounding of harm and suffering. Too often there is a disconnect between policies, funding streams, and the reality of what people actually need to heal and recover. There is also a massive mismatch between supply and demand for services.

As lawmakers have increasingly realized the need for intervention and have begun allocating tremendous amounts of money to address the crisis, it is essential that the voice of people with lived experience of addiction and recovery, academic experts, organizational leaders in SUD prevention, treatment and recovery, and front line workers inform decisions.

A small subset of these leaders came together to express their perspectives, reach consensus on some crucial issues, and share their insights with policymakers in a unified voice. This is not intended to be a comprehensive report representing all perspectives or all of what needs to happen to create a functional continuum for SUD prevention, harm reduction, treatment and recovery. But it provides a framework to guide the development of a system, and highlights some crucial high-impact recommendations that can be implemented urgently in the short term, with benefits that will continue to grow as our system develops and expands.

Thank you for taking the time to review this Report and consider our insights and recommendations.

A special note of gratitude:

I want to thank everyone who participated in these conversations for taking time out of their tireless work to come together to think about the big picture. No one knows better than those on the front lines what works and what doesn't; what barriers and opportunities exist in our current system; and how the pieces can fit together to create a functional continuum of services that is centered on people rather than programs. Every member of the team contributed tremendous value and insight. I believe that if we listen, we can make a difference now, while building a better path forward toward.
Sharon Meieran, MD, JD, Multnomah County Commissioner