Fentanyl State of Emergency 2024

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The Portland City Center Fentanyl Crisis Response Report

May 3, 2024

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Executive Summary

Over the past four years, fentanyl has emerged as a national crisis and a multi-billion-dollar international trade. It demands international, federal, state, and local governments and partners to intervene. Portland has experienced an acute increase in fentanyl trafficking, use, and overdoses in this same period. In Oregon, leaders recognized that a single-pronged approach is not enough; we need to triage the crisis on our streets at every level of government. We cannot afford to operate in silos or choose between a public health or public safety response. Addressing the fentanyl crisis in Portland's central city requires everyone – behavioral health providers from the public, private and non-profit sector, city, county, and state officials, and law enforcement – to respond and work together to close gaps in services to provide services to users and hold sellers accountable.

On January 30, 2024, Oregon Governor Tina Kotek, Multnomah County Chair Jessica Vega Pederson, and Portland Mayor Ted Wheeler each declared a 90-day State of Emergency to address a public health and public safety crisis to operate between January 31 through April 29. The emergency response was a recommendation by the governor's Portland Central City Task Force. All three emergency orders directed the city, county, and state to commit available resources to a unified response within the Portland central city on both the east and west sides of the Willamette River.[1] A command center was activated in the central city where a team of over 50 city, county, and state employees coordinated strategies and response efforts. The Portland Central City Fentanyl Crisis Incident Management Team (IMT) was led by a Unified Command with Commanders representing each jurisdiction.[2] This report details their objectives, accomplishments, and next actions following the end of the emergency orders.

IMT Overview

An Incident Management Team (IMT) was established and staffed by over 50 dedicated employees from city, county, and state agencies. An IMT typically follows the Incident Command System (ICS) which is a standardized approach to incident management that:

- Enables a coordinated response among various jurisdictions and agencies.
- Establishes common processes for incident-level planning and resource management.
- Establishes five functional areas for management of major incidents: command, operations, planning, logistics, and finance/administration.
- Allows for the integration of resources (such as facilities, equipment, personnel) within a common organizational structure.[3]

[1] Appendix A
[2] ♦ Denotes that peer-reviewed evidence identified in a rapid literature review supports this recommendation. See appendix C
[3] https://emilms.fema.gov/is_0029a/groups/27.html

Response Objectives

The coordinated response established the following objectives:

- Augment urban revitalization through additional resources to achieve a clear improvement in livability in the central city.
- Review, refine, improve, and develop systems to coordinate and augment access to: naloxone, housing, treatment, and recovery services in the central city.
- Identify and merge existing health, law enforcement, fire, ambulance, and other relevant data into a meaningful countywide dashboard for response and monitoring purposes.
- List and describe relevant policy options to address gaps and barriers identified through this effort, including likely future scenarios of substance misuse.
- Generate relationships and dialogues between organizations whose work involves fentanyl/housing/substance use disorder treatment etc. across the central city.
- Create a 90-day transition plan to extend and scale up response activities including intermediate and long-term considerations.

Accomplishments

To operationalize the objectives above, the IMT's charge was to refocus existing resources, publicly report data on the impacts of fentanyl in the central city, use data to identify and respond to acute needs and gaps in service, and establish a coordinated system that can be sustained beyond the 90-day emergency declaration period and used as a model for other areas that experience substance related crises.

The 90-day emergency declaration yielded accomplishments in direct response to the objectives as well as additional, secondary outcomes, precipitated by the enhanced coordination resulting from the orders.

<u>Primary Accomplishments:</u>

- **Established a daily (M-F) Rapid Needs Assessment and Coordination Call**

  The daily call included multidisciplinary representatives from the IMT, behavioral health service providers such as the Mental Health & Addiction Association of Oregon, Recovery Works NW, Multnomah County Behavioral Health Resource Center, the Street Services Coordination Center, Portland Street Response, CHAT, Portland Police Bureau, Downtown Clean and Safe, the Multnomah County Sheriff's Office, the Joint Office of Homeless Services and many more. The objective was to combine collective efforts and intelligence to triage areas with acute fentanyl activity and overcome gaps to treatment for users.

- **Established a first-of-its-kind group of data analysts that produced 5 unique overdose data dashboards and a dynamic map of fentanyl-related deaths occurring in Multnomah County (hosted on Multnomah County website)**

Having one, centralized venue across multiple governments and relevant agencies to provide a snapshot of the impacts of fentanyl in Multnomah County was an unprecedented effort that was expedited through the emergency. Data sharing across governments is typically time consuming and tedious, however the emergency afforded the city, county and state the opportunity to not only fast track the data sharing itself, but the distribution on a single platform. Data can now be better used by law enforcement, government, and the public to understand the impacts of fentanyl and progress across the region.

- **Expanded a peer outreach program in the central city between the Portland Police Bureau, the Oregon State Police, and the Mental Health & Addiction Association of Oregon, including funding a coordination center and additional workers**.

In recognition of the early success of this pilot program in winter of last year, the IMT worked with stakeholders to understand what the program would need to be even more successful including a venue to coordinate outreach and additional staff, and requested the city, county, and state to continue it through the year. The expansion, funded equally by the city, state, and county, will continue to bring addiction recovery providers and Portland area law enforcement together to save lives to help some of our community's most vulnerable people.

- **Identified a preliminary private sector partnership in the next steps to address the fentanyl crisis.**

To fully leverage leadership, actions, and momentum created from the 90-day response to address the fentanyl crisis, a long-term, sustained, and resourced effort. This work will require a small, dedicated team funded by private sector investors coordinate with the city, county, and state to strengthen and expand the substance use disorder (SUD) Continuum of Care in partnership with the homelessness response system. Preliminary discussions with United Way Columbia Willamette (UWCW) are underway to be a conduit for private-sector involvement.

<u>Additional Accomplishments:</u>

- Directed the county's Emergency Medical Services (EMS) program to establish a practice of rapidly deploying naloxone at county managed severe weather shelters.
- Established an incident command center and facilitated collaboration and communication between 50+ government staff from the city, county, and state that had not previously worked together.
- Requested Multnomah County Health Department to convene a fentanyl summit with 150+ diverse community partners to better understand existing work across the county and identify new ways to collaborate and coordinate.
- Expanded the Portland Police Bureau (PPB) Central Bike Patrol to increase police presence in the central city in the evenings and on weekends.

- Expanded the PPB Narcotics and Organized Crime (NOC) unit to focus on both overdose death investigations and increase capacity for drug supply interdiction efforts with regional and federal law enforcement partners.
- Coordinated distribution of naloxone throughout the central city.
- Established a website through Multnomah County, with weekly updates to the public.
- Temporarily suspended two Bottle Drop sites associated with fentanyl activity to provide relief to neighbors and gather data on impact to community wellness and safety.
- Initiated a land exchange between the Portland Bureau of Transportation and Oregon Department of Transportation to provide additional capacity for Safe Rest Village shelter.
- Secured 52 housing placements for clients at the Clinton Triangle Temporary Alternative Shelter Site (administered by All Good Northwest, in partnership with Urban Alchemy and the City of Portland), as part of the Housing Multnomah Now pilot program.
- Leased seven units at the Ankeny Apartments run by Central City Concern for individuals who are post-detox and/or treatment and working with the City's Outreach team.

Cumulative summary of Situation Status Report Metrics as of 4/24/2024		
Reporting Metrics	***Cumulative Amount**	**Comment**
Number of arrests for fentanyl distribution	19	PPB, MCSO, OSP
Grams non-fentanyl narcotics seized	70.9 gm	PPB, MCSO, OSP
Grams fentanyl seized	420.47 gm	PPB, MCSO, OSP
Number of M110 citations	310	PPB, MCSO, OSP
Number of treatment or detox referrals	79	PF&R-CHAT, PP&R, PSR, SSCC, CCC, BHRC-MHAAO, PPB, MC HR, VOA
Number of shelter referrals	292	SSCC, PF&R - CHAT, PP&R, CCC, VOA
Number of housing program referrals	33	PF&R/CHAT/PSR, SSCC, CCC, BHRC - MHAAO, MC HR
Number of naloxone doses distributed	4,216	PF&R /CHAT/PSR, PPB, PP&R, SSCC, CCC, BHRC - MHAAO, VOA, MC HR
Number of overdose reversals	178	PF&R/CHAT/PSR, PP&R, BHRC - MHAAO, VOA SSCC
Number of buprenorphine inductions	6	PF&R/CHAT/PSR, BHRC - MHAAO
Number of aftercare engagements	825	PF&R/CHAT/PSR
Number of outreach contacts	1,692	SSCC, PF&R/CHAT/PSR, CCC, BHRC - MHAAO
Number of lights installations / upgrades	50	PEMO, Enhanced Service Districts -through 4/6/24
Number of blocks of sidewalk washed	196	PEMO, Enhanced Service Districts -through 4/6/24
Number of blocks of sidewalk power-washed	78	PEMO, Enhanced Service Districts -through 4/13/24
Number of areas washed with enzyme for bacteria removal	35	PEMO, Enhanced Service Districts -through 4/6/24

* Some cumulative numbers have changed due to recent verification by data analysts

Next Actions

The following are a set of next actions that have been vetted and prioritized by Unified Command as the most crucial to address the fentanyl crisis in the near term. These next actions reflect the voice and input of dozens of community partners and IMT members with lived and professional expertise. Details and additional next actions that are project-specific are described in the full report. The next actions are:

- Develop an intake facility that accepts referrals from all sources (law enforcement, community organizations, medical professionals, etc.) to match those seeking SUD treatment to the appropriate level of care and supportive services.
- Support the Joint Office of Homeless Services to bring a shelter bed tracking system online as soon as possible.

- Increase staffing for key public services, including behavioral health services, street outreach, and first response services, during evenings and weekends as much as possible.
- Continue to saturate high-risk areas and groups with naloxone.
- Create and support mobile clinics offering Medically Assisted Treatment.
- Inventory and evaluate culturally-specific services.
- Continue coordination across jurisdictions with one representative assigned on a coordination team to facilitate ongoing discussion between first responders, service providers, related programs, and partners.
- Expand Oregon Health and Science University (OHSU) Mission Control's capacity to provide real-time addiction treatment bed-tracking system.
- Assure that a range of recovery housing options exist to support individuals in different stages of recovery.
- Use data for evaluation to drive more action.

Conclusion

The IMT was tasked with executing a viable set of strategies to address fentanyl-related problems in the central city. This includes addressing overdoses, recreational use and abuse, dealing, arrests, deaths, treatment access and more within the three-month time frame. Staff worked tirelessly to approach each objective of the response with integrity and a commitment to serve those who have been impacted by fentanyl use and the public at large. People who have never spoken to one another began collaborating and sharing ideas to address an unprecedented emergency declaration that had no pre-existing framework for how to properly approach the many variables at play during a drug-related response.

The IMT faced challenges, many of which were successfully addressed throughout the duration of the response. How to address logistics, data, personnel, requests, and city-wide/county-wide coordination while thoughtfully crafting multiple ways of approach for every fentanyl-related issue in Portland was meticulously questioned, discussed, and carried out by different sections of the IMT.

This was an incredible task to execute in three months, and an enormous amount of time, empathy, consideration, and planning went into the work accomplished by a dedicated staff. The projects and recommendations presented have been scrutinized, discussed, and implemented to the degree appropriate for 90 days with the utmost importance being placed upon equity considerations, safety, and feasibility for our communities.

Fentanyl is so dangerous, so addictive, so accessible, and so present in the central city of Portland. This is a topic everyone wants to address and solve. The IMT and coordination partners have begun that discussion, and many others for that matter, to create sustainable positive change in our community. Although the outcomes are imperfect, and there is still work to be done, we must start making strides, and this is a great leap.

IMT Actions Overview

The executive summary above describes primary and secondary accomplishments of the IMT and the associated work. The report is organized by IMT actions over the course of the emergency declaration that should continue and be expanded on. It concludes with additional long-term actions based on input from a wide range of subject matter experts (SMEs) brought together by the emergency declaration.

IMT Actions Recommended to Continue and Expand

Harm Reduction and Behavioral Health

For the purposes of the work during the emergency declaration, the IMT defined *harm reduction* as naloxone use, distribution, and training. The IMT worked with service organizations and first responders to saturate the emergency's focus area with naloxone offered free of charge, no questions asked.

During the emergency, the State Opioid Settlement Board funded an immediate naloxone purchase for the state clearinghouse. However, due to the lack of sustained funding, additional purchases will require support during the next legislative session. Reducing naloxone costs to distributors and consumers will increase access. Additionally, naloxone was placed in the Joint Office of Homeless Services (JOHS) warehouse downtown. When a winter storm hit during the emergency declaration period and severe weather shelters opened, the IMT directed the county's Emergency Medical Services (EMS) team to rapidly deploy naloxone at those shelters. On-site training was provided to shelter staff to prepare them to respond to opioid-related incidents.

Data and Service Mapping

The Data Group brought together during the emergency declaration joined analysts from city, county, and state agencies and SMEs to address the response-related data needs and requests. The Data Group created mechanisms to report a series of metrics related to the fentanyl crisis and developed a process to track activities reported by law enforcement, health and medical workers, outreach and shelter referral workers, substance use treatment facilities, and livability data. Response activity reporting was accomplished with a situation report (SitRep) that was distributed weekly during the 90-day emergency to IMT staff and published publicly on the website by the Joint Information Center (JIC). Information reported included progress toward meeting incident objectives and expectations from Agency Administrators' Letter of Expectations.[4]

[4] Appendix D

One of the Data Group's key successes during the emergency was the development and publication of a dashboard of fatal and nonfatal fentanyl overdoses with data from five sources.[5] This public dashboard of data helped the IMT understand incongruities in data collection across organizations that could be addressed. This emergency declaration allowed for multi-agency data sharing and increased speed for making data publicly available. The team also sought service information, compiling a comprehensive list of SUD, housing, sheltering, outreach, and criminal justice organizations operating within the central city.

An additional dashboard, with counts and percentages of SUD treatment services provided by Multnomah County vendors, is in development by the Multnomah County Health Department (MCHD), Division of Behavioral Health, with draft completion expected during summer of 2024.

The Data Group also created a new data inventory of agencies and the types of fentanyl-related data they collect.[6] Only a few organizations had developed datasets related to fentanyl use and overdoses, and in other cases, datasets were not recorded in compatible ways. For example, the Data Group could not incorporate law enforcement data into the overdose dashboard because of the way that those data are processed. Collecting response activity data proved to be difficult because of the lack of a unified data infrastructure within the organizations/agencies that were active in the focus area. Additionally, every service provider offers slightly different services within the central city, making it difficult to standardize and categorize data that informs decision-making. No two treatment providers offer the same types of treatment with the congruent requirements for entry, and it is not abnormal for a single organization to provide some combination of outreach, stabilization, detox, and treatment.

Social Network Analysis

The Social Network Analysis mapped the community of interest and partners involved in the fentanyl crisis response to improve communication between organizations and network efficiency. The initial identification of primary partners and stakeholders is complete. IMT network analysts are interviewing partners and constituencies to identify and code relational ties between individual members of the network addressing the multiple problems associated with the fentanyl epidemic. Once the initial network visualizations and objective visualizations are complete, a course of action to identify solutions to address the gap between current network structure and optimal network structure can be initiated.

[5] Appendix E
[6] Appendix E

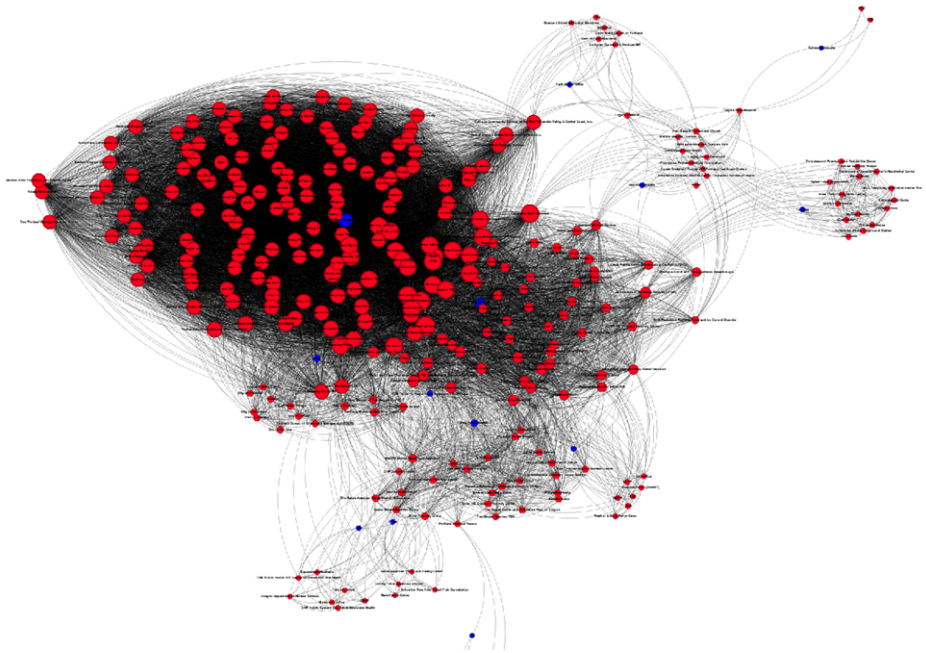

Figure 1. Portland Fentanyl Response Community of Interest

Figure 1 depicts the almost 300 organizations with a direct role in fentanyl response, from law enforcement to medical responders to graffiti abatement. Nodes in red depict organizations, while nodes in blue depict the roles that organizations support within the community of interest. Law enforcement organizations, for example, are depicted in a small cluster and linked to the blue node labeled LE. In this graph, the node size reflects the relative centrality of the nodes, which in this graph indicates nothing more than the percentage of the community of interest in support of that role. The largest nodes (easily identified in a large cluster in the upper left) represent the many Community-Based Organizations (CBO) which form the contact layer of fentanyl response. Early assessments support the general conclusion that CBOs are the center of gravity in fentanyl response, and efforts to support and empower CBOs will likely provide the greatest return on investment.

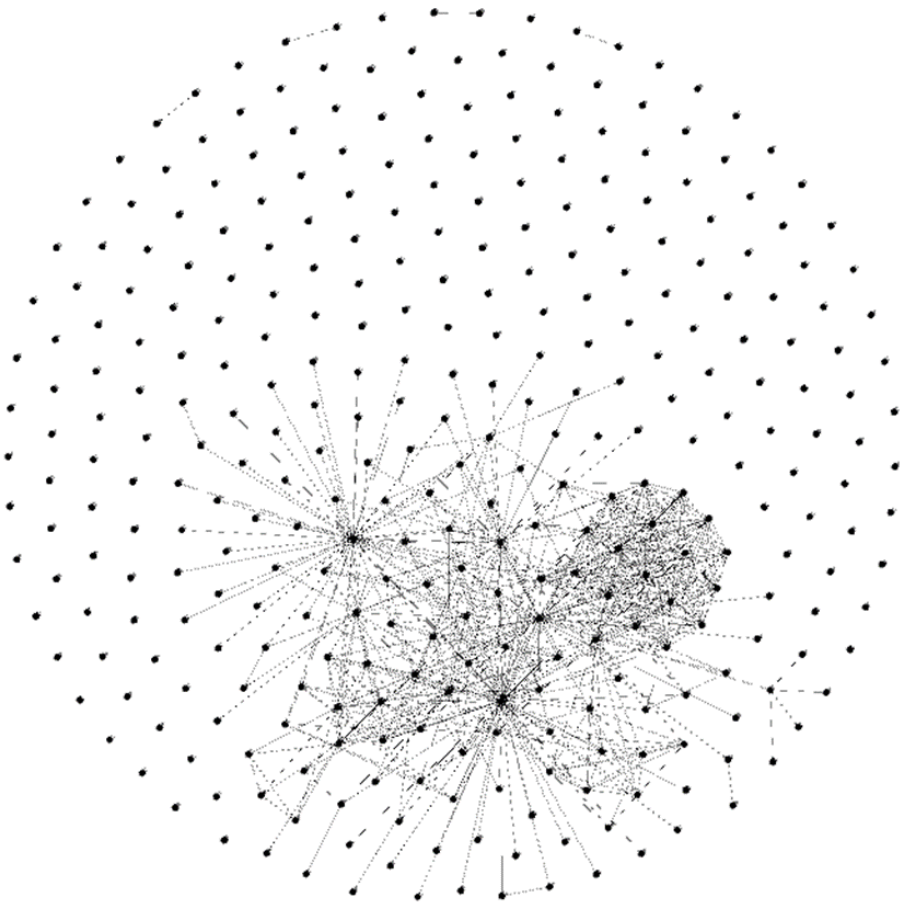

Figure 2. Fentanyl Response Community of Interest Ties

Figure 2 represents the identified relational ties between members of the fentanyl response community of interest. This graph does not represent the number of ties that exist. It represents only the number of ties that have been identified. While several cohesive subgroups (subnetworks of well-connected actors) have been identified, relational ties between many stakeholders have not been reported. Figure 3 has been excluded from the report to protect identities. However, it demonstrates the interconnectedness of several organizational partners in the fentanyl response. [7] Several organizations (and their assigned, employed, or volunteer personnel) support more than one role in the fentanyl response. This graph highlights the connection between the IMT and response partners, where ties are based on structural equivalence, or similar roles in response. This graph depicts only role-based ties and will increase in density dramatically as relationships between individual actors are identified, coded, and visualized.

[7] Figure 3 is excluded from the report to protect identities.

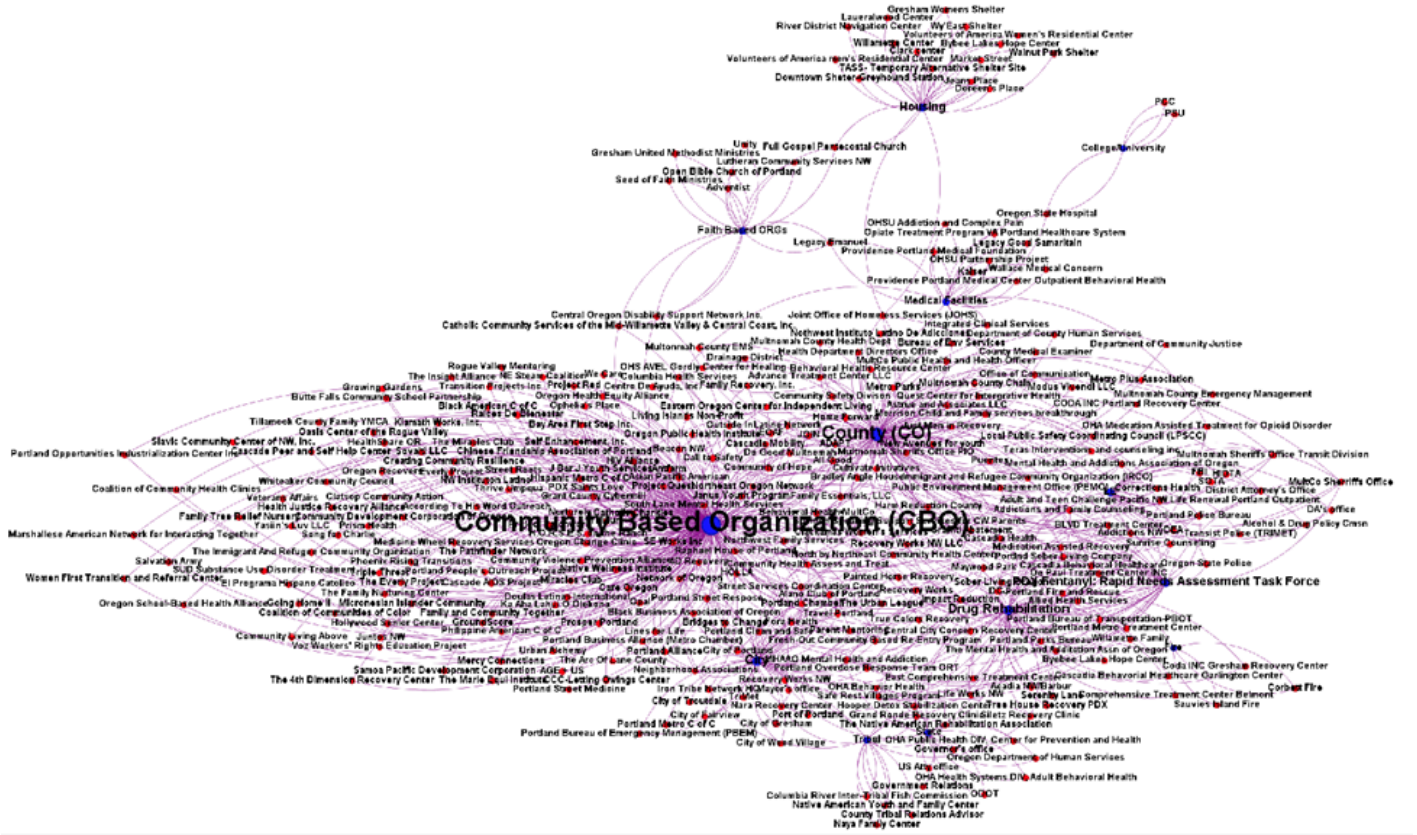

Figure 4. Fentanyl Emergency Response Community of Interest by Role

The IMT network analysts are currently collecting and coding relational data between response partners and stakeholders in preparation for more detailed analysis. Data collected includes exclusively publicly available information, such as individual name and response organization represented as well as fentanyl response roles and efforts supported by sponsoring organizations. Only professional ties such as organizational, coordination, and support are reported. The interpersonal work ties will enable response planners to identify robust networks ideal for support to specific lines of effort, as well as identify less-connected networks that require focused development to optimize response capabilities.

Outreach and Education

The emergency declaration demonstrated growing gaps in our systems that consistently create inequitable outcomes in our community. Through individual outreach, listening sessions with government agencies, a large summit, and regular convening of frontline workers, the new Equity Needs Assessment focused work or recommendations on six communities at high risk for overdose.[8] The emergency response focused on engaging folks on the street, disrupting street supply, and linking people to treatment services. Going forward, there must also be a focus on prevention, including for youth, BIPOC, and LGBTQ+ communities.

[8]Appendix H

System partners have robust, if incomplete, sources of overdose information. They lack more granular information about the experiences of people who use fentanyl, including what their primary concerns are, barriers they face to services, unmet needs, how they receive health and safety information, and what their perception of the fentanyl response has been. The March Fentanyl Summit recommended that leaders incorporate community wisdom by consulting with those with lived- and living-experience.

Substance Use Treatment and Recovery Support

The IMT immediately identified substance use treatment and recovery support as a critical element for the 90-Day Emergency Declaration. After holding listening sessions with community partners, meeting with substance use disorder (SUD) service providers, and gathering community feedback, the IMT identified the need for an increase in clinical sites that offer access to effective opioid use and dependence treatments. Methadone is an example of a dependence treatment that can be used for motivated individuals seeking medication for opioid use disorder (MOUD). To make methadone more readily available for people seeking medication for OUD, action was taken to create mobile options in the Portland city center.

Options were evaluated to use available supportive housing services (SHS) to bring more recovery supportive housing online, initiate conversations with coordinated care organizations (CCOs) to identify ways to partner and collaborate with them after the emergency declaration period. These partnerships expand the dialogue on how best to make more services reimbursable and align with relevant best practices and standards developed by CCOs.

First Responders: Law Enforcement and Other Responders

Law enforcement efforts targeting the supply of fentanyl and other drugs serve a critical role in responding to the impacts across Oregon. Fentanyl has prolific international origins that require coordination across local, state, and federal law enforcement agencies. Portland is just one destination along several transit channels that constitute the Oregon-Idaho High Intensity Drug Trafficking Area (HIDTA).

The Oregon-Idaho HIDTA consists of 16 counties in Idaho and Oregon, including Multnomah County. Working together, law enforcement agencies, including the Portland Police Bureau (PPB), the Oregon State Police (OSP), and the Multnomah County Sheriff's Office (MCSO), coordinate with federal law enforcement agencies in a task force to respond to the increasing flow of drugs into the Portland metro area. Critically, these efforts also include significant collaboration with both the United States Attorney's Office and local prosecutors.

Efforts during the Emergency Declaration also led to successes around funding. The city, county, and state together allocated $683,000 for a pilot partnership between Portland Police, providers, and the MHAAO to provide a coordination space, staffing, and a van to connect individuals with services.

Spotlight: The Community Health Assess and Treat (CHAT) Program

Portland Fire & Rescue partnered with CareOregon to create the CHAT program to address community needs and emergency department overload. CHAT focuses on responding to low-acuity 9-1-1 calls, treating patients in the community, and connecting them to resources instead of transporting them to the emergency department. The aftercare team follows up with patients after the 9-1-1 call to provide nurse case management, including wound care and in-field treatment for patients with complex health care needs. CHAT not only responds to overdose calls but also provides naloxone training for both the individual served and anyone adjacent (typically a friend or bystander), and leaves behind naloxone.

In collaboration with the Tri-County Health Officer, CHAT offers MOUD such as buprenorphine, a warm handoff to MOUD clinics, and close follow-up to facilitate ongoing treatment services. The MOUD pilot program started in February 2024. The MOUD pilot is a collaboration with CareOregon, Multnomah County, Oregon Poison Control, and Central City Concern.

Preliminary Data: MOUD pilot (Date Range: February to April 2024):

- Overdose engagements – 9
- Buprenorphine inductions – 6
- Warm hand-off to MOUD clinic – 7
- Aftercare follow-up visits – 96

During the emergency declaration, CHAT's Overdose Response Team diverted 48% of 9-1-1 calls they received from local emergency departments. This team improved the emergency health care system by implementing a "single-role" response team that eliminates requests for additional fire or ambulance services.

CHAT's aftercare program provides low-barrier transitional support to promote stabilization. It is well documented that buprenorphine reduces the mortality rate of those with OUD by 62%. By providing naloxone to clients and bystanders and administering MOUD medication in the prehospital setting, many lives are saved.

Throughout the emergency declaration period, the IMT frequently heard two primary requests related to law enforcement efforts. First, the need for increased staffing to expand law enforcement presence during the evenings and weekends. During daily coordination calls, service providers expressed an interest in working with first responders to accomplish this. Second, the need for holding arrested drug dealers in jail until the first court appearance.

In response, PPB has committed to increasing staffing for both the Neighborhood Response Team and Narcotics and Organized Crime Unit. PPB is adding four new officers and a sergeant to the NRT, which will provide increased evening and weekend police presence. PPB will also add two detectives to the NOC unit focused solely on overdose death investigations and two officers and a sergeant to increase capacity for the larger supply interdiction efforts with our regional partners.

Homeless and Housing Services

In January 2024, Governor Kotek signed Executive Order (EO) 24-02 to maintain the added capacity to the state's shelter system, rehouse people experiencing homelessness, and prevent homelessness to merge and further extend the State of Emergency Due to Homelessness (which began as EO 23-02). JOHS is working with Oregon Housing and Community Services to establish goals for EO 24-02, Oregon Rehousing Initiative.

Multnomah County's active pilot project, Housing Multnomah Now (HMN), aims to rehouse 300 unsheltered households by summer of this year. HMN has been active in the Old Town neighborhood for several months, engaging with individuals living unsheltered, including providing basic needs and housing navigation services. HMN's work has so far resulted in 16 successful housing placements combined with services and 40 additional connections to housing navigation services.

Multnomah County and the City of Portland unveiled a strategic reset of the community's response to homelessness – the Homelessness Response Action Plan (HRAP). This plan is a comprehensive two-year road map for improving our community's response to homelessness. The plan commits to improve detailed goals and metrics, budgeting and financial reporting with increased transparency, data sharing, and establishing a new governance structure that expands and unifies the work of addressing the root causes of homelessness.

Among other key goals, the plan includes new metrics and other concrete steps on how the community can work together to house or shelter at least 2,700 more unhoused individuals over the next two years. Many of the needs expressed during the 90-day fentanyl response are addressed in the HRAP.

During the emergency declaration period, there was also success with a land exchange between Portland Bureau of Transportation (PBOT) and Oregon Department of Transportation (ODOT) to expand the Queer Affinity Safe Rest Village. State and private partnership funding for pods ($2,000,000 for duals before or after detox or treatment) is in the works.

Livability

During the emergency declaration, the response team worked to increase livability by utilizing environmental design intended to lower crime in partnership with the City's Public Environment Management Office (PEMO) and Downtown Clean and Safe. Through these programs and their community relationships, the response team was able to learn more about experiences of community members who work and live in impacted areas and identify action to help revitalize them. Actions taken were graffiti abatement, trash removal, street and sidewalk cleaning, addition of barriers, and place-based lighting. PEMO focused on this work prior to the emergency declaration and collaborated with the IMT in focus areas during the emergency. PEMO worked to address issues in the primary hotspots in the areas of SW 10th and Jefferson, the South Park Blocks, and the Multnomah County Central Library, which reopened during the

emergency. This work will be ongoing as further hot spots are identified after the 90-day emergency by the continuity team and partners.

Under the Governor's direction, the Oregon Liquor Control Commission (OLCC) suspended enforcement of bottle returns at one hot spot location and tracked bottle returns at all central city sites. Bottle returns did not clearly align with police calls for service, and improvement at the bottle drop sites seemed to be the result of concentrated effort by law enforcement and outreach workers rather than suspension of bottle returns. However, the bottle return data and input from sites that accept bottle returns led to recommendations for program improvement, including a recommendation that retailers should not be required to accept late-night returns.

Collaboration

One of the IMT's most crucial focus areas was cataloging and developing resource collaboration. Providers cannot take the most effective action without understanding the ecosystem in which they work.

Prior to the emergency declaration period, there was no communication hub connecting the many agencies and service providers who address the fentanyl crisis in the focus area. Providers did not have a comprehensive understanding of who else was working on this issue, their specialties, and their qualifications for care. During the emergency, the daily PDX Fentanyl Rapid Needs Assessment Collaboration Call created a broader multidisciplinary approach and provided a vital touchpoint for many working on this crisis. By sharing aloud and in chat, as well as reporting out in finer detail in the video call's associated Activity Collection Forms, participants not only developed their broad knowledge of activity in the city but also were able to directly connect their teams with real-time available resources to help those in need. The invitee list grew as resources were realized, so the knowledge base was always expanding.

The Rapid Needs Assessment Collaboration Call resulted in significant de-siloing of service, outreach, and patrol resources in the focus area. Due to the success downtown, the appendix to this report includes a description of how additional neighborhoods and areas can use the structure created to individualize a coordinated response to other identified areas of need.

In addition to regular calls and report-outs, the IMT realized the benefit of dedicated in-person coordination. The Fentanyl Summit brought together more than 150 community members, government staff, and clinicians. Though there had been other opioid summits, this was the first dedicated to fentanyl. While discussing outreach, harm reduction, recovery, the justice system's role in withdrawal management, and data, among other topics, participants emphasized the perspectives of those providing culturally-specific care and those with lived experience.

Repeatedly when people came together, they asked for centralized trackers, databases, and codebooks. Much of this falls under data and technological needs, but the policy recommendation spreadsheet appendix documents the collaborative work being done. It also

identifies housing, health, and law enforcement gaps and obstacles, and details specific policy recommendations to leaders and lawmakers for better coordination.[9]

Partnership and collaboration also manifest in very concrete ways, such as the proposed expansion of OHSU Mission Control's real-time treatment bed-tracking system. Initially created to track hospital beds during the pandemic and then expanded to include behavioral health beds, the bed tracker now includes a 24-hour staffed coordination center to support patients who would benefit from a different level of care. The IMT along with OHSU are exploring expanding this app to track withdrawal management and SUD residential treatment services beds. Additional funding may be needed[10] to fund staff within the OHSU coordination center to assist with data collection, following EHRs (electronic health records) protocol or establishing viable workarounds, as well as for staff within provider organizations to support any needed IT expansions and regular data entry.

Spotlight: Community Engagement

Many organizations across Portland have a long-term commitment and history of community engagement and education work. This important work, while not initiated by the 90-Day Fentanyl Emergency, provides essential contributions to decreasing the negative impacts of fentanyl in the community. Several programs are spotlighted here:

County Public Health Community Partnership and Capacity Building ("CPCB") Indigenous communities liaisons are working with the Future Generations Collaborative to create by May a Native-specific opioid overdose training for Native community health workers. This training could also be tailored for community members.

CPCB Latinx community liaisons share information with the community on the 90-day emergency during monthly Colaboradores Latinx meetings. One meeting incorporated a workshop presented by the County Harm Reduction team. They plan to host a training follow-up on further information on harm reduction in the coming months.

The County Prevention and Health Promotions team ("PHP") focuses on upstream prevention strategies for drug overdose in an approach that is culturally specific and focused on working with adolescents and various marginalized and intersecting identities. They work in schools, collaborate with the Student Health Action Council, and partner with four community coalitions to conduct presentations and workshops introducing topics such as fentanyl, harm reduction, and Measure 110. The groups have included diverse youth and populations including but not limited to Black/African American, Native, Latine, and Pacific Islander youth, immigrant and refugee youth, LGBTQIA2S+ youth, and youth with disabilities.

[9] Appendix H
[10] Appendix H

Under the REACH Program, the Public Health Leadership Academy has engaged youth in identifying podcast topics, including ones on fentanyl and the implications of Measure 110 for youth. REACH aims to host these discussions before the end of the school year. At the request of the Oregon Health Authority (OHA), REACH will partner with OHA to organize a community forum with our ACHIEVE Coalition in late May. Additionally in collaboration with OHA, REACH will host a forum for the African immigrant and refugee community, who requested support after several overdoses in the community.

The majority of Promoting Access To Hope (**PATH)'s** full-time staff have cultural or population-specific lived experience. In addition, 80% of the organization's contracted addictions and prevention programs are culturally specific, gender specific, and/or justice involved, with targeted (African American, Latinx, Indigenous, LGBTQ, Gender Specific, Justice Involved) including:

- Residential and Outpatient SUD Treatment
- SUD Supportive housing
- Population specific recovery groups
- Targeted prevention messaging for marginalized communities.

Future Action and Further Development

Unified Command has engaged the private sector to develop a strategy to sustain a multi-government, multi-disciplinary approach following the emergency declaration period. It will require persistence, resources, and coordination between the public and private sectors to sustain a meaningful response, and this exploration is currently underway. Below are the actions identified by the IMT and SMEs that require further development:

- Continue to invest in activities and strategies (i.e., establishing goals that require cross-sector collaboration, identifying shared metrics) that support coordination, communication, and relationship building.
- Track and coordinate policy and legislative development efforts across the city, county, and state, with an emphasis on expanding continuum of care capacity, prevention, workforce development, technology tools, and efforts focused on communities of color, LGBTQIA+, and other communities disproportionately impacted by the fentanyl crisis and underrepresented in care.[11]
- Build a fully staffed multi-agency data team with designated leaders and analysts. Staff response activity areas with project managers to track relevant metrics.[12]

[11] Appendix H
[12] Appendix N

- Establish a data integrity process that dates, vets, and stores data and information being collected in a way that can be referenced.
- Use epidemiological data on overdoses for situational awareness rather than to assess the effectiveness of short-term interventions.
- Continue to improve fentanyl overdose data sharing among organizations.
    - Formalize data sharing agreements among MCHD, PF&R, and Bureau of Emergency Communications to continue updates for the overdose dashboard.
    - Extend data-sharing agreements among governments to service providers to continue to provide consistent, repeatable, and transparent data collection and information sharing with the public.
    - Consider opportunities for data sharing through centralized data repositories.
- Develop an outline describing the benefits and challenges of making nonfatal overdoses a reportable condition.
- Coordinate with Oregon Recovers and their app Recovery Network of Oregon, a map application that anonymously connects individuals with treatment options.
- Place a geographic information system (GIS) overlay of treatment agencies and partners on a map of the focus area and countywide to show what substance use treatment services are available.
- Collect, analyze, and report data to frontline workers and community members.
- Continue service mapping by determining relationships among organizations (who they work with and for and identify any gaps that this analysis can assist them to better their work for fentanyl support).
- Build a peer overdose response team that includes people with lived experience in partnership with harm reduction service providers.
- Expand safe syringe programs to lower the risk of HIV, hepatitis C, and other harms associated with injection drug use.
- Modify bottle return rules to allow retailers to close bottle returns during late nights.
- Further analyze data on BottleDrop return closure impacts.
- Enforce consistent OLCC rules at all bottle return sites.
- Expand PF&R CHAT and PSR EMS Naloxone Leave Behind policy to all of PF&R and expand into all countywide EMS & first responder programs.
- Seek funding to support continued purchasing of naloxone.
- Initiate naloxone distribution using the JOHS warehouse for central distribution to county outreach teams (including harm reduction, behavioral health, and housing services teams).
- Maintain city/county/state data sharing through an MOU and continue sharing overdose data through the dashboard on the county fentanyl webpage.
- Continue to leverage Joint Information Center (JIC) to boost MCHD recovery education campaign.
- Create community-specific educational and communications needs to support harm reduction and prevention that is culturally-specific and time-sensitive.
- Continue to inventory and evaluate culturally-specific services. The Fentanyl Summit helped accelerate efforts to assure the availability of low-barrier, high-quality services to communities who suffer disproportionately from the harms of addiction.

- Continue PF&R's CHAT program in coordination with Portland's Street Services Coordination Center (SSCC) and other shelter teams.
- Continue Mental Health & Addiction Association of Oregon (MHAAO) coordination with SSCC and other shelter teams for reserved pods specifically intended for individuals entering pre-detox and/or treatment or post-detox/treatment (which started during the emergency).
- Develop and expand multi-jurisdictional partnership among PPB, MCSO, and OSP to mobilize joint operation opportunities and a long-term task force to address fentanyl-related issues in the central city.
- Implement the pilot partnership between Portland Police, providers, and the MHAAO that was funded during the emergency by the state, county, and city.
- Increase safety for social service workers, law enforcement, and security on nights and weekends. Reduce overtime and add additional staff for nighttime and weekend shift outreach.
- Continue Housing Multnomah Now pilot program through the end of June 2024.
- Develop data governance process that is led by the values of racial equity and data justice in data use and matching; include people with lived experience and community partners.
- Continue PEMO investment in lighting and other environmental design improvements in areas experiencing livability concerns, including collaborating with the Multnomah County Central Library.
- Continue to invest in activities and strategies (i.e., establishing goals that require cross-sector collaboration; identify shared metrics) that support coordination, communication, relationship building.
- Track and coordinate policy and legislative development efforts across the city, county, and state, with an emphasis on expanding continuum of care capacity, prevention, workforce development, technology tools, and efforts focused on communities of color, LGBTQIA+, and other communities disproportionately impacted by the fentanyl crisis and underrepresented in care.[13]
- Hold quarterly fentanyl summits hosted by MCHD with a focus on different topics (e.g., outreach, treatment), and prioritizing disproportionately impacted communities.
- Centralize fentanyl-related mapping and analysis through the City Bureau of Technology Services and Corporate GIS and provide a single point of contact for coordination with Multnomah County.
- Align recommendations to pre-existing and ongoing efforts including, but not limited to, the Multnomah County Health Department Overdose Prevention and Response Plan, Homeless Response Action Plan, Portland Solutions, and Portland City Transition planning.
- Support expansion of OHSU hospital bed tracker to include treatment beds.
- Expand the PATH program so that it is adequately staffed to provide care coordination for those referred to triage.
- Improve coordination of care for people exiting correctional facilities.

[13] Appendix H.

- Consolidate phone and in-person assessments for shelter sites.
- Create spaces to secure individual's belongings while in detox, treatment, or shelter.
- Increase options that allow for animals and couples housing.
- Improve facilitation from handoff from first responders and outreach workers to housing and treatment services.
- Increase availability of immediate transport to services.
- Pilot the Intrepid Response situational awareness app for a 90-day beta test in Portland.
- Coordinate with Volunteers of America (VOA) to conduct outreach with police in the evenings.
- Create a livability map to report areas of concern and interventions deployed.
- Facilitate recurring coordination calls (such as the Rapid Needs Assessment Coordination Call) between multidisciplinary teams that build partnerships across organizations.
    - Create District Coordination Action Teams (D-CAT) that represent a diversity of fields, including SUD and behavioral health street outreach, crisis response, transit, and law enforcement. Hold monthly strategy and planning calls. Allow organizations to send the appropriate representative for this call.
    - Hold weekday operational coordination calls with a focus each day on each of the four future city districts and a fifth day for East County. Allow organizations to self-select which calls to attend.
    - Determine what activity metrics would be captured and disseminated.
- Facilitate a shelter bed tracking system that JOHS will launch by November 2024.
- Explore harm reduction vending machines, naloxone distribution in all city and county government buildings, and expanded leave behind policies.
- Research impact and viability of overdose prevention sites in Multnomah County to increase the scope of local comprehensive harm reduction strategies.
- Expand drug supply testing by creating sites for fentanyl users to bring their drugs to be tested and/or explore the viability of distributing fentanyl test strips.
- Invest in return centers that have a social justice focus, provide homeless community services, and welcome returns from people experiencing homelessness.
- Develop targeted fentanyl awareness health education campaigns.[14]
- Conduct a study of specific and unique aspects of fentanyl and needs of fentanyl users in Portland.
- Expand the PATH program to include at least three additional culturally-specific peer outreach workers focused on the communities reflected by the data dashboard.[15]
- Fund PF&R's CHAT Overdose Response Team to operate 24/7 so that they can respond to overdoses at all hours.
- Explore new reimbursement models with CCOs to fund recommended expansions to SUD treatment and recovery support services.
    - Identify ways for potential reimbursement of pre-treatment activities.

[14] While there is literature that supports the use of education campaigns to reduce fentanyl, these must be taken on carefully to reduce risks of inadvertently increasing drug use due to ineffective messaging and/or targeting of appropriate populations. See Literature Review for more discussion.
[15] See Data and Service Mapping section.

    - Increase reimbursement for peer support services.
    - Identify areas where Medicaid reform would improve outcomes for those with MOUD.
- Develop a triage center that includes sobering within its operations, which is often called observation beds, or it can be designed to send individuals out to a sobering center. Unified Command acknowledges the need for both triage and sobering functions.
- Expand funding culturally-specific programs, such as The Miracles Club, Bienstar, Tribal-specific communities, African-American Medical Providers Network, IRCO, and African-specific organizations, based on the proportion of impact the community experiences instead of the demographic representation within the general population.
- Examine options to modify Oregon Administrative Rules for Social Detox. OHA will accept variance requests, but changes cannot be made to American Society of Addiction Medicine (ASAM) criteria as it is a national standard.
- Fund program evaluation and include it early in program design and assure it lasts through final review.
- Connect tribally-affiliated persons with appropriate resources. Compensate Native and tribally specific organizations to provide culturally humble training to first responders about how to ask drug users if they have a tribal affiliation, in order to better connect people with tribally-specific substance use treatment, peer and housing resources, and better coordinate with tribal law enforcement partners.
- Fund a pilot program proposal for an alternative shelter site to partner with Cultivate Initiatives to start a workforce development program by teaching life and work skills to residents.[16]
- Create a targeted health education campaign around fentanyl awareness, including its presence in most recreational drugs and pressed pills, and the risk of xylazine. The campaign should be designed to reach family and friends of people who use fentanyl, as well as users themselves, focusing on education, access to resources, and harm reduction; it should avoid scare tactics and stigmatization.
- Continue PF&R's CHAT program in coordination with Portland's Street Services Coordination Center (SSCC) and other shelter teams.
- Continue Mental Health & Addiction Association of Oregon (MHAAO) coordination with SSCC and other shelter teams for reserved pods specifically intended for individuals entering pre-detox and/or treatment or post-detox/treatment(which started during the emergency).
- Expand the SUD system of care to include mobile MOUD services.
- Designate an organization to create connections for those who access mobile or other MOUD services to recovery supportive housing.
- Have real-time bed availability information for individuals seeking placement in withdrawal management or SUD residential treatment.
- Expand MOUD options, including but not limited to mobile methadone treatment that supports improved linkages for those seeking treatment and recovery services.[17]

[16] See Appendix S.
[17] Gap funding could cover staff and operational costs for a first pilot phase.

- Research impact and viability of overdose prevention sites in Multnomah County to increase the scope of local comprehensive harm reduction strategies.
- Remove barriers for peer educators/outreach workers with lived experience of substance use with criminal backgrounds to join the workforce.
- Monitor the MCHD and OSP pilot program to streamline suspected overdose death reporting and confirm suspected overdose deaths. Continue the pilot if it achieves the stated goal.
- Increase Medication Assisted Treatment (MAT) capacity in county jails and detention centers to include therapeutic dosing of U.S. Food and Drug Administration (FDA) approved MOUD, i.e., naltrexone, buprenorphine, and methadone. This will reduce overdose during and after incarceration and decrease racial disparities.
- Fund $228,000 to Fora Health treatment center for guardrails to reduce emergency room visits for patients in withdrawal. Guardrails are shown to reduce patient injury by reducing falls.
- Negotiate changes to labor agreements and understand any legal or legislative barriers to allow PSR and CHAT to transport patients to medical and behavioral health treatment centers.
- Explore Medicaid reimbursement expansion options with the State to allow sustained funding for CHAT and PSR programs, street medicine, SHS, and other behavioral health programs.
- Conduct a study that interviews trusted community-based organizations and fentanyl users. This research would help leaders better understand demographics of fentanyl users, perceived barriers to treatment, daily use, desired services, and other rich information that could help inform ongoing and future approaches to people who use fentanyl. With resources, this could be done by the MCHD in collaboration with community outreach programs, trusted community partners, culturally specific organizations, and established drug treatment providers for each level of care and communications staff. This report could be made public for all communities to learn and build from.
- Move the livability-improvement grants program from Prosper Portland to PEMO, when it becomes part of Portland Solutions.
- Create equity evaluation programs for homeless and housing services and programs that will reduce racial disparities in service access and/or outcomes.
- Invest in establishing data infrastructure and build collaborations with community organizations outside of emergency situations so that trust built will support data mobilization and other emergency activities when required.

Conclusion

Using an emergency management mechanism to address a chronic and complex set of social problems is not new, but issuing three concurrent emergencies across governments and disciplines was a bold, unprecedented step in the face of the fentanyl crisis. While a full IMT staffing model is not sustainable past the 90 days, it is clear that this focused effort catalyzed a series of concrete actions to mitigate the impacts of fentanyl. Such unprecedented

multi-disciplinary, multi-government coordination, and idea generation would not have occurred absent the emergency declaration.

The 90-day tri-government fentanyl emergency achieved its objectives in full as reflected in the accomplishments and the categorical requests for next actions detailed in this report. The IMT worked to improve livability within Portland's central city by augmenting existing resources. Systems were developed to coordinate and increase access to naloxone, housing treatment and recovery services, and multiple dashboards with public safety and health data from multiple governments were created and made available to the public. The IMT identified policy options to address gaps and barriers identified through this effort and forged relationships between governments and organizations whose missions to address the impacts of fentanyl overlap. This effort has resulted in an exportable model to other regions that are seeking to mitigate the harms of fentanyl by leveraging a coordinated public safety and public health response.

Significant challenges remain, particularly in depleted and overworked first responders, medical, behavioral health, and social service provider workforces. The underlying systemic drivers of addiction among individuals and communities, such as poverty, trauma, poor economic circumstances, and historical and ongoing racial discrimination are also the major factors underlying the crisis that cannot be adequately addressed within 90 days. The emergency declaration was intended to address the *urgent* matter of public fentanyl use in the central city and across the community, the immediate risks to users, and the broader livability needs of residents, visitors, and businesses in the focus area.

Furthering this work will be the responsibility of many people across the three governments and community partners as the emergency declaration period ends. Unified Command recommends continuing coordination with a representative from each jurisdiction to remain assigned as a coordination team. This team will continue to host regular coordination calls with first responders and service providers, establish or continue check-ins with their jurisdiction’s programs and partners, continue shared tracking of policy work, report progress on closing gaps, and make further recommendations to elected officials.

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311
4D Recovery
AC Disaster
Central City Concern
City of Portland
- Attorney's Office
- Bureau of Emergency Communications
- Bureau of Emergency Management
- Community Safety Division
- Street Services Coordination Center
- Fire & Rescue
- Mayor's Office
- Neighborhood Emergency Teams
- Portland Parks & Recreation
- Portland Police Bureau
- Public Environment Management Office
- Office of City Commissioner Rene Gonzalez

CODA Inc.
Downtown Portland Clean & Safe
EMSI
Fora Health
Mental Health and Addiction Association of Oregon
Miracles Club
Multnomah County
- Behavioral Health Resource Center
- Chair's Office
- Department of Community Justice
- Department of County Human Services
- District Attorney's Office
- Emergency Management
- Government Relations
- Health Department
- Joint Office of Homeless Services
- Library
- Local Public Safety Coordinating Council
- Office of Communications
- Sheriff's Office

State of Oregon
- Oregon Department of Human Services
- Oregon Department of Human Services- Office of Resiliency and Emergency Management
- Oregon Department of Transportation
- Oregon Department of Emergency Management
- Oregon Health Authority
- Oregon Health Authority Behavioral Health Division
- Oregon Health Authority Health Policy & Analytics
- Oregon Health Authority- Public Health Division- Health Security, Preparedness and Response
- Oregon Health Authority- Public Health Division
- Oregon Office of the Governor
- Oregon State Police

Oregon Health & Science University
Oregon Health Sciences University-Portland State University School of Public Health Portland
Portland State University- Homelessness Research and Action Collaborative
Portland State University- The Center for Public Service- Mark O. Hatfield School of Government
Providence- Better Outcomes thru Bridges
Recovery Works NW
TriMet & Portland Streetcar
URTA
Volunteers of America Oregon

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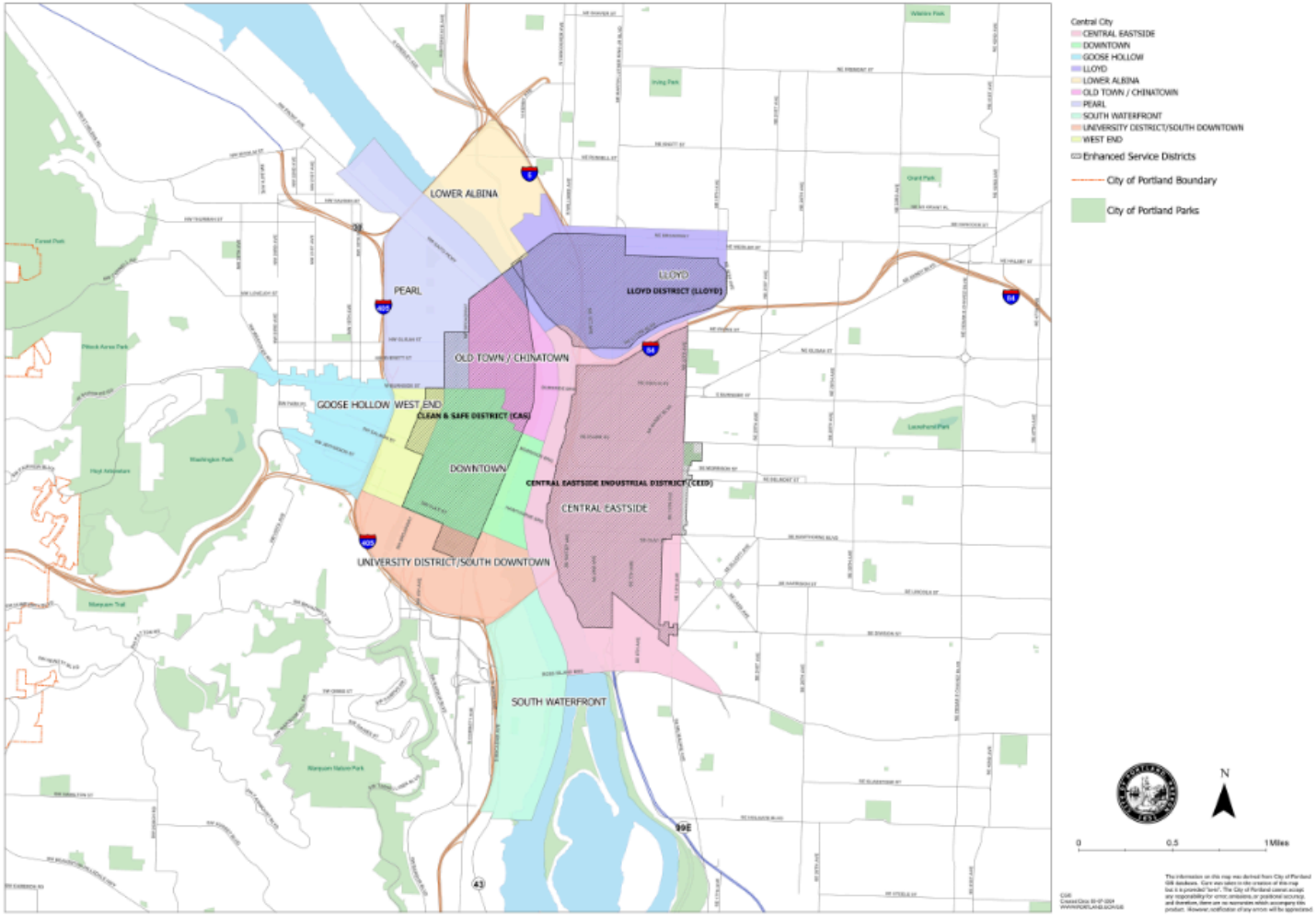
Appendix A

Map of Portland City Center Fentanyl Crisis Emergency Declaration Area



Appendix B

Acronym List and Glossary of Terms

Table B1. Acronym List

Acronym	Name	Agency Reference
AA	African American or Agency Administrator	
AAR	After Action Report	
ALS	Advanced Life Support (vs. Basic Life Support)	
AMR	American Medical Response	
AOC	Agency Operations Center	
AOR	Area of Responsibility	
BAA	Black African American	
BHD	Behavioral Health Division	Multnomah County
BHP	Behavioral Health Program	Multnomah County
BHRC	Behavioral Health Resource Center	Multnomah County
BHRN	Behavioral Health Resource Network	Multnomah County
BIPOC	Black, Indigenous and People of Color	
BOEC	Bureau of Emergency Communications	City of Portland
CAB	Community Advisory Board	
CAH	Community & Adolescent Health	Multnomah County Health Department

C&G	Command and General Staff	
CBO	Community Based Organization	
CCC	Central City Concern	
CCO	Coordinated Care Organization	
CCTF R/R	Central City Task Force Report and Recommendations	
CFRC	Coordinated Fentanyl Recovery Continuum	
CH	Corrections Health	Multnomah County
CHAT	Community Health Assessment and Treat	Portland Fire and Rescue
CHAT	Coordination Housing Assessment Team	
CHW	Community Health Worker	
CPCB	Community Partnerships & Capacity Building	Multnomah County Public Health
CoP	City of Portland	
DCAT	District Coordination Action Team	
DCJ	Department of Community Justice	Multnomah County
DCS	Distribution of a Controlled Substance	Law Enforcement
DOCL	Documentation Unit Leader	Incident Management Team
EHR	Electronic Health Records	
EMS	Emergency Medical Services	
EO	Executive Order	

EO 23-02, 23-09, 24-02	Homelessness Emergency Executive Orders	
EQO	Equity Officer	
FSC	Finance Section Chief	Incident Management Team
GIS	Geographic Information System	
HDDO	Health Department Directors Office	Multnomah County
HIDTA	High Intensity Drug Trafficking Area	
HRAP	Homeless Response Action Plan	City of Portland and Multnomah County
HSPR	Health Security, Preparedness, and Response	State of Oregon, Oregon Health Authority
IAP	Incident Action Plan	Incident Management Team
IC	Incident Commander	Incident Management Team
ICP	Incident Command Post	Incident Management Team
ICS	Integrative Clinical Services	Multnomah County
ICS	Incident Command System	
IMT	Incident Management Team	
IRP	Impact Reduction Program	City of Portland
JIC	Joint Information Center	Incident Management Team
JOHS	Joint Office of Homeless Services	Multnomah County
KATU	Local News Outlet	
LE	Law Enforcement	
LGBTQIA2S+	Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual, and Two Spirits	
LOE	Letter of Expectation	

LOFR	Liaison Officer	Incident Management Team
LSC	Logistics Section Chief	Incident Management Team
M110	Measure 110: Drug Addiction and Treatment Recovery Act	State of Oregon
MAT	Medication Assisted Treatment	
MC	Multnomah County	
MCEM	Multnomah County Emergency Management	
MCHD	Multnomah County Health Department	Multnomah County
MCSO	Multnomah County Sheriff's Office	Multnomah County
MHAAO	Mental Health & Addiction Association of Oregon	
MOUD	Medication for Opioid Use Disorder (Official Term for buprenorphine pilot program)	
MSR	Medication Supportive Recovery	
NET	Neighborhood Emergency Team	City of Portland
NRT	Neighborhood Response Team	Portland Police Bureau
OAR	Oregon Administrative Rules	State of Oregon
ODEM/OEM	Oregon Department of Emergency Management	State of Oregon
ODHS	Oregon Department of Human Services	State of Oregon
ODOT	Oregon Department of Transportation	State of Oregon
OHA	Oregon Health Authority	State of Oregon
OHSA	Optimized Hot Spot Analysis	

OHSU	Oregon Health and Sciences University	
OLCC	Oregon Liquor Control Commission	
OREM	Office of Resiliency and Emergency Management	State of Oregon, Oregon Dept. of Human Services
ORT	Overdose Response Team	City of Portland, Portland Fire and Rescue
OSC	Operations Section Chief	Incident Management Team
OSP	Oregon State Police	State of Oregon
OST	Overdose Support Team	City of Portland, Portland Fire and Rescue
OUD	Opioid Use Disorder	
PATH	Promoting Access to Hope	Multnomah County
PBEM	Portland Bureau of Emergency Management	City of Portland
PBOT	Portland Bureau of Transportation	City of Portland
PCS	Possession of a Controlled Substance	Law Enforcement
PDX	Portland	
PEMO	Public Environment Management Office	City of Portland
PF&R CHAT	Portland Fire and Rescue Community Health Assess and Treat	City of Portland, Portland Fire and Rescue
PHD	Public Health Division	State of Oregon, Oregon Health Authority
PHP	Prevention and Health Promotions Team	Multnomah County
PIO	Public Information Officer	
PPB	Portland Police Bureau	City of Portland

PPB BHU	Portland Police Bureau Behavioral Health Unit	City of Portland
PPB NOC	Portland Police Bureau Narcotics and Organized Crime	City of Portland
PPB NRT	Portland Police Bureau Neighborhood Response Team	City of Portland
PSC	Planning Section Chief	Incident Management Team
PSOB	Portland State Office Building	State of Oregon
PSR	Portland Street Response	City of Portland, Portland Fire & Rescue
PSS	Peer Support Specialist	
REALD	Race, Ethnicity, Language and Disability	REALD was passed into Oregon law and is a new type of demographic information that is collected by health care providers
RESL	Resource Unit Leader	Incident Management Team
RN	Rapid Needs	
RR	Resource request	
RWNW	Recovery Works NorthWest	
SCT	Service Coordination Team	City of Portland, Portland Police Bureau
SHMAT	Shelter Housing Medical Assist Treatment	
SHS	Supportive Housing Services	
SITL/SITU	Situation Unit Leader	Incident Management Team
SitRep/SitStat	Situation Report	
SME	Subject Matter Expert	
SNA	Social Network Analysis	

SPMI	Severe & Persistent Mental Illness	
SSCC	Street Services Coordination Center	City of Portland
SUD	Substance Use Disorder	
TASS	Temporary Alternative Shelter Sites	City of Portland
TF	Task Force	
TPI	Transition Projects	https://www.tprojects.org/
UC	Unified Command	Incident Management Team
VA	Veterans Affairs	
VOA	Volunteers of America	
WAP	Weekly Action Plan	
YAB	Youth Advisory Board	Multnomah County Health Department

Table B2. Glossary of Terms

Term	Definition
Activity Collection Form	A form that collects data from key agencies involved in the emergency declaration response (Law Enforcement, Behavioral Health and Medical, Outreach & Center/Shelter, Substance Use Treatment, Livability, etc).
Addiction	A primary, chronic disease of brain reward, motivation, memory and related circuitry. Addiction is characterized by an inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response.
Analgesic	Pain relief
Behavioral Health	Generally refers to mental health and substance use disorders, life stressors and crises, and stress related physical symptoms
Bottle Return	The refund received when an empty container is returned to a supermarket or other redemption center
Buprenorphine	A synthetic opioid partial antagonist, it is the first medication to

	treat OUD
CCO-Oregon	A coordinated care organization is a network of all types of healthcare providers (physical health care, addictions and mental health care) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid).
Common terms of substance use disorder (Behavioral Health)	Any of a group of mental health conditions characterized by chronic use of a psychoactive substance over which the affected person has limited
Community Service providers, CBO vs NGO vs County Health	CBO, CSP, NGO VS County Health are all non governmental VS governmental agencies. These terms just represent that
Continuum of Care	A concept involving an integrated system of care that guides and tracks patients over time through a comprehensive array of health services spanning all levels of intensity of care
Data stratification	The process of sorting data into defined segments or groups and can make data analysis efforts more comprehensive and easier to evaluate
Detox services	A set of interventions aimed at managing acute intoxication and withdrawal.
Electronic Medical Record (EMR) vs Electronic Health Record (EHR)	The main difference is that EHRs are maintained by multiple providers, while EMRs are only maintained by a single provider. EHRs contain more information.
Epidemiological	Relating to the study of epidemic diseases or other health-related conditions occurring within a population
Equity	The recognition that each person or group has different circumstances which requires requires the allocation of resources and opportunities to reach an equal outcome
Fentanyl	A synthetic opiate which is a powerful analgesic
Frontline Worker	Working at the forefront of an organization's public activity
Harm Reduction	Keeps people who use drugs alive and as healthy as possible by reducing negative consequences associated with drug use
HB4002	New criminal penalties for drug delivery and drug possession while reducing barriers to behavioral health services
Homeless (houseless)	An individual who belongs to one of the following categories: (1) An individual who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) An individual with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; (ii) An individual living in a supervised publicly or privately

	operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals); or (iii) An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution; (2) An individual who will imminently lose their primary nighttime residence, provided that: (i) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing; (3) Any individual who: (i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual that has either taken place within the individual's primary nighttime residence or has made the individual afraid to return to their primary nighttime residence; (ii) Has no other residence; and (iii) Lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, to obtain other permanent housing.
Illicit Pills	Not authorized or allowed; unlawful. Refers to the use and misuse of illegal and controlled drugs.
Incident Management Team (IMT)	A rostered group of qualified personnel consisting of an Incident Commander, Command and General Staff, and personnel assigned to other key ICS positions
Leave Behind Policy	Policies for first responders that leave behind Narcan with individuals who have recently administered Narcan as a first aid response. Separate from policies about harm reduction, which are about distributing Narcan for potential future use.
Len Bias Law	Known as the Anti-Drug Abuse Act of 1986. Provides a mandatory minimum prison term of 20 years for cases of drug distribution that led to the death or serious injury of a person
Livability	Efforts that encourage and promote economic vitality, community safety, and community space usage
Lived Experience	Knowledge based on someone's perspective, personal identities and history beyond their professional or educational experiences

Marginalized Communities	Marginalized communities are those excluded from mainstream social, economic, educational, and/or cultural life.
MAT Medication Assisted Treatment (MAT)	Pertains to the use of specific medications, such a methadone, buprenorphine, and naltrexone, the help individuals recovering from OUD to avoid recurrence of use
Measure 110	The Drug Addiction Treatment and Recovery Act
Medicaid	Established in the United States, provides state and federal funds for the use of persons requiring medical assistance
Medication Supported Recovery (MSR)	Refers to medications used to treat SUD and medications that aid in the recovery process
Methadone	A synthetic opiate analgesic used as a medication with longer-lasting and less sedative effects that morphine.
Naloxone (Generic of Narcan)	A synthetic opioid antagonist which resembles nalorphine in its chemical structure and that rapidly reverses an opioid overdose
Naltrexone	A synthetic morphine derivative that is a potent opioid antagonist
Narcan (Brand name)	see Naloxone
Opioid Use Disorder (OUD)	The chronic use of opioids that causes clinically significant distress or impairment
Oregon Health and Science University (OHSU) Mission Control	A center that uses predictive analytic and real-time data to coordinate patient care from the time they enter the hospital until they are discharged
ORS 135.233	An Oregon law that pertains to implementing policy about how to decide who is released or detained in jail after arrest and booking.
Outreach	Outreach includes any activity which interfaces with community members with the intention of delivering care, resources, or information.
Overdose	Dose of opioids or combination of opioids and other drugs that causes the person to be unresponsive to stimulation and/or breathing is inadequate
Peer support services	Augments the recovery process by offering a level of acceptance, understanding, and validation found with other experiencing similar situations
Pre-treatment	Pre-treatment generally refers to any support or services provided to an individual before services are reimbursable through Medicaid
Pressed Pills	Fentanyl pressed into pills in order for pill to look like legitimate prescription medication
Protective Factors	Characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's (biological, psychological, family, community, or cultural) impact
Recovery	Restoration or return to health from illness or injury

Recovery Support Housing	Recovery housing is a recovery support service that was designed by persons in recovery specifically for those initiating and sustaining recovery from substance use issues.
Recreational Drugs	A drug taken for its psychoactive nature
Rehouse	housing a household that was previously homeless or living unsheltered outside.
Revitalization	The action or an act of bringing something back to life or restoring its health
Risk Adversity Cycle	The cyclic gaps in a continuum of care created by individual organizations' decisions to reduce risk within their organization through policies that reduce access for complex patients, discharge or exclude participants for risky behaviors, and/or deny services. Most activities at an individual level are designed to create safer environments while at a macro level they exacerbate poor outcomes for socially complex populations.
Service Mapping	The action of creating an inventory of services and plotting them on a GIS.
Short- Term Intervention	Designed for those who need a temporary treatment program
Sobering	To make sober; to free from intoxication
Social Detox	Social detoxification programs are defined as short term, nonmedical treatment services for individuals with substance use disorders. A social detoxification program offers room, board, and interpersonal support to intoxicated individuals and individuals in substance use withdrawal. There should always be medical surveillance, including monitoring of vital signs, as part of every social detoxification program.
Social Network Analysis Code Book	A macro-level reference for social network analysis practitioners to facilitate the sharing of quality, consistent data. The code book describes relational and attribute categories to improve consistency for data collection and analysis.
Stabilization	In the substance use field, stabilization generally refers to individuals entering withdrawal management services, or individuals leaving an acute setting or withdrawal management that may meet discharge criteria from those settings, but may not be stable enough for the next level of care. Stabilization services generally refers to the services that are provided to ensure that they are stable for that next level of care, such as peer mentor services, ongoing medical support services, and clinical screening and assessments.
Street Supply	The supply of illicit drugs distributed and sold to street drug users.
Substance Use Disorder (SUD)	A treatable mental disorder that affects a person's brain and behavior, leading to the inability to control their use of substances like legal or illegal drugs, alcohol, or medications

Supportive Services	Services such as treatment programs, detox programs, shelter or housing, case management, employment, legal aid, behavioral health, benefits enrollment, harm reduction, medical care, community supports
Synthetic Opioids	Substances that are synthesized in a laboratory that act on the same targets in the brain as natural opiates (E.g. morphine, codeine) to produce analgesic effects
Treatment	Professional assistance intended to help a person overcome or recover from an addiction
Tri-government (City, County, State)	A collaboration consisting of the City of Portland, Multnomah County, and the State of Oregon
Triage	The action or process of determining the most urgent or important thing that requires a degree of urgency
Unhoused	Not provided with or lodged in a house, a person sleeping in a place not meant for human habitation (e.g. living on the streets) or in an emergency shelter; or a person in transitional housing for homeless persons who originally came from the street or an emergency shelter. Also, a person may be considered homeless if, without assistance from a service-provider, they would be living on the streets. This includes persons being evicted within a week from a private dwelling with no subsequent residence identified and lacks the resources and support networks needed to obtain housing; or being evicted within a week from an institution in which the person has been a resident for more than 30 consecutive days with no subsequent residence identified and he/she lacks the resources and support networks needed to obtain housing.
Unified command (UC)	An Incident Command Structure (ICS) application used when more than one agency has incident jurisdiction or then incidents cross political jurisdictions
Warming shelters	A short-term emergency shelter that operates when temperatures, or a combination of factors, cause environmental conditions to become dangerously inclement
Withdrawal Management	Services provided during the initial period of care and treatment of an individual intoxicated or incapacitated by substance abuse

Table B3. Activity Collection Glossary

Term	Definition
Aftercare engagements	Connections with individuals early in their recovery, to prevent relapse, and help them achieve their goals. It typically includes things like interventions, and resources to help a recovering person cope with triggers, stress, and cravings that they may face

	when treatment is over.
Agency reporting	Agency that completed the work and is reporting out
Amount of enzyme cleaning agent used	Gallons of enzyme used to remove bacteria from sites impacted by trash and human waste
Average number of officers active in area per day	The average number of officers/rangers who were stationed within the operational area or conducting relevant activities within the area on the reported date.
Buprenorphine inductions	A process to transfer the patient from an abused opioid to a dose of buprenorphine which will provide relief from withdrawal and assist the patient in discontinuing or markedly diminishing use of other opioids.
Graffiti sites removed	Number of sites, where graffiti was removed/painted over
Lights installed	Number of light installation projects. These are typically targeted in areas where poor light conditions have made it favorable for the use and/or distribution of drugs
Naloxone kits	One kit contains 2 doses of naloxone (AKA Narcan), a medication used to reverse an opioid overdose.
Number of naloxone kits distributed	Number of naloxone kits that were given out to community members, not including the doses that were used by an agency to reverse an overdose.
Outreach Activities	Outreach includes any activity which interfaces with community members with the intention of delivering care, resources, or information.
Overdose reversals	Reversal of an opioid overdose through the use of naloxone. Naloxone quickly reverses an overdose by blocking the effects of opioids. It can restore normal breathing within 2 to 3 minutes in a person whose breathing has slowed, or even stopped, as a result of opioid overdose.
Permanent Housing	Affordable, often subsidized housing, available for individuals that do not require the level of ongoing care as those in permanent supportive housing
Plywood sheet removal	Number of sheets removed from structures that were previously damaged (doors/windows). The removal of the plywood signifies the repair and revitalization of an area or business. Currently, the IMT is not aware of anyone who is tracking this metric.
Referral	Directing one to services such as treatment programs, detox programs, shelter or housing that an individual has expressed interest in.
Reporting Date	The date during which the reported activities occurred. If you are reporting activity that occurred during more than one day, please select the most recent day during the period of activity and include a comment specifying the reporting period.

Shelter	Temporary or alternative housing options available for those who are unsheltered
Sidewalks power washed (feet)	Linear feet or miles of sidewalks pressure washed as a part of the effort to clean up areas with the Central City footprint
Situation Status Report (SitRep)	A form of reporting that provides decision-makers and readers a quick understanding of the current situation (progress, accomplishments, challenges, key metrics, etc). On this incident the situation report was the primary tool for reporting out on the IMT accomplishments and those of the providers and officers working in Law Enforcement, Behavior Health and Medical, Outreach and Shelter, Substance Use Treatment and Livability.
Total grams narcotics seized	The total weight (in grams) of non-fentanyl seized by the reporting entity on the reporting day.
Total number of arrests for fentanyl distribution	Number of arrests for distributing a controlled substance (fentanyl) on a given day
Total number of law enforcement missions	Number of larger scale, coordinated, multi agency missions conducted. Not to be confused with daily patrols.
Trash picked up	Number of bags of trash or weight in pounds of trash removed on a given day
Treatment Services	Services provided to identify, prevent, eliminate, ameliorate, improve or stabilize specific symptoms, signs and behaviors related to, caused by, or associated with a behavioral health disorder.
Violent crime reports in area	Serious criminal offenses that are more severe than misdemeanors. Examples of felonies include murder, robbery, sexual assault, aggravated domestic assault, and aggravated assault.

Appendix C

Evidence Supporting Emergency Responses to the Fentanyl Crisis

A rapid review of the literature

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Abstract

The opioid epidemic continues to devastate communities and families across the United States. The rise of fentanyl, a potent opioid that is often cheaply and illegally made, constitutes a new era of the opioid crisis that requires swift and effective response. The purpose of this rapid literature review is to identify resources and evidence that can inform jurisdictions as they enact emergency responses to the fentanyl crisis. Evidence-based recommendations from key institutional leaders were identified and summarized yielding several consistent and evidence-supported recommendations for action. These include increasing naloxone distribution and accessibility; improving access to treatments and medications for opioid use disorder; working collaboratively across sectors; and using data to inform action. Education was a popular strategy, but evidence indicates it must be undertaken carefully to ensure targeted messaging results in desired effects, such as decreased drug use, whereas in some situations it has inadvertently increased it. Further, comprehensive, whole-of-system approaches are needed to address intersections between drug use and other social issues - such as homelessness, public health and racism - and reduce negative outcomes associated with strategies that incorporate a heavy emphasis on policing. Prioritizing racial equity in opioid responses is necessary to address a legacy of racism and overcome disparate health, mortality, and wellbeing outcomes. There is good evidence to support the use of supervised consumption sites, though this was not a recommended strategy by most institutions. Further, diversion programs that direct users to treatment rather than prosecution is an emerging practice with increased relevance. There is little information about the content and efficacy of current emergency responses, and this represents an area where national leadership could facilitate communication and knowledge sharing. In the meantime, communities should combine evidence-informed strategies alongside local data and input from stakeholders - including people with lived experience - to inform responses that attend to locally specific characteristics of fentanyl use.

Report Overview

Project Purpose, Scope of Work, and Approach

On January 30, 2024, the Oregon Governor, Portland Mayor and Multnomah County Chair all stated their intent to declare a state of emergency to address fentanyl in their respective jurisdictions. The three jurisdictions declared states of emergency and appointed incident commanders to create a Unified Command operation tasked with standing up an Incident Management Team, drafting objectives, creating strategies and tactics related to those objectives, and carrying out those strategies and tactics. This literature review was commissioned by the Unified Command as part of a final report on the 90-day Fentanyl State of Emergency.

The purpose of this rapid literature review is to identify emerging best practices, and provide an overview of evidence that will be helpful to inform jurisdictions as they enact emergency responses to the fentanyl crisis. This report begins with a summary overview of recommendations derived as a result of conducting this literature review. This is followed by a brief overview of the context of the current fentanyl crisis. The next section summarizes research and evidence-informed recommendations from key reports and institutions guiding the US opioid response. The final section provides an overview of the characteristics of current emergency fentanyl responses in the USA, noting that this is a very emergent situation and little detailed information exists on how communities are enacting responses; no literature was identified on how and if these responses are being evaluated. This section also identifies emerging and promising practices, not fully considered in the institutional recommendations.

To identify sources, searches were conducted between April 8-12, 2024 using Google, GoogleScholar, EbscoHost, PubMed, and Policy Commons to identify academic and gray literature (i.e. reports, websites and white papers from governments and institutions) about community- and policy-level responses to addressing fentanyl. Additional searches were conducted to find supporting and emerging evidence to further expand and contextualize the institutional recommendations that are summarized here. Undertaken in a limited amount of time, this review attempts to provide resources and guidance for emergency responses, yet a more thorough review of specific interventions is prudent. For example, deflection programs were identified as a relevant, promising strategy but a further review of the literature to support best practices in this space is needed. Finally, very little information on current emergency response strategies were identified. As this is an emerging issue and jurisdictions are ramping up responses and communication platforms, availability of information may change rapidly over time.

Summary of Recommendations Identified by this Review

1) Assess and plan for locally-specific aspects of the fentanyl crisis, including ensuring the response identifies and appropriately addresses needs and cultures of relevant subpopulations

2) Prioritize a racial equity lens in opioid response to address a legacy of racism and overcome disparities in health, mortality, and wellbeing outcomes

3) Involve people with lived experience of substance use and their families in planning and implementing responses

4) A whole-of-system approach is necessary for ensuring impact and reducing unintended consequences

5) Draw on key practices from over two decades of action and research from the opioid epidemic. The following strategies are well supported by evidence:

    a) Increase naloxone distribution and accessibility

b) Increase access to treatment and medications for opioid use disorder

c) Work collaboratively and across government sectors and with non-governmental community organizations

d) Use data to inform local action and streamline goals, and to track progress and impact

6) While public communication is important, be cautious of content and ensure that educational campaigns are targeted towards appropriate populations so as not to inadvertently increase drug use

7) Identify policy-level responses to aid in opioid response, including by identifying, amending and/or removing laws that may pose barriers to treatment and overdose response including administering treatment and reporting overdose.

8) Consider emerging and innovative, evidence-based approaches such as deflection strategies, supervised consumption sites and drug testing services

9) Establish mechanisms to communicate across jurisdictions where emergency actions are occurring or have occurred to share and build on lessons learned

Introduction

The opioid epidemic continues to devastate communities and families across the United States. Combating opioid use and overdoses has proven intractable as the nature of the problem continually shifts; originally conceptualized as a prescribing issue in the 1990s, the epidemic evolved with the introduction of heroin and now to synthetic and illegally manufactured fentanyl, an opioid 50 times more potent than heroin (1). There are two forms of fentanyl: pharmaceutical fentanyl is prescribed to treat severe pain, and illegally made fentanyl. Unlike in the early opioid epidemic, most current cases of overdose are linked to illegally made fentanyl. Additional complications include that illicit fentanyl is cheap and potent, which also makes it more addictive and dangerous. It is commonly mixed with other drugs - including cocaine, heroin, and methamphetamines - so that users may be unaware that these drugs are laced. This is leading to the fact that most opioid-involved deaths now involve other drugs (2).

Over the last two decades considerable research, funds and political attention have been devoted to addressing the opioid crisis. In 2016, the 21st Century Cures Act created State Targeted Response to the Opioid Crisis grants, which helped many states build and improve infrastructure to combat and monitor opioid abuse and overprescription (3,4). However, the most recent increases in availability and potency of synthetic fentanyl, alongside decreased cost, has again changed the nature of the problem leading to a four-fold increase in overdose deaths between 1999-2010 (5). Within the last year alone, jurisdictions across the United States have enacted executive and emergency action to address fentanyl (6–12).

With a death rate from synthetic opioid overdoses, like fentanyl, now averaging 150 people a day (13), it is clear that existing opioid responses must shift, increase, or both to combat this new wave of the opioid epidemic. Across the United States, jurisdictions are taking executive action to address the illicit fentanyl wave of the opioid crisis.

Summary of Current Considerations, Best Practices and Recommendations for Addressing Opioids Including Fentanyl

Risk Factors and Priority Populations

Although the nature of the opioid epidemic has changed significantly with the introduction of illegally manufactured opioids, the underlying causes of substance use remain unchanged. Social, cultural, and economic factors, including socio-economic status, homelessness, incarceration, and others are determinants that underlie individual risk-factors for substance use (14).

There are several priority populations at risk for fentanyl use identified in the literature including, for example, people who are or were recently incarcerated, mothers and babies, youth, Hispanic populations, and rural communities (15–18). It is beyond the scope of this review to provide a detailed analysis of each. Research underscores that specific characteristics of place and culture can influence who is at risk for opioid use and mortality (19,20). Therefore, it is essential that approaches to mitigate opioid use consider which groups are most at risk for the specific community/ies where interventions will be directed.

However, it must be acknowledged that not all groups are impacted equally. Black, Indigenous and People of Color (BIPOC) communities continue to disproportionately experience the impacts of the opioid epidemic. Nationally, American Indian and Alaska Natives and Black communities experience higher rates of mortality from opioid overdose than white communities (69.1 and 54.0 deaths per 100,000 vs 34.6, respectively) (21). These rates are further exacerbated in Oregon where the rates of opioid overdose mortality is two to three times higher for American Indians and Alaska Natives (76.8) and Black community members (86.6) vs white community members (31.4). Most of these deaths are due to synthetic fentanyl (21). Racism continues to act as a significant barrier to addressing overdose mortality as stigma, fear, and mistrust due to a legacy of racism in healthcare and law enforcement contribute to poor knowledge of naloxone administration and fear of consequences for seeking help (22). Prioritizing racial equity in opioid response is necessary to address a legacy of racism and overcome disparate health, mortality, and wellbeing outcomes. Equity strategies may include developing culturally-specific approaches in collaboration with communities and people with lived experience of substance use.

There are also additional intersectionalities that increase risk for opioid use and mortality that include individual-level characteristics (e.g. gender, lifecourse stage, etc), and structural drivers of disparities (law enforcement interactions, access to prevention and treatment, employment, etc) (14). For example, American Indian and Alaska Native populations are at increased risk for homelessness due, in part, to intergenerational trauma from involuntary displacements (e.g. the Indian Relocation Act of 1956, boarding school removals, and other government harms and disinvestment in American Indian populations have all contributed to modern homelessness in the population). These traumas in turn increase barriers to accessing opioid treatment and increase opioid mortality risk (23,24). Homelessness increases risk for opioid mortality due to the trauma of homelessness that may lead individuals to opioid use as a coping strategy, and displacement from and barriers to accessing medical treatment and behavioral health supports (22,25). Considering intersections between opioid use and homelessness more broadly is imperative given that homelessness is a significant risk factor for overdose mortality in general (26). A recent study identified a 488% increase in mortality deaths due to opioid use among homeless populations (27) signifying this is an important population in need of consideration.

Evidence-Based Strategies to Address Opioids

There is an inherent connection between individual behaviors and the physical, cultural and economic environment where people live (28). Therefore, mitigation approaches that effectively address opioids, including fentanyl, must apply a big picture or “systems” approach that incorporates individual-level interventions (e.g., medical care, behavioral health services) with community-level responses (e.g., addressing housing, improving referrals and collaboration between service sectors) with policy-level responses (e.g., decriminalizing drug use) (29,30). Taking a systems approach to fentanyl use is increasingly important when evidence underscores that interventions focused only on one aspect will not only be incomplete but may cause unintended consequences. For example, evidence has shown that locales in which fentanyl has been seized by law enforcement then experience spikes in fatal overdose rates shortly thereafter (31,32). These spikes are attributed to a reduction in tolerance among people who lose their supply, coupled with increased withdrawal leading individuals to seek new supply sources at an increased risk to themselves (31). This scenario underscores that the drivers of drug use are complex and actively evolve in response to environmental, social and policy changes.

Evidence from over two decades of opioid response emphasizes the importance of multi-stakeholder and multi-sector responses (15,33,34). Incorporating a multi-stakeholder response means engaging people at all levels of the system, from elected officials to community members. Meaningfully including people with lived experience of substance use is becoming recognized as a best practice and an essential perspective to ensuring targeted, relevant and timely approaches (35,36). Multi-sector means that a cross-government plan of action is required coupled with a collaborative strategy that engages non-governmental organizations. Cross-sector collaboration is facilitated by clear, collaborative goal setting, centralized support and communication, and incorporation of data use for monitoring and tracking action and impact so that coordinated responses can adapt and adjust to respond to emergent needs (37–39).

Specific aspects of drug use and behavior will vary between communities and jurisdictions; therefore, locally-specific inputs including stakeholders and data are required to formulate the most effective responses for each locale (19,20).

The NIH's Helping to End Addiction Long-term initiative (HEAL) initiative provides useful and current emerging evidence on best practices in addressing opioids (40). The associated HEALing Communities Study is one of the largest randomized control trials in addiction research (37,41). Funded by the National Institutes of Health and the Substance Abuse and Mental Health Services Administration (SAMHSA), the recently concluded study aimed to prevent opioid misuse and reduce opioid deaths in 67 hard-hit communities (37). The HEAL framework is useful for considering a community-level approach that incorporates a menu of evidence-based interventions aimed at addressing multiple phases of opioid use, from prevention, to risk reduction, to treatment and recovery (41). Importantly, the approach emphasizes collaboration from community experts, including people with lived experience and people who use drugs, to select evidence-based strategies that are appropriate for the specific community (33). Community involvement in intervention selection attends to the fact that the specific nature of fentanyl use–including supply, drivers, and protective factors–will vary amongst communities and require tailored approaches. While the HEAL study provides useful information for setting up community-level responses, the study only recently completed in December and outcome research on effectiveness and impact has not yet been released. This will be a space to watch in the future.

Overview of Quality of Evidence and Recommended Priority Actions

A variety of institutions have issued guidance, based on evidence reviews and research, for opioid mitigation strategies. Table 1 summarizes the recommended, evidence-informed actions of a number of leading United States institutions in opioid response including Johns Hopkins, the Centers for Disease Control and Prevention, and SAMHSA. However, only one report evaluated the strength of the evidence of mitigation strategies. In 2020, the Legal Action Center published a comprehensive, systematic review and assessment of the evidence of opioid mitigation strategies (15). Their report provides detailed information on the quality of the evidence and is an excellent overview of the opioid mitigation literature. Their assessment of evidence for key strategies is likewise summarized in Table 1.

In Table 1, the recommended actions are numbered in order of most frequently recommended to least; the actions are further described below alongside their corresponding number. There are several consistent recommendations for action across all reports that were reviewed. These include: 1) increasing naloxone distribution and accessibility; 2) improving access to treatments and medications for opioid use disorder (MOUD); and 3) education for communities and providers. The Legal Action Center reports that naloxone distribution and improved access for MOUD are well-supported by evidence, and these are cornerstone strategies across all institutions and emergency responses (see next section on "Emergency Fentanyl Responses").

Increasing naloxone distribution and accessibility is a key strategy in both institutional guidance and in emergency responses. Naloxone can reverse opioid overdose if administered quickly and appropriately (42). Studies indicate that laypersons can effectively administer naloxone to reduce opioid mortality (43,44). Increasing education and access by reducing prohibitive laws and increasing distribution sources (e.g. through third-party prescriptions for individuals in a position to revive someone; facilitating pharmacy dispensing without prescriptions, naloxone "vending machines"), is strongly recommended. Though it is highly effective and availability has recently improved (45), ongoing work is needed to further reduce barriers to access - including reducing costs and prohibitive laws.

There is extensive literature documenting the efficacy of medications to treat opioid use disorder including methadone, buprenorphine, and naltrexone. Methadone has been shown to reduce opioid use, transmission of associated infectious disease and crime (46–48). It has positive long-term outcomes, even in the absence of regular counseling services, and increases likelihood of patients staying in treatment. including that patients were more likely (49,50). Buprenorphine can be just as effective as methadone if prescribed at sufficiently high doses (50,51). They are, however, highly underutilized (52) and therefore, increasing implementation of medications in treatment programs and by medical providers is an important strategy.

Educational interventions, although widely recommended, range from "very low" to "supporting" evidence. Interventions that had "very low" evidence include continuing education for medical providers including academic detailing. The CDC, however, reports that "academic detailing," which involves structured visits where healthcare providers receive tailored training and technical assistance, is a best practice (53,54). This discrepancy is likely due to the rapidly changing evidence; a recent scoping review supports the CDC recommendation academic detailing (55) but further research should be considered. Other educational initiatives considered to have "supporting" evidence include education as part of treatment programs and services for a variety of populations (e.g., families and children and incarcerated persons) and for naloxone use.

Public communication campaigns are also widely adopted in fentanyl responses, however not all are evaluated for effectiveness, which reduces the quality of available evidence. Anti-drug communications research indicates that communications must be carefully designed and targeted. One evaluation of 14 anti-drug communication campaigns showed that most had no impact, and two even increased drug use (56). Tailoring anti-drug messaging towards audience subgroups is an important strategy. For example, communication campaigns may be more successful among young people who have little or no experience with opioid misuse, but conversely, can increase misuse among young people who already have some experience (57).

Most institutions also recommend 4) improving collaboration across government sectors and with non-governmental organizations and 5) using data and conducting research to support a comprehensive opioid response. These activities are also well-supported by evidence from the opioid epidemic, as well as other public health and safety issues (i.e., homelessness, HIV/AIDS, obesity, and more) and several of the institutions provide useful evaluation toolboxes (58),

frameworks (41), and/or identify lists of useful variables and databases to guide assessment and monitoring of opioid responses (15).

Several institutions recommend 6) limiting the supply of prescriptions through greater regulation and monitoring of prescribing practices. Notably, however, is that the quality of evidence for the effectiveness of many prescription monitoring and regulatory interventions were considered “very low” or “low”. These interventions include prescription drug monitoring programs, state opioid prescribing guidelines, doctor-shopping laws, and others.

Interestingly, the Legal Action Center identified two intervention approaches with good supporting evidence of effectiveness at mitigating negative outcomes from opioids that were only recommended by one or two of the other institutions. The first, supervised consumption sites, was considered a promising practice. Supervised consumption sites have been well researched, and evidence demonstrates the effectiveness of these sites in reducing drug harms and yielding health and community benefits, including no increase or reductions to crime and public nuisance (59–61). However, they continue to be a highly contentious issue, with many misperceptions among stakeholders including that sites “promote” drug use or increase crime (62,63). Though most evidence of successful supervised consumption sites comes from other countries, there are a few examples in the United States, including in New York City which has published guidelines for the establishment of future sites (64), a clandestine site studied by researchers (65), and the Tenderloin Center, a short-term, emergency site in San Francisco (see section Emergency Fentanyl Responses for more detail). Building community support for supervised consumption sites must be carefully approached. Philadelphia, for example, provides a cautionary tale. The city intended to establish an overdose prevention site as part of a systemic approach to the overdose crisis. However, their efforts backfired when the city council not only rejected the idea but passed legislation to preemptively ban supervised consumption sites entirely (66,67).

Secondly, recommendation number 8) syringe services were also considered well supported by evidence but only recommended by two institutions. Syringe services are programs that provide access to and disposal of sterile syringes for the primary purpose of reducing blood-borne infections. Syringe service programs originally developed in response to the HIV/AIDS epidemic, but the intersection of drug use, needle sharing, and blood borne infections provide an excellent example of how epidemics may overlap and work synergistically to perpetuate undesirable outcomes. Just as with the intersection between drug use, homelessness, and incarceration, it is critical to consider how opioid responses could attend to, or worsen, interconnected health and social issues. Syringe service programs may help address fentanyl use directly given that many programs provide a suite of additional services including linkages to substance use disorder treatment, linkages to health care, and to health services (68).

Almost every source recognizes that policy-level responses are needed to support opioid mitigation actions. For example, the Centers for Disease control recommend enacting good Samaritan laws that would protect individuals who report or aid in overdose response or reporting from prosecution. The Scattergood foundation and the Legal Action Center both

recommend that laws need to be adjusted to support decriminalization and aid in distribution of naloxone and other medications for treatment and overdose.

Table 1: Summary of the quality of evidence for opioid mitigation practices, and recommended actions from key reports and institutions guiding the US opioid response.

The Legal Action Center is the only institution to evaluate the quality of evidence. A summary of their quality review is provided in the second column. The other columns indicate whether the opioid mitigation strategy in column 1 are recommended in institutional guidance.

	Institution, Year (citation)							
	Legal Action Center, 2020 (15)	SAMHSA, 2023 (33)	John Hopkins, 2022 (69)	Scattergood Foundation, 2018 (70)	Centers for Disease Control (CDC), 2023 (53,71)	Collaboration between CDC and High Intensity Drug Trafficking Areas program, 2024 (72)	FXB Center for Health and Human Rights, 2020 (73)	National Governors Association, 2018 (74)
Opioid Mitigation Strategy	**Quality of evidence[a]**	**Strategy identified as a recommended action**						
1. Increase naloxone distribution and accessibility	Well supported	Yes	Yes	Yes	Yes	Yes	Yes	Yes

2. Increase access to treatment and medications for opioid use disorder (MOUD) For specific populations: *Criminal justice system *Pre/peri/post-natal and neonatal	Well supported Recommended Supported	Yes Yes	Yes Yes Yes	Yes Yes	Yes Yes	Yes Yes	Yes Yes	Yes
3. Education	Range: Very low quality to Supported	Yes	Yes	Yes	Yes	Yes	Yes	
4. Improve collaboration	Supported	Yes			Yes	Yes	Yes	Yes
5. Data and research	Recommends variables and sources	Yes	Yes		Yes, Evaluation toolbox (58)			Yes

6. Limit supply of prescriptions	Very low to low quality				Yes	Yes	Yes	Yes
7. Supervised consumption sites	Promising			Yes				
8. Syringe services	Well supported		Yes		Yes	Yes		
9. Warm hand-offs/ coordinated care	n/a	Yes	Yes					
10. Drug testing services	n/a			Yes				
11. Harm reduction oriented policing	n/a			Yes			Yes	
12. Policy recommendations to enhance response (summary of selected	-Medicaid expansion can increase coverage			-Improve policies to facilitate nalox	Enact good Samaritan laws	-Enact good Samaritan laws -Drug courts;	-Fund a non-profit national-level coordinated	Address regulatory barriers

policy recommendations where available)	of high-risk populations -Ease naloxone and MOUD restrictions			one distribution		Safe station programs; Pre-arrest diversion programs; Rapid response strategies for overdose clusters and pain clinic closures	response that can act as a government watchdog	

Notes: a - Well supported: evidence derived from multiple controlled trials or large-scale population studies; Supported: evidence derived from rigorous, but fewer or smaller, trials or restricted samples; Promising: findings that do not derive from rigorously controlled studies but make practical or clinical sense and are widely practiced; Low quality: evidence derived from consistent findings across multiple observational studies with weaker research designs; Very low: few studies available and have weaker researcher or inconsistent findings

Emergency Fentanyl Responses

As previously discussed, there already exists a strong evidence base to guide action for opioid response, with many interventions and programs suitable for application to the current fentanyl crisis. Future work in this area should employ basic public health and emergency response principles. These include using multiple data types and sources (including qualitative data) to monitor conditions, implementation, and impact, and to implement a systems perspective by involving stakeholders at all levels and across the system. Despite that several US jurisdictions have enacted executive orders to address fentanyl (6–12), most responses are very recent and so there is limited information available on what actions are being taken. A National Governors Association provides a white paper with a high-level overview of emergency actions across the US (these are identified in Table 1 above) with some useful information into the declaration process (74). Though published in 2018, it is now slightly dated. There is almost no information available on how responses are being evaluated. However, most states publicly report data on opioid statistics such as overdose deaths, emergency room visits, and prevention activities which provide useful metrics to consider, as well as the Legal Action Center report provides a list of variables and databases that can be used for monitoring and evaluation (15). In addition, there are a few notable examples of emerging practices with relevance for the current fentanyl emergency.

In San Francisco, the Tenderloin Center was developed as an emergency response to fentanyl in 2022 (75). A central, temporary location was established to quickly and efficiently reach people that are at risk of drug use and overdose. Essentially, the Tenderloin Center was operated as a safe consumption site while also linking people to additional supportive services. A recently published evaluation of the center demonstrated that staff were able to reverse 100% of overdoses (n=333) that occurred at the center, and were able to do so using oxygen, thus reducing the need for naloxone from 98%-66% (61). This is notable given that, despite the evidence supporting safe consumption centers, it continues to be a highly contentious issue in the United States. Yet the authors of the Tenderloin evaluation identify other positive benefits of the centralized center including reduced transmission of blood-borne diseases, minimized presence of public drug use and drug-related litter, did not increase crime, reached marginalized community members, supported uptake of services, saved taxpayer money, and contributed to real-time surveillance data (61).

Among the recent emergency actions and orders identified for this literature review, the hallmark features of responses include multi-stakeholder engagement, public communication and education, and using data to assess, monitor and track progress. Almost all responses include increasing emergency responses to overdose, improving access to MOUD treatments, public cleaning, and facilitating linkages. Some locales recognize and include a focus on homelessness. One location includes an additional focus on prioritizing law enforcement response to illegal sales and increasing police presence (8), and others are developing crisis intervention teams and deflection programs that establish linkages to supportive services. It will be important to ensure that law enforcement interventions are one strategy within a broader, comprehensive plan.

Several emergency responses to the fentanyl crisis have involved the deployment of fentanyl test strips (FTS). FTS are generally low-cost and easy to use pieces of paper that can identify the presence of fentanyl in various kinds of drugs. FTS have been shown to be effective at detecting fentanyl, though the sensitivity and reliability varies (76). Further, they have shown to be acceptable among users. Evidence suggests that they can reduce risky behaviors, for example, by resulting in users choosing not to use, to take less than planned, or to have a safety plan (e.g., ask someone to check on them) (77–79). FTS were not evaluated by the Legal Action Center and this omission likely reflect emergent changes in fentanyl deaths caused by users possibly being unaware of the presence of fentanyl in other drugs which had been laced. However, there is some indication that fentanyl use behaviors are again changing and that FTS may become a less impactful strategy as more users intentionally seek fentanyl.

Deflection programs were likewise not reflected in the guidance documents reviewed above. Deflection programs enable law enforcement to redirect low-level offenses from jail or prosecution to community-based services (80,81). There is emerging evidence that these programs can improve overdose rates including fatal overdose (81,82). Oregon briefly experimented with decriminalizing drug use (83), though there is conflicting evidence as to whether this approach improved overdose (84,85). Deflection programs now feature as a key

strategy in the state's recent recriminalization law (86) and so deserve more attention as a mitigation strategy.

Given that there are several jurisdictions who have launched emergency responses, and the strong likelihood that fentanyl will continue to be a problem in the future, there is opportunity for knowledge sharing across jurisdictions about the strategies implemented, lessons learned, and evaluation and monitoring approaches. This represents an opportunity for national leadership to facilitate knowledge sharing and cross-jurisdiction collaboration.

Conclusion

The current fentanyl crisis is rapidly evolving, and jurisdictions are working to respond quickly and effectively. Although information about the content and effectiveness of these responses is limited, there are substantial resources to draw on from over two decades of opioid and substance abuse research. This evidence can inform what strategies might be effective, and what strategies to avoid (e.g. traditional drug-enforcement approaches that rely heavily on policing). To reduce unintended outcomes and maximize impact, it will be important to consider the current fentanyl crisis as primarily a public health issue by recognizing the significant harms fentanyl brings to communities at large and not just for those who use drugs. A harm-reduction emphasis is needed that acknowledges the unique aspects of fentanyl use. A focus on public health and harm-reduction aligns with a system perspective that acknowledges that this new wave of the opioid epidemic is intertwined with other ongoing social epidemics including homelessness and a historical legacy of racism that results in disparate outcomes for Black, Indigenous and other People of Color. For maximum impact, ongoing approaches must include a strong commitment to advance racial equity. A whole-of-system approach that involves both multi- government sectors and community members, including people with lived experience of substance use, will be necessary to ensure a comprehensive response that saves lives.

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Appendix D

Letter of Expectations for Unified Command in Tri-Governmental State of Emergency from Agency Administrators

DATE: February 27, 2024

TO: Incident Commanders Nathan Reynolds, Jennifer Vines, Mike Myers Deputy Incident Commanders Sean McGann, Neisha Saxena, Anthony Jordan, Katy Wolf

FROM: Agency Administrators Jonna Papaefthimiou, Abbey Stamp, Stephanie Howard

RE: Expectations for Unified Command in Tri-Governmental State of Emergency

On January 30, 2024, Governor Kotek, Multnomah County Chair Jessica Vega Pederson, and Portland Mayor Ted Wheeler jointly declared states of emergency related to the impacts of fentanyl in Portland's central city. Each elected appointed agency administrators and incident commanders to lead these efforts.

Each emergency order identified specific authorities for each incident commander based on each government's unique role in responding to the fentanyl crisis. However, the shared goal was to create a Unified Command and bring each government's resources together strategically to increase collaboration and coordination of the many good efforts underway in this region aimed at reducing fentanyl impacts in the central city.

These impacts include, but are not limited to, overdose deaths, addiction, houselessness, vibrancy of public spaces, and criminal activity.

Understanding that there are many, many pieces to this complicated puzzle that will not be resolved within 90 days, it is critically important that the Unified Command have a clear understanding of the expectations of the Agency Administrators for this effort.

We also recognize the unique opportunity presented by using an Incident Management Team structure to address the chronic crises presented and exacerbated by fentanyl. In order to benefit from this structure, leaders and participants need to be fully engaged in the IMT structure. Agency Administrators will also be fully engaged - to create open communication with leaders and the public, establish accountability of the effort, remove institutional barriers, and ensure efforts are fully supported by home agencies.

EXPECTATION 1: Coordinate and align existing resources working to address fentanyl (objectives 1 and 2)

- Inventory current efforts among partners, including:
    - Outreach and engagement services
    - Transportation resources
    - Behavioral Health and Health efforts:
        - Sobering and treatment resources and beds
        - Medical treatment, including in-field treatment resources
        - MAT, MSR, Naloxone, or other SUDs medication interventions
    - Housing resources

        - Temporary shelter resources
        - Long-term housing resources
        - Permanent supportive housing resources
    - Criminal Justice
        - Law enforcement resources
        - Corrections resources
    - Other services and programs identified to meet the needs of the city center and target population(s)

TIMELINE: An initial inventory should be complete no later than Monday, March 4.

- Coordinate efforts among existing resources
    - Facilitate real-time collaboration by bringing identified partners together to align individual efforts in a coordinated manner
    - Identify any barriers to coordination and collaboration and make recommendations (staffing, funding, programming, etc) to overcome these barriers
    - Identify systems of communication currently in use by partners (mobile applications, cell phone, dispatch, 311, etc.)
    - Develop unified communication systems and coordination that can be sustained and expanded beyond the city center after the 90 day emergency has ended (is there a software, mobile app or other solution that could help partners coordinate more efficiently?)

TIMELINES:

- **2-1-1 should have real-time insights into shelter bed availability no later than March 31.**
- **A plan to sustain this should be provided no later than April 15.**
- **The partnership between Peer Support and Law Enforcement and other key partners should have regularly scheduled weekly hours no later than March 31.**
- **A plan to sustain this effort, including staff from all participating partners, should be provided no later than April 15.**

EXPECTATION 2: Develop a coordinated data collection and reporting system (strategy 3)

- For each area data effort, disaggregate data by race and/or ethnicity (or other demographic, like gender) whenever possible to create equity pathways
- Inventory existing data and data reporting systems in use by partners (including, but not limited to, overdose deaths, addiction, houselessness, vibrancy of public spaces, and criminal activity). Develop metrics for both baseline and ongoing reporting by partners, including at a minimum (if metrics should be reported but are not immediately available due to data-sharing legal or technological obstacles, document data work to be tackled post emergency):
    - # people contacted during outreach missions
    - # people moved to shelter sites
    - # people moved into long-term housing
    - # referrals to different services
    - # people enrolled in treatment programs
    - # outreach workers deployed
    - # of law enforcement missions
    - # of arrests for fentanyl distribution
    - #M110 citations issued
    - Amount of fentanyl and other drugs seized
    - # Narcan given
    - # overdose deaths
    - # overdose reversals
    - # bupe given
- Identify or develop a process to centralize the collection and reporting of data

    - Identify or create a standard reporting template and process for ongoing collection of information if it does not currently exist in an automated system
    - If due to data-sharing obstacles this is not possible to complete in 90 days, detail the key people and resources needed to continue work beyond 90 days
- Launch a data dashboard on the UC website
    - Ensure the Agency Administrators have approved all information to be shared publicly
    - Develop recommendations about what data and information should be included in the dashboard (including updating cadence)
    - Develop recommendations about regular static reports that may be needed to ensure anonymization of data
    - If due to data-sharing obstacles this is not possible to complete in 90 days, detail the key people and resources needed to continue work beyond 90 days

TIMELINES:

- **Provide the data inventory no later than Friday, March 8.**
- **Provide a draft dashboard of data for internal review no later than Friday, March 22.**
- **Go live with a public dashboard no later than Monday, March 25.**
- **Provide a plan to sustain the data dashboard after the expiration of the emergency order by no later than Monday, April 15.**

Expectation 3: Publish weekly reports on UC progress via a centralized website (JIC)

- PIOs shall create public-facing template for situational reports or other reporting that will be published every Friday on the website
    - These reports should provide preliminary data that is collected during the week at coordination meetings, with the understanding that confirmed data will be included in the dashboard as it flows in from partners
- PIOs shall create public-facing version of incident objectives and command emphasis to immediately publish on the website (subject to Agency Admin final approval)
    - Tactical information should be included, though it can be summarized
- PIOs should be kept abreast of efforts in the field and, when appropriate, document them with photo and/or video for additional public reporting and transparency
- Agency Administrators shall approval all information prior to public reporting

TIMELINE: Publish weekly updates beginning this Friday, March 1 and continue weekly through the emergency.

Expectation 4: Establish communication pathways for information gathering and sharing (JIC/UC)

- Establish clear roles and responsibilities for all IMT members
    - Ensure requests for data coordinated and designate points of contact for each request
- Establish a mechanism to track UC efforts that is accessible by all IMT members
    - Even if this is just a shared document that identifies different efforts, points of contact, and allows those working on these efforts to update it in real-time
- Maintain regular communication with Agency Administrators and keep them apprised as needs arise
    - We can and are happy to help facilitate getting the team access to information and systems

    - Additionally, there are many political efforts currently underway that we can provide updates on if we know the UC needs information
- Update Agency Administrators of the following at regular Monday and Thursday check-in meetings:
    - Comms updates
        - Status of public-facing information sharing
            - Including plans for any public/media events or
                - Communications
        - Update on any anticipated comms issues Principals should be updated on
    - Data team updates
        - Status of metrics development
        - Update on any outstanding data requests from the UC to partners
            - Would Agency Administrator assistance be helpful
        - Updates on any new or outstanding data requests from Principals
            - Would Agency Administrator assistance be helpful
    - Street coordination team updates
        - Coordination meeting updates
            - Who is attending
            - Who needs to be attending
            - Successes and challenges
            - Status of real-time data collection and reporting
    - Future policy development & recommendations team updates
    - Identify any UC needs for Agency Administrators and Principals

TIMELINES:

- **Establish daily close-out briefings for section chiefs, unified command, and agency admins beginning Wednesday, February 28. Ensure notes are taken and stored in an accessible place.**
- **Establish weekly all-hands meetings no later than Monday, March 4. Ensure notes are taken and stored in an accessible place.**

Expectation 5: Policy and Strategic Planning (strategies 4 & 5):

- Identify housing, health and law enforcement gaps and obstacles, then make specific policy recommendations to leaders and lawmakers for better coordination.
    - Ensure calling out the unique needs and obstacles presented by fentanyl
    - Prioritize requests that could be expedited by the authority of the emergency declarations (such as licensing reciprocity or locum tenens opportunities for behavioral health workforce, suspending or expediting regulatory requirements or processes for relevant services, etc.)
- Develop a 90-day plan to expand and improve response efforts, with focus on both short-term and long-term needs
    - Include recommendations specific to the city center and across Multnomah County
- While working to meet these expectations and command strategies, document any complexities that shall require work beyond 90 days, including but not limited to:
    - Legal obstacles and legislative asks
    - Funding gaps
    - Needed policies
    - Data collection, reporting, and sharing
    - Any other obstacle or opportunity identified through the emergency declaration

TIMELINE: Provide an initial policy brief no later than Monday, March 11. Provide updated / new / additional policy briefs On April 11 and at close of emergency.

Appendix E

Data Sources Inventory for Portland City Center Fentanyl Crisis

This inventory includes detailed data information for a variety of agencies, much of which has been redacted for efficiency of this report and appendices. The full inventory can be accessible on the shared document platform of the IMT.

Table E1. Data Sources Inventory for Portland City Center Fentanyl Crisis

Data Sources Inventory: Portland City Center 90-day Fentanyl Emergency Response											
Leadership Request: Inventory existing data and data reporting systems in use by partners (including, but not limited to, overdose deaths or, addiction, houselessness, vibrancy of public spaces, and criminal activity). Due to Agency Admins Friday March 8 (need UC review prior to deadline)											
Source Agency	**Department**	**Indicator**	**Use of Data in Response**	**Status Notes**	**Barriers**	**Point of Contact**	**Cadence of Reporting**	**Format of Reporting**	**Disaggregated Demographic Data?**	**Most recent contact/ report**	**Other - questions or comments**
Portland Fire and Rescue	Community Health	Buprenorphine inductions	Situation reporting	Received 3/6/24	Gathering data requires a lot of staff time		Daily	Google forms and 0800	No		
Portland Fire and Rescue	Community Health	Naloxone kit distributions	Situation reporting	Received 3/6/24	Gathering data requires a lot of staff time		Daily	Google forms and 0800	No		

Appendix F

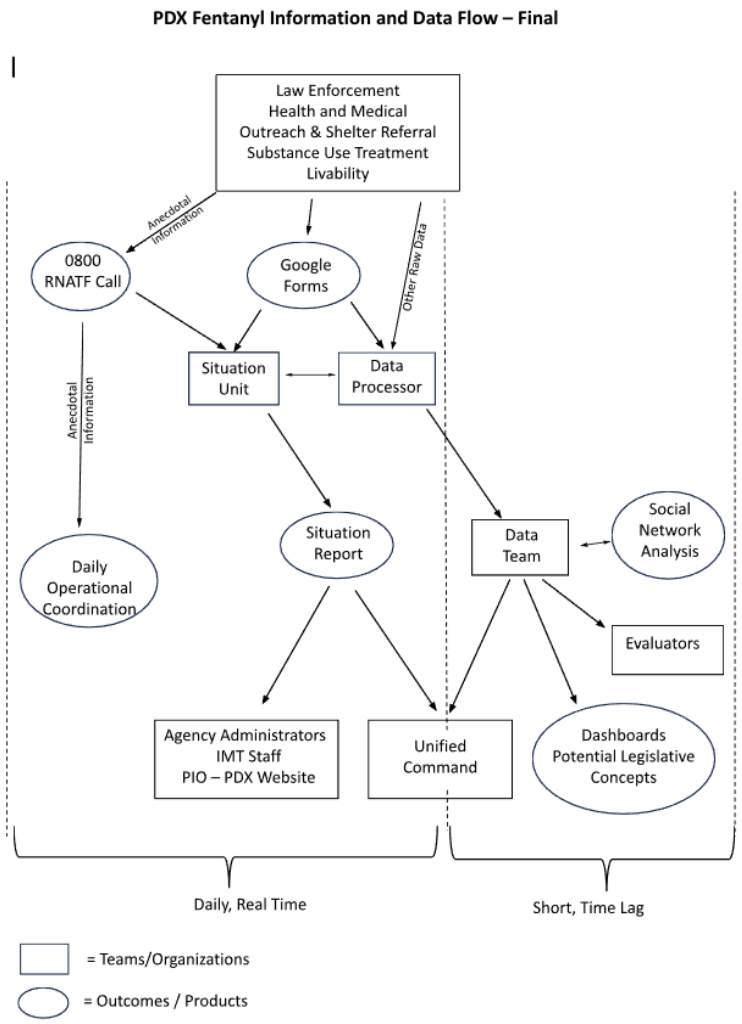
Details on Response Activity Tracking Process

Agency Administrators requested that the following metrics be collected over the course of the response:

- # people contacted during outreach missions
- # people moved to shelter sites
- # people moved into long-term housing
- # referrals to different services
- # people enrolled in treatment programs
- # outreach workers deployed
- # of law enforcement missions o # of arrests for fentanyl distribution
- #M110 citations issued o Amount of fentanyl and other drugs seized
- # Narcan given
- # overdose deaths
- # overdose reversals
- # bupe given

To capture these data points Agencies verbally reported out during the Rapid Needs Assessment Coordination Call or emailed their information to a Google Group email address that was monitored by the Data Group members. The development of a set of sharable forms for daily reporting to be filled out by agencies, transferred the onus for collecting and reporting from the IMT to the agencies doing the work in the field. Collection and organization of this information were begun by the Data Group reporting leads and later taken on by project management within the Planning Section of the IMT. Figure F1 captures the pathways for situation reporting information collection.

Figure F1. PDX Fentanyl Information and Data Flow



Appendix G

Equity Needs Assessment

Communities:

- Tribal Communities:
    - **Community Engagement Findings**:
        - Concerns:
            - Highest rate of overdose per embargoed Health Department data when using the multi race data method.
            - Community members coming to the city to access resources are easily lost if they leave a program.
            - Community members are not regularly identified while in the continuum of care which prevents them from accessing resources and perpetuates "the invisibility" of the community; while this lack of identification has real world impact, the way we ask about tribal affiliation needs to be done in a culturally affirming way due to current and historical harm that continues to impact this community
        - Community Feedback:
            - They have to do something specific for the Indian country, because they don't have the same rules as everyone else.
            - There will need to be a Tribal Relations communication strategy.
            - Community wants data shared with them. Data sharing strategy was not communicated to all tribes leaving some feeling like it was an opaque process.
            - Low Barrier access to the services their community needs that includes wraparound services for the individual.
            - Have Case Managers inside of non-profit outreach so it can be a soft hand off.
            - Government funds for culturally specific work (at the rate of disparity) not population.
            - Great Circle could expand service and access if they could get a bigger building. They are looking to provide greater wraparound services in a single location in order to close the gaps.
    - **Recommended Resources**:
        - Support partnerships between philanthropic agents and private non profits: connect the agents offering building space to Great Circle.

    - **Policy:**
        - Get police and firefighters on board to ask people when they are being arrested or in contact with people who are addicts if they belong to a federal tribe.
        - Tribal-specific briefings and funding strategies
- African American:
    - **Community Engagement Findings:**
        - Concerns:
            - OHA data identifies this community as having the highest rate of Overdose due to fentanyl.
            - Access to treatment appears to be lower in MAT services.
            - No known pathways to receive supplies from the Naloxone Clearinghouse system.
            - Booking rates for fentanyl related charges are higher for this community based on the last 5 months of PPB data.
        - Community Feedback:
            - Focusing on downtown shunts resources to areas that have a lower black population. If black folks are dying more why are we focused on places where black folks aren't.
            - Worries about the impacts of mental health disorders on the community like psychosis induced by drug use more than overdoses.
            - Need targeted marketing and outreach.
    - **Policy:**
        - Increase Medication Assisted Treatment (MAT) capacity in county jails and detention centers to include therapeutic dosing of U.S. Food and Drug Administration (FDA) approved Medications for Opioid Use Disorder (MOUD): Naltrexone, Buprenorphine, and Methadone.
- African
    - **Community Engagement Findings:**
        - Concerns:
            - Disconnection between immigrant parents and American born children creates complexities for both understanding and communicating about addiction.
            - Narcan is accessible in some parts of the community but how and when to use it is not widely known.
            - Baseline information on what addiction is and looks like within the community does not currently exist.
        - Community Feedback:
            - The African diaspora has varied needs based on the specific community of focus.

                - There are many organizations that exist to support pan african communities as well as country and community specific organizations, none that we are aware of that focus on SUDs though.
                - Culturally for many African communities talking about addictions within the community is taboo, however this is changing based on the communities recognition of need and a rise in both overdose and within one particular community gun violence.
                - Support in creating educational materials as well as systems to align current organizations with current needs would be helpful to the community.
        - **Recommended Resources:**
            - Connected Health Department communications with immigrant outreach strategists to create the identified educational materials outlined above.
- Latine:
    - **Community Engagement Findings:**
        - Concerns:
            - Community perception is that fentanyl is not an issue within their community; meth is the major concern. Embargoed data shows an increasing rate of fentanyl related overdose within this community. Drug treatment programs with urine drug screen data report increasing rates of fentanyl mixed with meth supplies.
            - Booking rates for fentanyl related charges are higher for this community based on the last 5 months of PPB data.
        - Community Feedback:
            - Culturally specific materials to heighten awareness in this area for high risk community members would be helpful for the community and providers.
    - **Recommended Resources:**
        - Assigned to Health Department communications the community requested culturally specific harm reduction materials.
    - **Policy:**
        - Increase Medication Assisted Treatment (MAT) capacity in county jails and detention centers to include therapeutic dosing of U.S. Food and Drug Administration (FDA) approved Medications for Opioid Use Disorder (MOUD): Naltrexone, Buprenorphine, and Methadone.
- SPMI:
    - **Community Engagement Findings:**
        - Concerns:

- This community sits at the intersection of most of the gaps created by our risk adversity cycles (eg. Behavioral Health causing disruption in care due to being discharged from services, Behavioral Health instability making it difficult to maintain stability within housing, etc.)
- Due to the risk adversity cycle of this population often lack systems for coordination across all levels of services, from community safety to medically managed withdrawal to outreach and drug treatment exacerbate poor outcomes for this community.

■ Community Feedback:

- Behavioral Health needs for this community are sometimes greater than the capacity of providers to support, leaving emergency services such as community safety and emergency rooms as the de facto placement for these folks.
- Folks leaving the jails have a high incident rate of SPMI; since they are not convicted of crimes, they are usually booked based on the above statement, they are released without the benefit of the probation system's resources. This leaves corrections officials in the position of releasing folks into unsafe environments under unsafe circumstances knowing the heightened risk of overdose.

○ **Recommended Resources**:

■ A previous Rapid needs assessment coordination call from the city was expanded to fill the cross systems coordination gap for the Central City area.

■ Further expansion of this call by district is required to coordinate similar services across the county in small enough sections to maintain coordination calls without an overwhelming number of participants while maintaining a broad enough spectrum of service providers (i.e. community safety, outreach, shelter, livability and drug treatment).

- Veteran:
  - **Community Engagement Findings**
    - Concerns:
      - We have had difficulty determining what are the main areas of concern for this community as the programs that support vets experiencing SUDs have neither participated in any of our outreach events, nor have we been able to communicate directly with anyone providing direct services to them due to administrative barriers.
    - Community Feedback:
      - We have not been able to receive community feedback.

Common Themes:

- All of the communities we spoke with shared the following common themes of need and/or recommendations needed to address the situation:
    - Community specific, time sensitive, communication materials are needed to support, respond, and inform the community quickly and effectively around this rapidly evolving crisis.
        - All communities identified the need to have campaigns that encourage adults to play an active role in the lives of youth as a key prevention strategy.
- Naloxone/Narcan access; identifying routes of access to these communities must be a priority given the higher rates of overdose within these communities.
    - Culturally/community specific educational materials about administration and identifying when to use the medication are needed.
- Payer systems need to incentivize high acuity person needs over quantity of people served.
- Contract systems need to be simplified for both reporting and access to funding. These contracts need to be built in a holistic way with vision that creates coordinated systems of care instead of unintentionally creating competition between contracted CBOs.

Appendix H

Executive Order Policy Recommendations

Table H1. Executive Order Policy Recommendations

Recommendation	Description	Responsible party/parties	Identified cost, if any	Identified code or regulation change, if any
Program & Operational Expansions				
Expand the Queer Affinity Safe Rest Village	Expand the Queer Affinity Village in Portland with adjacent ODOT property by finalizing land swap agreement. The expansion is 25 additional pods and will cost $2,000,000 including the pods and 1 year of operations. Explore private partnership options to fund pods in collaboration with State.	City	$2,000,000	
MHAAO Peer/Police Pilot Expansion	$683,000 invested by City, County, State for one year of leasing a coordination space, staffing, and a van. Implement a pilot.	City, State, County	$683,000 (split between all three jurisdictions)	
Naloxone Funding	State Opioid Settlement Board funded immediate naloxone purchase for the state clearinghouse, but because sustained funding is not secured, ongoing lobbying will be required in the next session.	Representation from City and State	$706,000 (in state opioid settlement dollars)	
Post-overdose response/aftercare	Continue CHAT buprenorphine program coordinating with SSCC and City Shelter team for aftercare shelter	City	N/A	

coordination	placement which started during the emergency.			
Housing placements out of Clinton Triangle Temporary Alternative Shelter Site	52 housing placements identified through JOHS to connect clients at Clinton Triangle with rapid rehousing between now and June 30, 2024	City and County	$1,000,000 (?)	
MHAAO/SSCC Care Coordination pre- and post-detox	Continue MHAAO coordinating with SSCC and City Shelter team for set-aside pods specifically intended for staging pre-detox and/or treatment or post-detox/treatment, which started during emergency.	City	N/A	
Nighttime Outreach Partnership: VOA/PPB	Initiate coordination of VOA peers working with swing shift lead for PPB Central to provide outreach alongside patrol police in the evenings in the central city core.	City	N/A	
Expand access to Naloxone during evening hours	Continue to allow broad access to naloxone to outreach workers during evening hours.	City/County		
Expand availability of Naloxone in JOHS warehouse	Continue to stock Naloxone in the JOHS warehouse for distribution to outreach workers.	County		
New Projects & Proposals				
Declare a national emergency on opioid epidemic	Following the lead of the 2023 National Tribal Opioid Summit, we will call on the President of the United States to declare a national emergency for the opioid epidemic to open additional resources and authorities to address the crisis.	City/State/County/Federal		
Fund FORA treatment center guardrails to reduce emergency room visits	Environmental design changes at FORA Treatment Center to reduce the need to take clients to ED when restless and withdrawing.	State	$228,000	
Mobile Medicated Assisted Treatment	Expand MAT resources in Multnomah County by providing services through a mobile van in areas of high need. This proposal can be scaled depending on	County	500k for a new mobile unit, 54k per month for personnel	Possible City zoning changes

	available funding.		and admin costs.	needed depending on parking location for van.
Ankeny Apartments (CCC)	City will partner with CCC to lease 7 rooms at the Ankeny Apartments for individuals leaving detox/treatment	City	$100,000+	
PEMO Lighting/Environmental Design around Central Library	City installed lighting and gates/barriers in areas around Central Library to encourage safety through environmental design	City	$3,000	
Pilot: Provide Narcan in publicly accessible locations in or outside government buildings	Purchase cabinets for lobby interiors and outside buildings, at 2 locations. Use Harm Reduction or grant funds to purchase vending machines/ cabinets and supply Narcan.	City/County	TBD	
Workforce Development at Shelter Sites	Pilot program proposal for Clinton Triangle TASS; partnership with Cultivate Initiatives to start a workforce development program by teaching life and work skills to residents.	City/County/State?	$500,000	
Shelter tracking system for providers	This work has begun as part of the Homelessness Response Action Plan (HRAP). JOHS is in the early phase of confirming the Minimum Viable Product with their partners. JOHS will determine a short term solution to tracking shelter space availability while they work towards a longer term tool.	County	TBD	
OHSU treatment bed tracker	The OMCC/BMCC is a joint cooperative arrangement between OHSU, Providence, Kaiser, Legacy, and other hospitals in the area. OHSU operates the system. The project is funded through June 2024 but will need funding beyond that to maintain the system and continue	State		

	the project.			
Create the position of MAT/MSR Coordinator for Multnomah County Jail	The position will work with on implementing the federal waiver related to MAT/MSR medicaid reimbursement as well as administering MAT/MSR in the Multnomah County Jail.	County		
Strategy for impacted communities	Work with impacted communities to review the HD report on overdose deaths and develop a strategy aimed at addressing racial disparities.	County		
Monitor pilot with Multnomah County HD and OSP to streamline suspected overdose death reporting.	The County and OSP began a pilot related to confirming suspected overdose deaths. Monitor pilot and continue if it achieves stated goals of streamlining data collection.	State/County		
Longer Term Projects & Proposals to Address Systemic Gaps & Barriers				
Research impact of overdose prevention sites in Multnomah County	As a part of a comprehensive harm reduction strategy, research the impacts and viability of OD prevention sites.	County/State		
Equitable data collection	To ensure the benefits and risks associated with the drug addiction crisis and proposed interventions are distributed justly, Oregon should lead in equitable data collection.	City/County/State		
Equitable data collection - part 2	Move towards a system that earmarks funding for culturally specific work at the rate of the disparity not populations.	City/County/State		
Create a Triage Center Services Program in Multnomah County	To include referral pathway, screening and evaluation to determine the clients service needs, and continuity of care to link the client to housing and appropriate health and social service needs.	City/County/State funding; County to execute	$12-15 million annually (to include withdrawal management, excluding billable services revenue)	

MSR with supportive housing pilot	PATH will coordinate the housing and other services associated with expanding housing to the mobile MSR program.	County		
Expand youth SUD prevention programs	Most SUD begin before the age of 25. For that reason, we should develop robust SUD prevention programs targeted at youth.	County/State		
Allow PSR to transport individuals to treatment centers	City working with Fire union	City/County/State		
4002 Transport Legal Opinion re: Police and PSR transport option	Pending pathway to legislative council.	City and State		
Medicaid Reimbursement Expansion (street medicine, housing supportive services, behavioral health)	City and County working on proposal for billing with providers	City, County, State		
Background Checks for Behavioral Health Workers	Specific concern was Peers who have criminal background.	State		
OARs for Social Detox	OHA will accept variance request but changes can not be made to ASAM criteria as it's a national standard.	State		
Methadone Regulation Changes	42 CFR Part 8 Final Rule | SAMHSA	State (OHA and ADPC)/Federal		
Staffing at Multnomah County Corrections Health	Review County and MCSO hiring process for opportunities to streamline and improve recruitment and retention of Corrections Health staff	County		
Workforce - improve and increase recruitment and retention for behavioral health and treatment providers.	Streamline licensing requirements and reciprocity for licensing healthcare workforce and partner with private sector for national recruitment campaign and increase reimbursement rates.	State		

Appendix I

Post 90-Day Fentanyl Response Task Force

Background: The 90-day Fentanyl Emergency Response expires at the end of April. Unified Command requested a plan to continue the resource coordination that has been occurring during the emergency declaration beyond the 90 day response window. The mobilization and organization created by the emergency declaration has functioned as a hub to connect many disparate agencies and service providers to address the fentanyl crisis in the Downtown/Old Town area of Portland. Specifically, the daily Rapid Needs Assessment Coordination Call provided a vital touchpoint for call participants. To maintain the positive momentum that was created during the emergency response, there is a desire to continue this coordination by creating a "task force" that meets regularly.

Proposal: To continue the work of the PDX Fentanyl Rapid Needs Assessment Coordination Call in addressing fentanyl use in the central city, the IMT Operations Section proposes creation of a new pilot task force.This new task force would be centered around Multnomah County voting District 1 (with the idea that this model could be replicated in other Cities or County voting districts). The pilot task force would be relatively small and meet regularly. There would be a continual process of assessment and process improvement to adjust and create a sustainable model that can be replicated across other districts, including East County coordination.

The District Coordination Action Team (DCAT) would be made up of up to 12 to 15 representatives with operational knowledge and leadership buy-in from their respective fields, which will include (but not be limited to):

- Street outreach
- Behavioral health
- Crisis response ex:(*PF&R*, *PSR, CHAT*)
- Public Health
- Harm reduction services
- Detox/treatment
- Transit (ex:*Portland Streetcar, Trimet*)
- Parks department
- Law enforcement (PPB and Sheriff's office)
- Rapid Response/Street Cleaning
- and any applicable city/county agencies

Specific representation would vary by district, as some organizations might have more presence in certain areas over others. Meetings would be coordination sessions designed for participants to work together to address issues of overdose prevention, "hot spots" of substance use, opportunities for mutual support, and other areas where cross agency/organizational

collaboration could improve clients' lives and community health. The goal would be to reduce overdoses, link people with the services they need, and improve the quality of life for all who reside in that District. This call would help troubleshoot service gaps in:

- access to treatment
- access to detox
- lack of access to basic needs supplies
- livability concerns
- general health concerns
- Navigation to homeless services

The District Coordination Action Team (DCAT)--would meet via phone for half an hour Monday through Friday to coordinate agencies and service providers around fentanyl use in District 1, with the understanding that services addressing substance use can overlap into those that address homelessness. The frequency of calls may be subject to change depending on the needs of participants. The meeting should be coordinated by an agency or organization with capacity to organize the meeting, including facilitation of meetings, follow up with participants, note taking and disseminating information. The organization or agency should also have some familiarity with one of more of the disciplines represented in the call. Portland Solutions and Multnomah County Emergency Management have potentially agreed to host calls during the interim period while a sustainable model is developed and a permanent home is determined.

There is an open question relating to activity metrics, and the collection and dissemination of those metrics. For example, the DCAT could maintain an active dashboard of information pertaining to their collective work, including a map of the district displaying overdoses and other pertinent information. This map could be accessible to all DCAT participants (an example of a similar map is the Impact Reduction Program's GIS map of encampments in Portland). DCAT data collection could include number of engagements on the streets, referrals to shelter, referrals to detox/treatment, overdoses, and any other data deemed important to the group that they have capacity to collect and record. This information could potentially be available to DCAT members, agency leads, and elected officials. The meeting coordinator could provide a report out of DCAT activities, as well as recommendations from the group to agency leads and elected officials. Once a sustainable and scalable model is created, it could be replicated in other City and/or County voting districts. There is an open question as to whether the model would be located at the City, County or another entity. The final model will likely result in 3-5 coordinating calls, roughly covering each City or County voting district and including an East County coordination call. Scaling across the County will necessitate another level of coordination among those groups. For example, the Centralized Coordinated Action Team (CCAT), with a representative from each DCAT, could meet regularly to communicate trends and issues within their district, and work to build service connections county wide.

Appendix J

Triage Center for OUD/SUD

Triage would improve the quality of services for those suffering with opioid use disorder and substance use disorder. It is known that no single treatment is effective for all individuals, and that matching individuals to services they need improves the likelihood of their success in treatment.

A triage center will improve immediate access to opioid and other substance use disorder treatment services, reduce health disparities among those with substance use disorders, and alleviate strain on the emergency care system. An interdisciplinary treatment team would provide walk-in medical triage, or drop off, addiction assessment/screenings, and linkage to inpatient, outpatient SUD treatment and housing services. Individuals experiencing substance use will be evaluated for safety and treatment needs, and then linked to the best treatment options for them. Matching to specific treatment interventions also is cost-effective and improves the quality of services within existing programs.

This proposal is to open a brick-and mortar SUD triage center where people with OUD/SUD could immediately access treatment, care coordination, observation, and access to any of the other recovery supportive services they need,including, but not limited to, pathways to recovery supportive housing. In addition to creating pathways to essential services, the triage center will reduce burden on first responders who would be able to refer individuals to the center for screening and assessment.

Program Design

1. Target Population: Any individual with OUD or SUD who are seeking and treatment and recovery services and wrap-around services (e.g medical, behavioral health, housing)
    a. Within Multnomah County
    b. May be actively using but voluntarily seeking to stop
2. The length of stay: dependant upon screening and assessment and based on best practices
3. Referral pathways entry processes: Broad range of referrals sources and entry pathways expected as shown in Figure K1.
4. Service Description: The Triage Center will provide MAT and observation services on site.
   PATH Staff will be on site to provide care coordination services. The Triage Center staff will have narcan on hand, and the Triage Center will have narcan to distribute, as well as other harm reduction supplies.

   Behavioral Health staff will assess and refer individuals to appropriate SUD services, including, but not limited to emergency room, withdrawal management, sobering,

Medication Assisted Treatment, outpatient treatment, inpatient treatment, and recovery supported housing. ADRC staff will do Medicaid eligibility and referral to aging, disability, and veteran services.

1. Facility Description: The Triage Center should be, for maximum effectiveness, open 24 hours or schedule open hours in such a way to offset existing daytime services and fill service gaps. The Triage Center should have capacity for 50 to 60 guests, with an appropriate staff to guest ratio. The space will be drug and alcohol free and will be set up as a modified congregate environment that would allow for maximum privacy while still enabling observation.

2. Staffing: As much as possible, staff needs are expected to be met through linkages to available resources and partnerships in a variety of service areas. PATH staff will be available to provide care coordination. Additional core staff could include medical staff, peers, and clinical service staff.

3. Exit planning/transition to housing: The Triage Center will be a Coordinated Access point to refer individuals to recovery supportive housing.

Principles guiding program design and operation

Triage center operations will be guided by and designed around the principles of collaboration, coordinated service delivery, low barrier access, culturally specific services, adequate staffing for individualized care, wrap-around care for successful recovery, supported by peers with lived experience. The model is intended to:

1. Leverage existing community resources to address a key gap in the SUD continuum
2. Coordinate government resources to improve service access
3. Marshal essential public resources and funding from across sectors (e.g. SUD, housing, first responders, behavioral health etc.) for both immediate community benefit and individual recovery related successes and to sustain a long-term response long after the emergency declaration period passes.

Options for leveraging other resources/partnerships

Several options for leveraging existing resources and partnerships to make sure services are available are in the process of being explored and will be further developed. These include:

1. Working with City Outreach Teams in geographic areas
2. Multnomah County PATH team
3. Identifying ways to connect to the Behavioral Health Resource Networks to allow clients to access BHRN services
4. Housing Access
    a. Coordinated Access for Permanent Supportive Housing through CHAT hotline, 211, online application, assessment completed at shelter, and agency referral.

b. Housing Multnomah Now offering Rapid Rehousing Housing (up to 12 months of rental and client assistance) engaged at Old Town. The households must be identified in the engagement process by provider.

5. Identifying ways to connect with BHECN once that is launched

Outcomes

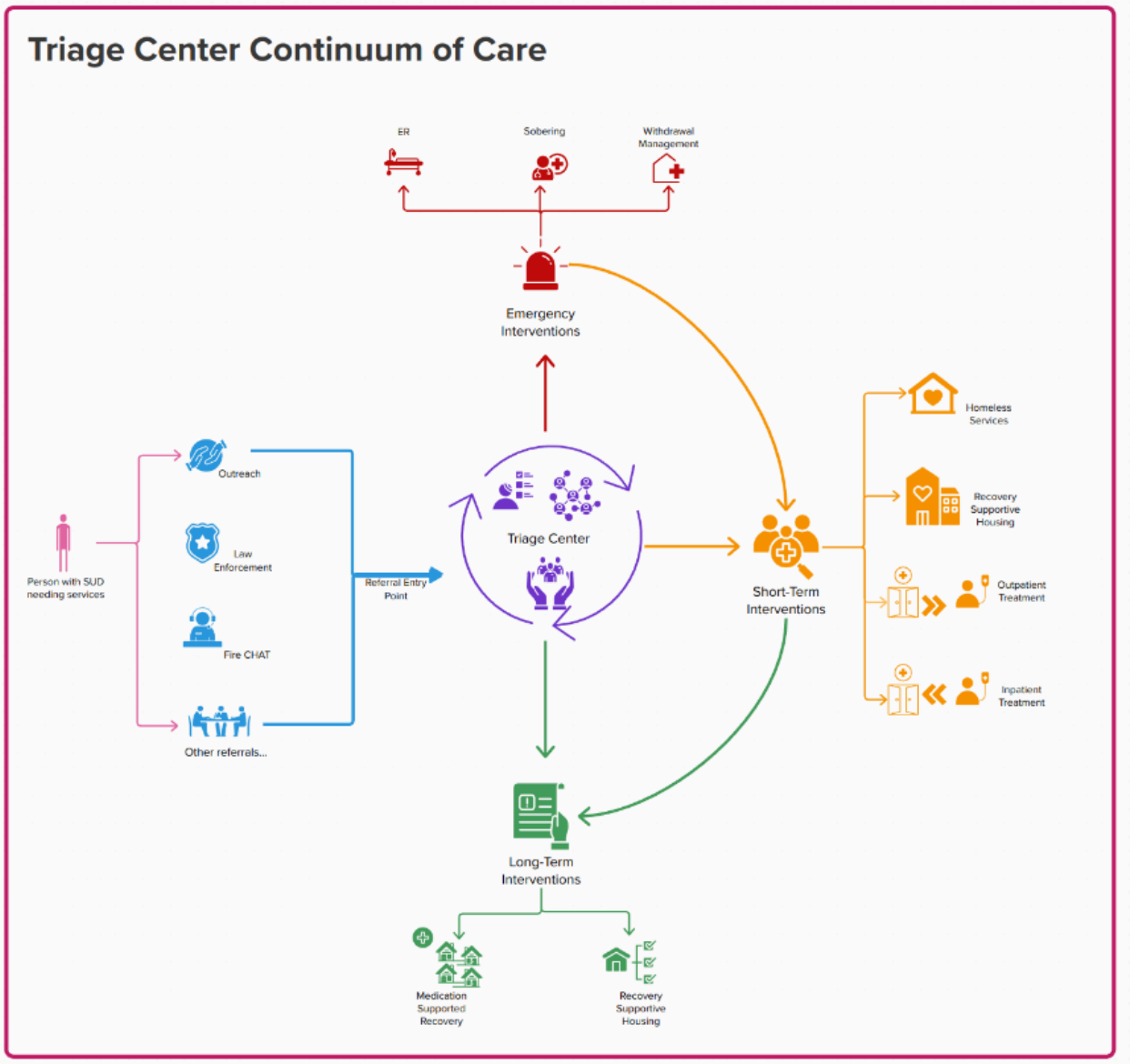
Initial outcomes would be greater retention of individuals seeking services for fentanyl use disorder and more supportive housing placements

Measures

To evaluate the success of the pilot the following data will be collected:

1. Referral source for both those who enter and those who do not enter. Specifically whether the referral was from other services or from the street
2. # turned away and for what reason
3. # admitted
4. Type of services received
5. Length of stay for each individual admitted
6. # receiving treatment
7. Demographics for those who enter

Figure K1. Triage Continuum of Care



Appendix K

Mobile MAT Expansion, Pilot Program with CRC/Allied

This pilot would expand Mobile Medication Assisted Recovery (MSR) in Multnomah County through a partnership with CRC/Allied. Eventually, this pilot would be broadened to connect with MSR plus recovery supportive housing services, care coordination by PATH and triage if needed. This would create an opportunity for those with opioid use disorder to access treatment with methadone, which is known to be highly effective for those with opioid use disorder.

The target population for services
Individuals from Multnomah County who are actively using but voluntarily seeking to stop using fentanyl, and who are assessed to be a match for MSR.

Number served
There is no pre-set limit to the number of individuals that can obtain their doses at the mobile site. CRC can operate the mobile van if a minimum of 30-40 individuals use the site, with up to 5 new admissions anticipated per day.

Referrals
Referral sources can be broad. Can be PATH, any of the city outreach teams, self referrals, community providers, peers, etc.

Service Description
Patients arrive at the van via referrals, including word of mouth with current patients, through a referral source (see above) or through CRC's national referral number. Patients usually arrive at the van on their own because the van is parked in a high-need area.

If a patient is seeking to start MAT, an uber or other transportation can be immediately arranged to transport the new patient to CRC's brick and mortar location, where they can be admitted, pending regulation changes that would allow for virtual admissions at the mobile location. Once patients complete an intake and admission, they will be able to medicate at the mobile unit on a move forward basis after they complete admission.

Returning patients are able to medicate at the van on an ongoing basis and do not need to return to the clinic unless they choose to.

Next steps for a client

CRC can provide connection to services, help with placements in the appropriate treatment programs, connections to housing, e.g. [18]

What is needed for implementation & barriers

CRC has requested assistance in getting a speedy determination from the city of Portland on how the mobile unit would be zoned. Next a site within the operational area for the van to set up each day needs to be determined. Once a location is identified, it would take approximately 45 days to make the service available. This estimate takes into account the 30 days notice that the provider news to extend the medicating hours. During those 30 days the provider will work to gather licensing and other information that will be needed. There is some variability due to the necessary DEA approvals that are outside the provider's control.

Additional funding may be needed for staff and potentially to cover operational costs until the census of 30-40 is reached.

[18] This is available at the CRC clinics. Options for peer engagement with those who access MSR at the van, including through the BHRC, can also be explored.

Appendix L

MSR with Coordinated Care and placement in Recovery Supportive Housing

Medication Supportive Recovery (MSR), which can be accessed at mobile locations or can be office based at a treatment center, is critical for people who want to stop using fentanyl. Two of the several well established benefits of MSR for those using opioids are well established which are increased retention in treatment and decreased illicit opiate use and other criminal activity among people with substance use disorders. There are several organizations in the Portland metro area, including drop-in clinics, where people can be prescribed medication, provided counseling, and referred to additional services without an appointment.

Providers of substance use disorder (SUD) services across the continuum, including withdrawal management providers and residential treatment providers, have noted that the rise of fentanyl use has resulted in it taking longer to stabilize people starting treatment and needing more frequent and earlier adjustment to medication doses. MSR providers have reported that they see greater treatment adherence if people can move into stable and supportive environments such as recovery supportive housing.

In this model, people who start MSR will be connected by their treatment providers to the Multnomah County PATH Team. For those clients, PATH will provide care coordination with a focus on securing placement in recovery supportive housing. In order to make sure that the best pathways are identified, PATH will be based out of a triage center (see triage proposal and accompanying diagram).

Program Design

1. Target Population: individuals eligible for MSR include:
    - Individuals who live in Multnomah County and are actively using but voluntarily seeking to stop using fentanyl
    - are in need of recovery supportive housing and other recovery supportive services
    - Who have received MAT/MSR initiation or induction at a partner organizations (CRC/CODA/RWNW/CCC Old Town Clinic/FORA/Hooper)
    - And have been assessed by a coordinator within one of the partner treatment or withdrawal management partner organization
2. Housing determination: dependant upon screening and assessment and based on best practices

3. Referral pathways/entry processes: Referrals would come from MSR providers. Those could include (CRC/Allied, CODA, Recovery North West (RWNW)/ Central City Concern (CCC) Old Town Clinic/FORA/Hooper
4. Service Description: Individuals receiving MSR through one of the partnersing treatment organizations identified above (or others) will be connected to a PATH care coordinator linked to the triage center. The care coordinator will be able to provide referrals to a variety of supportive services depending on client need and, in particular, will assist the client to secure a placement in recovery supportive housing. Other services to which clients could be connected to include:Peer services, Medical services, Case Management, Transportation, Behavioral Health services, Primary provider navigation, Employment support

   A number of recovery supportive housing options supportive of each individual's recovery. The goal will be for each person to be placed in the most appropriate type of SUD supportive housing for their individual recovery. Individuals could exit to County-funded supportive housing or recovery housing. These County-funded options may include, but are not limited to:
   - CCC Blackburn (Up to 20 could be available for this purpose)
   - CCC Riverhaven (currently 5 beds could be used for County referrals)
   - A range of low barrier options at Bridges to Change (up to 27 beds could be available for this purpose).
   - In addition, using SHS funds, the County anticipates bringing a significant number of recovery housing units online in the coming months

Principles guiding program design and operation

This model is centered around collaboration, coordinated service delivery, low barrier services, culturally specific services, adequate staffing for individualized care, wrap-around care for successful recovery, supported by peers with lived experience. The model is intended to:

1. Leverage existing community resources to address a key gap in the SUD continuum
2. Coordinate government resources to improve service access
3. Marshal essential public resources and funding from across sectors (e.g. SUD, housing, first responders, behavioral health etc.) for both immediate community benefit and individual recovery related successes and to sustain a long-term response long after the emergency declaration period passes.

Options for leveraging other resources/partnerships

Several options for leveraging existing resources and partnerships to make sure services are available are in the process of being explored and will be further developed. These include:

1. Working with City Outreach Teams in geographic areas
2. Multnomah County PATH team
3. Identifying ways to connect to the Behavioral Health Resource Networks to allow clients to access BHRN services

4. Housing Access
    a. Coordinated Access for Permanent Supportive Housing through CHAT hotline, 211, online application, assessment completed at shelter, and agency referral.
    b. Housing Multnomah Now offering Rapid Rehousing Housing (up to 12 months of rental and client assistance) engaged at Old Town. The households must be identified in the engagement process by provider.
5. Identifying ways to connect with BHECN once that is launched

Outcomes

Initial outcomes would be greater retention of individuals seeking services for fentanyl use disorder and more supportive housing placements

Measures

To evaluate the success of the pilot the following data will be collected:

1. Referral source (how the client was connected to PATH)
2. # turned away and for what reason
3. # of individuals were moved into recovery supportive housing
4. # of individuals referred to treatment
5. Type of treatment referred into
6. Type of recovery supportive housing entered
7. Demographics

Appendix M

Situation Report Template

Fentanyl State of Emergency 2024

Multnomah County • City of Portland • State of Oregon

Incident Name: **Report Date:**
Portland City Center Fentanyl Crisis **Report Type:** Update

Incident Overview:

Executive Summary:

Weekly Accomplishments:

Expectation 1: Coordinate and align existing resources working to address fentanyl.
Expectation 2: Develop a coordinated data collection and reporting system.
Expectation 3: Publish weekly reports on UC progress via a centralized website (JIC).
Expectation 4: Establish communication pathways for information gathering and sharing (JIC/UC).
Expectation 5: Policy and Strategic Planning.

Situation Overview:

	January	Februar y	March	April	Total Deaths
Overdose Deaths Related to Fentanyl (Multnomah County;					

confirmed and suspected)					

Portland Bureau of Emergency Communication (911) **preliminary medical discipline incidents*** are reflected in the table below:

	January	February	March	April
Fentanyl related incidents				
Medical discipline incidents				
Fentanyl incidents as % of total medical discipline incidents				

{This information is only available county-wide}

Reportable Data:
The Data Group works with partners and agencies across the tri-government team to collect the following points of data. Progress and continuous improvement efforts are ongoing to address time lags limitations in our reporting. The following data reflects those best known at time of reporting, within the declaration's operational area, and are subject to adjustment by the next SitRep.

Reporting Group and Respective Metrics	Cumulative Amount	Effective Date / Comment	Weekly Amount	Collection Period
Law Enforcement				
Average number of officers active in area per day				
Number of arrests for distribution of controlled substance				
Grams non-fentanyl narcotics seized				
Grams fentanyl seized				
Number of M110 citations				

Number of substance use treatment referrals				
Number of naloxone doses distributed				
Number of overdose reversals				
Reporting Group and Respective Metrics	**Cumulative Amount**	**Effective Date / Comment**	**Weekly Amount**	**Collection Period**
Health & Medical				
Number of buprenorphine induction				
Number of overdose reversals				
Number of naloxone doses distributed				
Number of aftercare engagements				
Outreach & Shelter Referral				
Number of referrals to treatment programs				
Number of referrals to shelter				
Number of referrals to housing programs				
Number of outreach activities				
Livability				
Number of lights installed and locations				

Current Situation of Public Health & Public Safety IMT:

Incident Management	State	County	City	Other**	Total

The Weekly Situation Status Report requires multiple inputs across the response area. Those responsible for reporting need to submit their updates no later than 12:00 pm Wednesdays to the IMT Planning Section: ***[redacted google group]*** and/or ***[redacted google group]***. ***Situation Status Reports are distributed on Thursdays. Please do not forward the report without approval from Unified Command.***

Appendix N

Response from Joint Office of Homeless Services Regarding Request for Shelter Bed Availability Tracking

To: Portland Fentanyl 90 Day Response- Unified Command
From: DeAnna Negrete, Director of MAC Operations & Housing SME for Operations
Date: March 8, 2024
Subject: **Re: Expectations of Unified Command in Tri-Governmental State of Emergency**

Expectation 1: Coordinate and align existing resources working to address fentanyl Timelines: 2-1-1 should real time insights into shelter bed availability no later than March 31.

There are multiple reasons why this cannot be met within the proposed deadline.

The Joint Office of Homeless Services (JOHS), in partnership with the City, is working towards a Shelter Availability tool as directed by the Chair. Specifically, a plan from the Chair and Mayor - to be released Monday - includes a goal for an “interim connection developed for shelter providers to report available access and appropriate placement spots available, to be tracked in real time” with a June 2024 target date. The June 2024 target is in of itself quite ambitious. While we understand the nature of an emergency order, it is simply not possible to create the requested tool in the timeline.

On the first level, it would not be possible to build the underlying technology in the time frame.

Even if the technology were available and ready to be developed in March (and it is not), this tool would depend upon the training and follow through for a complex network of service providers to enter data either in a new system or with fundamentally different pace and structure than is current practice. The shelter system in Multnomah County consists of over 60 shelters programs operated by many different providers and funding sources. The shelter system in Multnomah County has three primary funding sources- Joint Office of Homeless Services

(County), city and private. Each funding source has different expectations and contracts for reporting, none of which currently require real-time data entry for shelter beds. These providers do not have the capacity - particularly when already responding to multiple crises and plans - to abruptly change expectations, train thousands of staff providers, and require data on this cadence and at this level.

While 211 is an excellent service connector, they would not be able to act as a resource in this manner without the technology and provider data entry as described above. We are also in the stage of developing the minimum assumptions and needs for a tool, and those details will drive whether 211 is even the appropriate group for this work. That is currently unknown.

As noted, JOHS is actively gathering information to clarify minimum needs for a shelter availability tool, and is working with an extremely ambitious June 2024 timeline. We are happy to discuss this project and timeline further.

Appendix O

Response from Joint Office of Homeless Services(JOHS) on request to use JOHS Supply Center for Distribution of Naloxone

To: Portland Fentanyl 90 Day Response- Unified Command
From: DeAnna Negrete, Director of MAC Operations & Housing SME for Operations
Date: March 27, 2024
Subject: Use of JOHS Supply Center for Distribution of Naloxone

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Original request sent from Neisha Saxena, Multnomah County Deputy UC on March 21, 2024: Hi everyone, Chris Voss, Kenn Sutto and I were talking about the JOHS outreach supply warehouse as a potential hub for supplies. It doesn't sound like they distribute naloxone at the warehouse, but we are wondering if: 1) that is a supply that should be distributed there; 2) if that would be a funding/policy request through this emergency; and 3) if this could be a natural outreach hub during this emergency since it seems that a number of different outreach teams across disciplines use the JOHS warehouse to access supplies. Please let us know what you think.

Follow up from Joint Office of Homeless Services- Supply Center
The Joint Office of Homeless Services provides a central location where street outreach workers, volunteers and mutual aid groups can pick up supplies to distribute to people living without shelter. The Supply Center distributes supplies both through regular monthly appointments and as needed in response to severe weather events. These supplies include water, sleeping bags, hygiene kits and medical supplies, and more.

Currently, the Supply Center does not distribute naloxone.

The Supply Center would have the capacity to store, track inventory and distribution of naloxone for the emergency order and would be interested in continuing past the emergency order. This could be operationalized quickly once policy and procedures are developed and the naloxone is at the warehouse. They would be able to support rapid immediate distribution through a week-long event with scheduled pick up hours just for naloxone.

Needs at the Supply center to distribute:

- *Storage and Security*- There is space in a climate controlled area at the Supply Center. Supply center staff requires instruction on naloxone storage best practices. A security storage cage would be beneficial to ensure tracking of inventory especially if there are needs for increased tracking for grants.

- *Purchasing and Funding*- Currently funding has not been identified for the purchasing of naloxone. It would be best if procurement and purchasing could be coordinated by the Health Department. Multnomah County Emergency Management provides supplies during severe weather events.
- *Policy and Procedure for Distribution*- Request for the Health Department to determine policy and procedures including training and list of providers "approved for distribution".

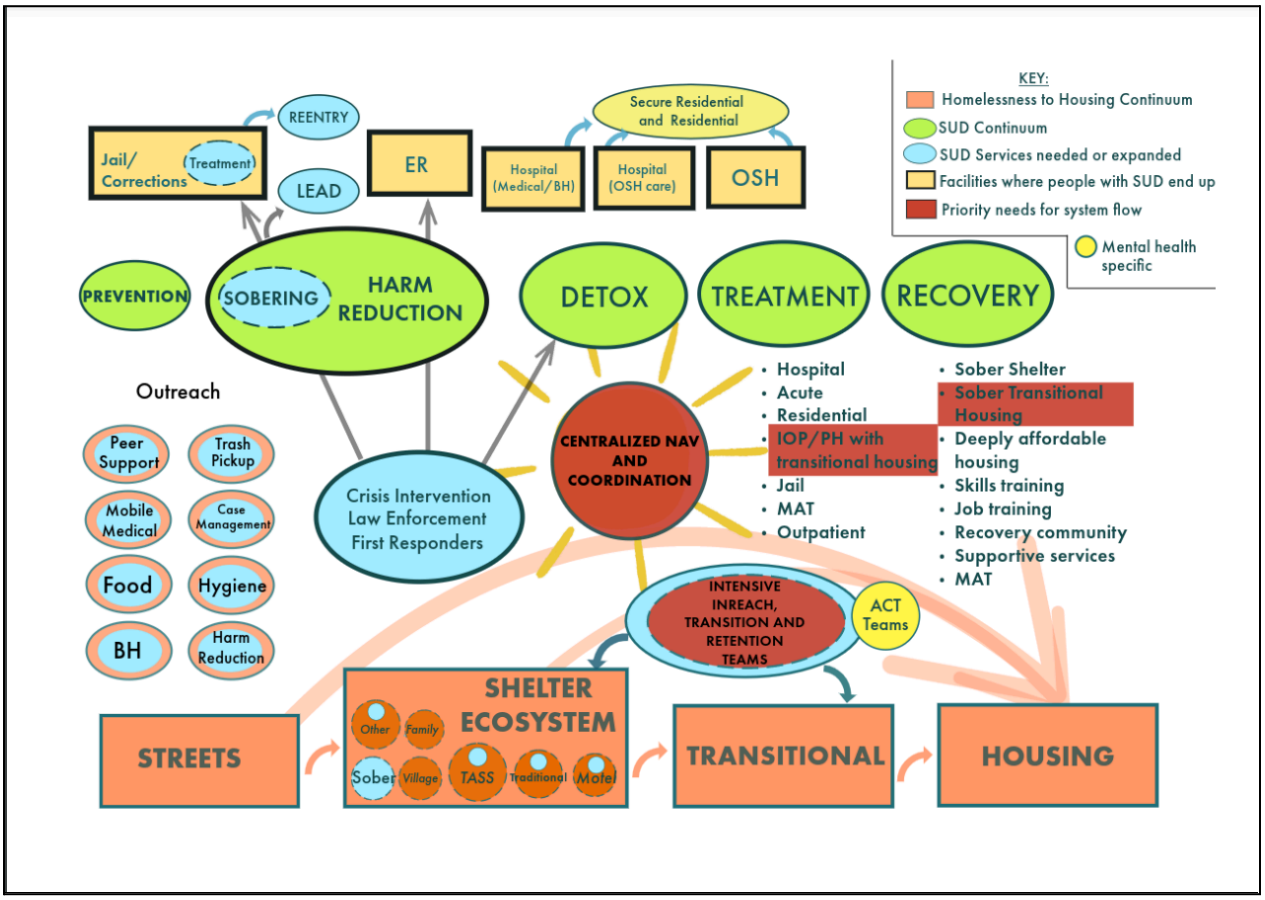
The JOHS Supply Center wants to highlight that the supply center is located in the Delta Park area. This might be a barrier for some providers. The Supply Center has discussed having a distribution location in partnership with the Central Library, though this has not yet been discussed with our contact there. The Supply Center may be able to support the coordination with the library and track the inventory.

Please contact DeAnna Negrete for coordination of next steps.

Appendix P

Multnomah County Visual of SUD and Homelessness Continuum

Figure R1. Visual of SUD and Homelessness Continuum created by the IMT Operations Section



Appendix Q

City of Portland Workforce Development Pilot Program

Workforce Development Pilot Program
The following is an approach to provide flexible, low-barrier workforce opportunities for individuals who are currently in shelter, who are ready to move out of shelter into permanent/subsidized housing, or have recently moved into housing from a shelter site. The pilot program can be described as a ladder approach, with three 'steps' designed to prepare and support individuals to move towards part- or full-time work opportunities and some level of financial stability. Regional and nation-wide studies emphasize that supported employment services are a vital part of the effort to end homelessness by advancing individuals towards health, wellness, community, and economic self-sufficiency. We propose to utilize local, non-profit groups who already have established workforce programs serving homeless individuals to provide targeted, scalable programs to serve a large population of individuals who are interested in re-entering the workforce.

Step 1: Work Opportunities in Shelter Sites.

- Proposal: Develop a 5-8 day program to pilot at large shelter sites (100 units or more) to provide regular work opportunities for interested shelter participants. The program would provide an opportunity for individuals to complete 4-5 shifts of work (estimated 4 hours per shift) and 1-3 classroom sessions to relearn basic skills related to employment and self-sufficiency.
- **Provider:** Utilize local, non-profit groups that already have experience providing similar services. For the pilot study, consider partnering with Cultivate Initiatives who already has a 5-day Internship Program that can be adjusted to provide work opportunities near shelter sites. Shelter Site Operators would partner to manage participant tracking, provide classroom lessons, and provide stipends/payment.
- **Pilot Program Details:** Cultivate to provide two 2-person crews to report to the shelter site Mondays, Wednesdays and Fridays every week from 10am-2pm to provide work opportunities for 10 individuals each day. Work opportunities would focus on neighborhood beautification projects including landscaping, graffiti abatement, trash/debris removal, etc.
- **Total Cost for 3 Months $120k:** 1 Program | 2 Shelter Sites | Work Program: $20k/month/site

Step 2: Work opportunities after graduation of shelter program (step 1), before/during transition to housing.

- **Proposal:** Work with various local, non-profit groups to develop a total of 4-10 unique work programs in a variety of occupational fields. Each program can vary in duration,

daily hours, and supportive services but should strive to provide at a minimum regular, part-time employment opportunities for 1-6 months.

- **Provider:** Utilize one organization to be the administrator for all 4-10 unique work programs. For the pilot study, consider Central City Concern to be the administrator. For the 4-10 unique work programs, consider partnerships with Trash for Peace, Constructing Hope, Feed the Mass, Street Roots, etc.
- **Pilot Program Details:** There is interest from the aforementioned groups to be involved. TBD on details.
- **Total Cost for 3 Months $375k:** Admin $5k/month | 3 Programs | Work Programs: $40k/month/program

Step 3: Partner with local companies/employers to establish work opportunities that include a supportive administrator/manager provided by WorkSystems. (Not covered by pilot program, will need additional $)

- **Proposal:** Local employers who are in need of a workforce can partner with a program that includes a WorkSystems Employment Assistance Specialist to hire and manage/support employment for 10+ employees. Positions can be contract, part-time positions with an opportunity for full employment.
- **Provider:** Consider Central City Concern and/or WorkSystems.
- **Pilot Program Details:** TBD.

PORTLAND POLICE BUREAU

STRATEGIC SERVICES DIVISION

Calls for Service
at Select Bottle Return Locations

Safeway (1030 SW Jefferson St), Plaid Pantry (1305 SW 11th Ave),
Stadium Fred Meyer (100 NW 20th Pl), Trader Joe's (2122 NW Glisan St),
Whole Foods (1210 NW Couch St), Safeway (1303 NW Lovejoy)
with 200ft Radius around each

note that the Jefferson Safeway and the 11th St Plaid Pantry were the only locations with a moratorium on bottle collections

for Year Prior (March 2, 2023 - April 30, 2023),
Prior 60 Days (January 2, 2024 - March 1, 2024),
Closure Period (March 2, 2024 - April 30, 2024)

Data Considerations

Calls for service can be divided between dispatched calls and self-initiated calls. Dispatched calls are calls for police assistance that are generated by the community, through a call or text to 911 or the non-emergency line (503-823-3333). Self-initiated calls are officer-initiated calls for service, which can be initiated in-person or scheduled in advance to proactively address a community issue.

Also note that the figures are inclusive of PPB responses only and do not capture activity by other agencies (e.g., other law enforcement agencies, fire, or EMS).

Business locations have been identified using their tax lots, with a 200-foot buffer extending from the edges of each lot.

Visual Notes

All maps have been sized and color-coded to the same extents.

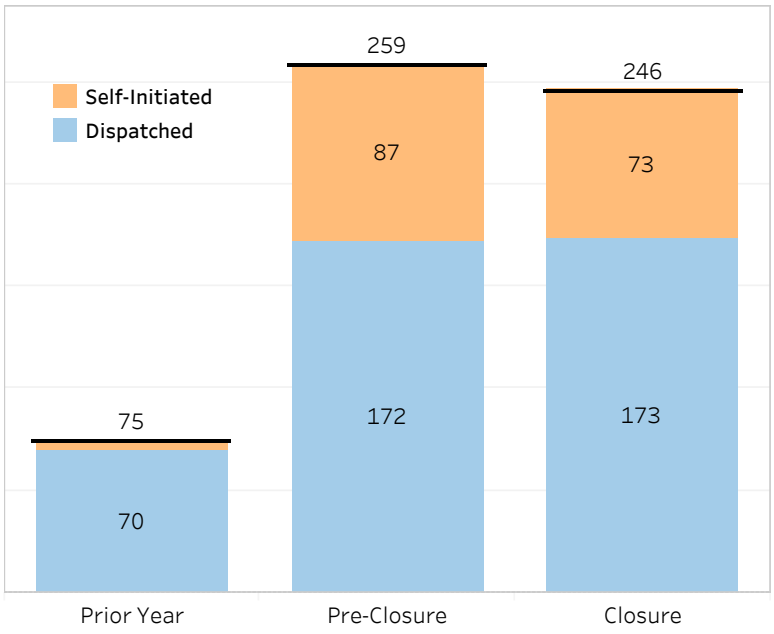
Click the following link to view definitions of call types:
https://www.portland.gov/police/open-data/police-dispatched-calls#toc-introduction-to-calls-for-service

Calls for Service

Safeway (Jefferson) + 200ft Radius

Prior Year (March 2, 2023 - April 30, 2023), Pre-Closure (January 2, 2024 - March 1, 2024), Closure (March 2, 2024 - April 30, 2024)

Total Calls per 60-day Period

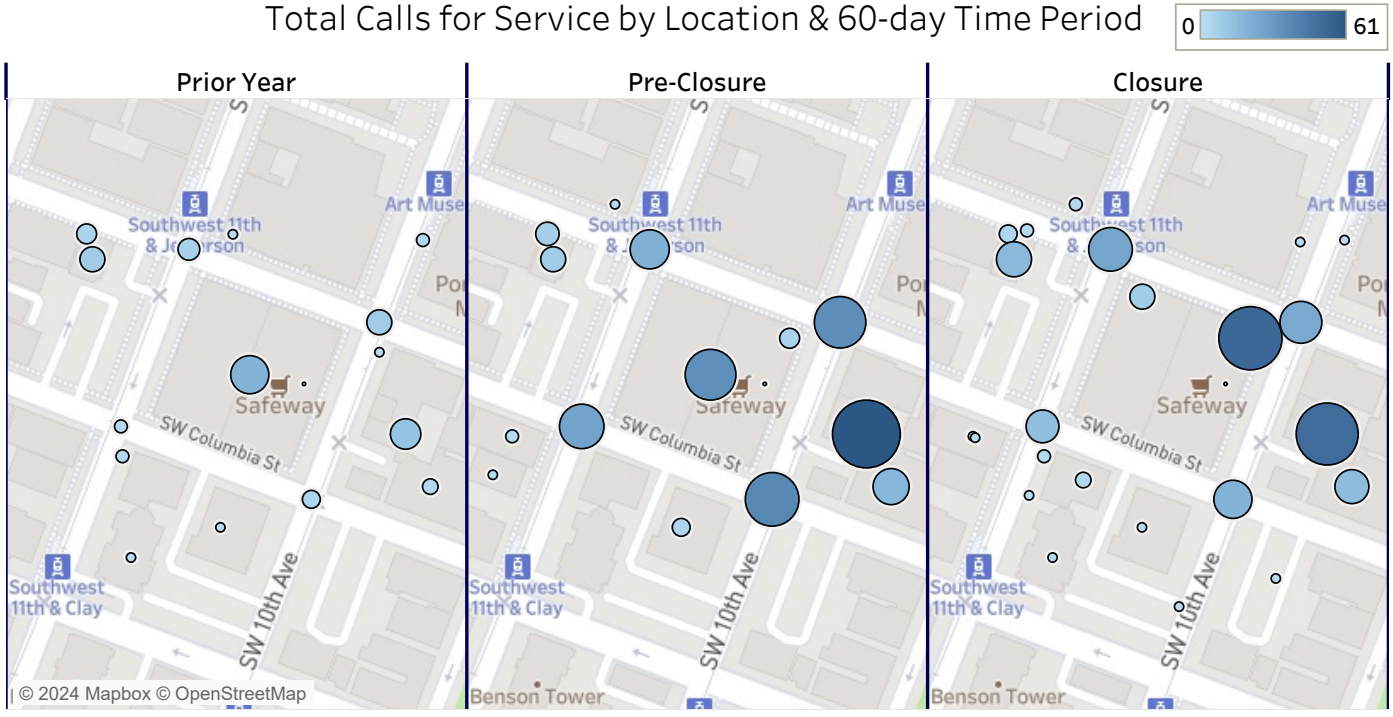


Compared to the year prior, calls for service more than doubled during the bottle return closure period, while they decreased by around 5% compared to the 60 days prior.

Dispatched calls for service remained relatively unchanged between the 60 days prior and the closure period, while self-initiated calls decreased by 14.

Calls at the Safeway itself increased during the closure period compared to both prior periods. The closure period (53) increased 36% from the prior 60-day period (39) and 178% from the prior year (19). These figures were driven by both increases in dispatched and self-initiated calls.

Total Calls for Service by Location & 60-day Time Period



Note: There are multiple coordinates associated with the Safeway address. Previously, the coordinates would map to the center of the store, but now they primarily map to the upper-right corner of the block.

Calls for Service by Call Type

Safeway (Jefferson) + 200ft Radius

Prior Year (March 2, 2023 - April 30, 2023), Pre-Closure (January 2, 2024 - March 1, 2024), Closure (March 2, 2024 - April 30, 2024)

Total Call Volume by Time Period and Call Type

	Prior Year	Pre-Closure	Closure
Vice	5	64	43
Unwanted Person	10	47	42
Welfare Check	12	32	26
Person Contact	0	22	14
Theft	6	6	24
Disturbance	7	10	17
Suspicious	3	13	13
Assault	5	10	6
Assist	5	9	3
Threat	1	9	4
Detail Patrol	0	6	5
Follow Up	2	3	6
Harassment	2	3	3
Area/Premise Check	1	3	3
Community Policing	0	5	2
Robbery	1	1	5
Vandalism	1	1	5
Flagdown	0	3	3
Stolen Vehicle	4	2	0
Warrant	1	3	2
Admin	1	1	3
Behavioral Health	0	2	3
Missing Person	0	0	4
Other	0	2	2
Alarm	1	1	1
Burglary	1	0	2
Civil	0	0	3
Shots Fired	0	1	1
Abuse	1	0	0
Animal Problem	1	0	0
Arson	0	0	1
Disorder	1	0	0
Domestic Violence	1	0	0
Illegal Dumping	1	0	0
Restraining Order Violation	1	0	0
Grand Total	75	259	246

The chart to the left shows all call types that occurred in the Jefferson St Safeway area. Total calls decreased during the closure period compared to the prior 60 days, however, were higher than the same time the previous year. The decrease from the prior 60-day period can mostly be attributed to a 33% decrease in Vice calls.

There were multiple call types with increases including: Theft, Disturbance, Vandalism, and Robbery. Robbery went from one occurrence in the prior 60-day period to five during the closure period. Theft calls had the largest increase, going up 300% compared to the prior 60-days (24 vs 6).

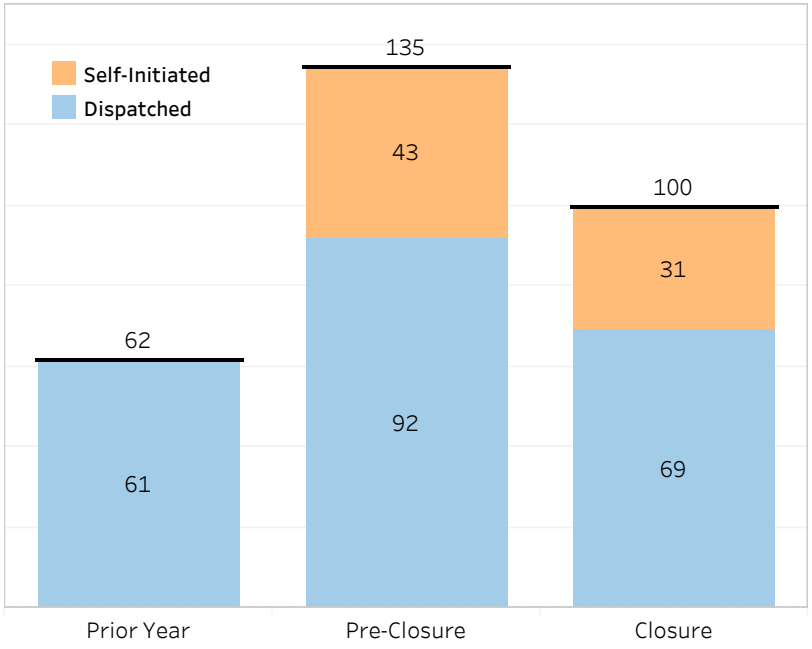
The decrease in Vice (activity most commonly associated with buying, selling, or using drugs), coupled with the increase in Disturbance, Theft, and Robbery calls could highlight a change in behavior of individuals who can no longer utilize the store's bottle redemption service.

Calls for Service

Plaid Pantry + 200ft Radius

Prior Year (March 2, 2023 - April 30, 2023), Pre-Closure (January 2, 2024 - March 1, 2024), Closure (March 2, 2024 - April 30, 2024)

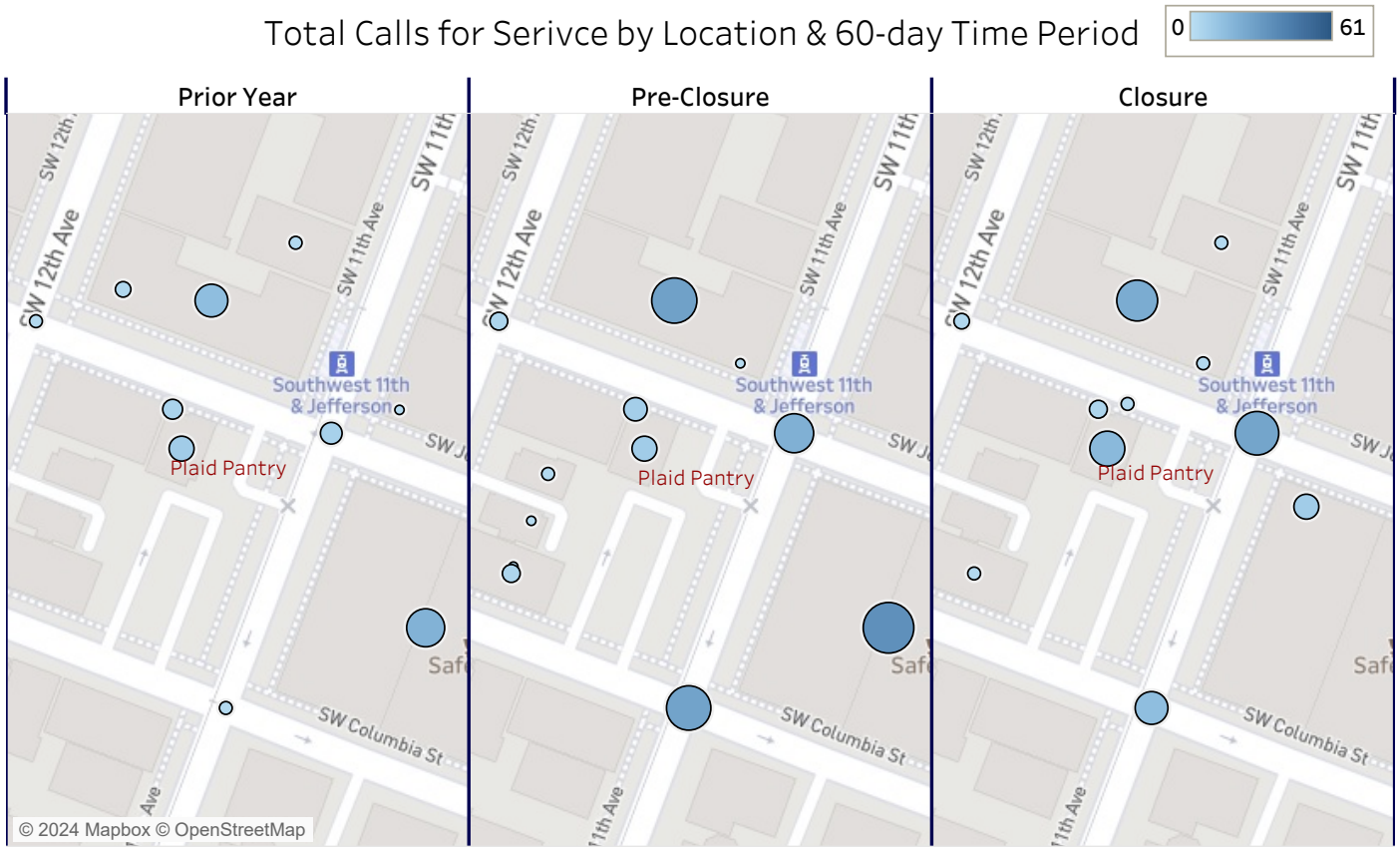
Total Calls per 60-day Period



Total calls for service in the Plaid Pantry area decreased from the prior 60-day period by 35 calls (-26%). However, there was a 61% increase from the same time frame the previous year.

Calls directly at the Plaid Pantry doubled during the closure period (16) compared to both the prior 60-day period (8) and the same time frame the previous year (8). This was predominantly a result of increases in dispatched calls for service during the closure period (13) compared to the prior 60-day period (4) and the previous year time frame (8).

Total Calls for Serivce by Location & 60-day Time Period



Calls for Service by Call Type

Plaid Pantry + 200ft Radius

Prior Year (March 2, 2023 - April 30, 2023), Pre-Closure (January 2, 2024 - March 1, 2024), Closure (March 2, 2024 - April 30, 2024)

Total Call Volume by Time Period and Call Type

	Prior Year	Pre-Closure	Closure
Vice	4	24	18
Unwanted Person	9	15	16
Welfare Check	10	16	12
Disturbance	9	8	8
Theft	3	9	6
Suspicious	3	6	7
Person Contact	0	9	6
Assault	4	5	3
Follow Up	1	4	5
Threat	1	6	1
Detail Patrol	0	4	3
Civil	0	5	1
Flagdown	0	4	2
Harassment	4	2	0
Assist	3	2	0
Admin	1	0	3
Area/Premise Check	1	1	2
Stolen Vehicle	2	2	0
Behavioral Health	0	2	1
Community Policing	0	2	1
Other	0	2	1
Vandalism	2	1	0
Warrant	1	2	0
Domestic Violence	0	1	1
Robbery	1	1	0
Shots Fired	0	1	1
Alarm	0	1	0
Animal Problem	1	0	0
Arson	0	0	1
Disorder	1	0	0
Missing Person	0	0	1
Restraining Order Violation	1	0	0
Grand Total	62	135	100

The chart to the left shows all call types that occurred in the Plaid Pantry Area. Total calls decreased during the closure period from the prior 60-day period. This was predominantly a result of a decrease in Vice calls (24 vs 18), a 25% percent decrease.

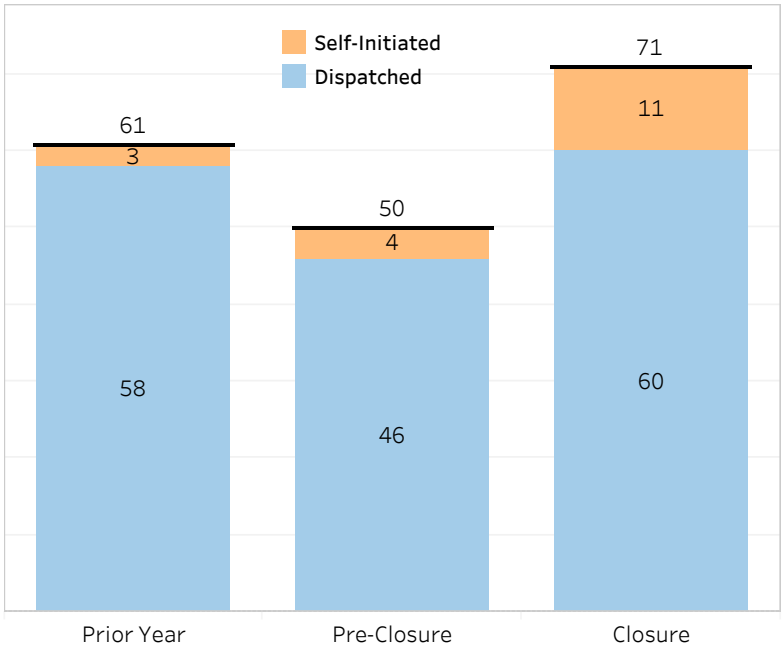
Multiple other call types also decreased, including Welfare Check (16 vs 12) and Threat (6 vs 1). Vice calls remained the most frequent call type during the 60-day closure period (18), which was a 350% increase from the same time period the previous year.

Calls for Service

Stadium Fred Meyer + 200ft Radius

Prior Year (March 2, 2023 - April 30, 2023), Pre-Closure (January 2, 2024 - March 1, 2024), Closure (March 2, 2024 - April 30, 2024)

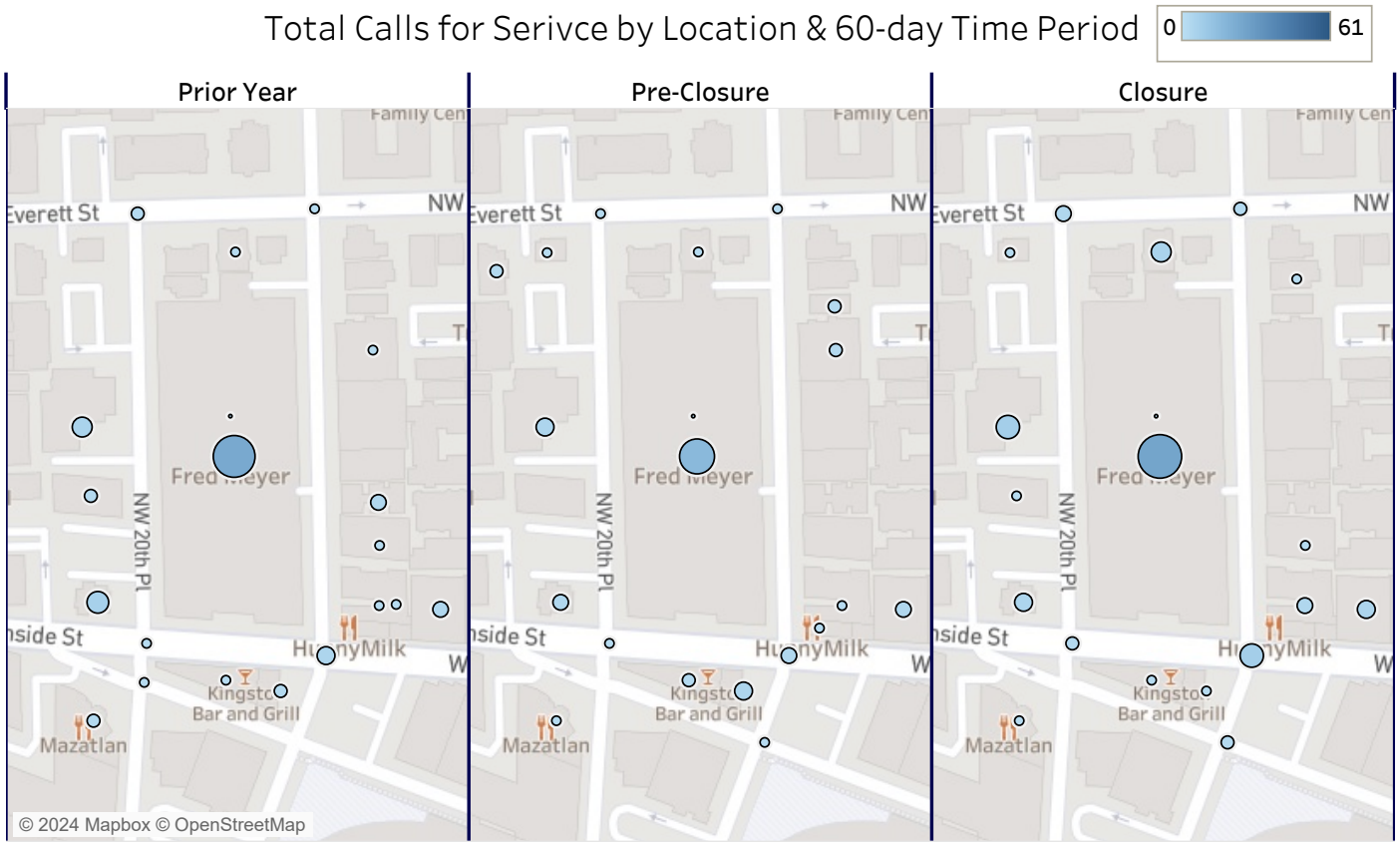
Total Calls per 60-day Period



The bottle return at the Stadium Fred Meyer on NW 20th remained open during the 60-day closure period, which took place at the Jefferson St Safeway and Plaid Pantry sites. Calls for service in the Stadium Fred Meyer area increased compared to both comparable time frames. Total calls (71) increased by 42% compared to the prior 60-day period (50). Both self-initiated (11) and dispatch calls for service (50) experienced an increase.

Total calls at the Stadium Fred Meyer itself increased during the closure period (25) compared to both the prior 60-days (16) and prior year (23).

Total Calls for Serivce by Location & 60-day Time Period



Calls for Service by Call Type

Stadium Fred Meyer + 200ft Radius

Prior Year (March 2, 2023 - April 30, 2023), Pre-Closure (January 2, 2024 - March 1, 2024), Closure (March 2, 2024 - April 30, 2024)

Total Call Volume by Time Period and Call Type

	Prior Year	Pre-Closure	Closure
Welfare Check	4	7	11
Unwanted Person	6	7	7
Theft	5	5	4
Suspicious	4	2	6
Harassment	3	4	4
Vice	3	3	5
Assault	2	2	6
Stolen Vehicle	5	2	3
Disturbance	1	3	5
Threat	2	3	4
Assist	8	0	0
Alarm	3	1	3
Vandalism	6	1	0
Burglary	4	1	1
Area/Premise Check	2	2	1
Follow Up	1	3	1
Flagdown	1	1	1
Behavioral Health	0	0	2
Person Contact	0	0	2
Robbery	1	0	1
Admin	0	1	0
Detail Patrol	0	0	1
Other	0	1	0
Sex Offense	0	0	1
Subject Stop	0	0	1
TriMet	0	0	1
Warrant	0	1	0
Grand Total	61	50	71

The chart to the left shows all call types in the Fred Meyer area. The bottle return at the Stadium Fred Meyer on NW 20th remained open during the 60-day closure period, which took place at the Jefferson St Safeway and Plaid Pantry sites. Total calls increased during the 60-day closure period compared to the prior 60-day periods.

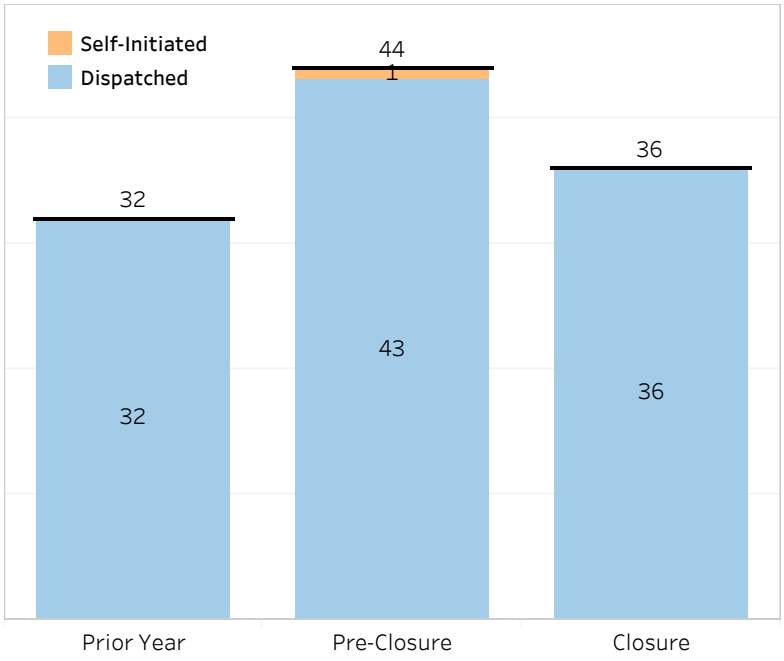
Multiple calls increased during the 60-day closure period compared to the prior two time periods. Welfare Check (11) increased by 57% compared to the prior 60-day period (7) and 175% compared to the prior year (4). Suspicious (6) and Assault (6) calls also had notable increases.

Calls for Service

Trader Joe's + 200ft Radius

Prior Year (March 2, 2023 - April 30, 2023), Pre-Closure (January 2, 2024 - March 1, 2024), Closure (March 2, 2024 - April 30, 2024)

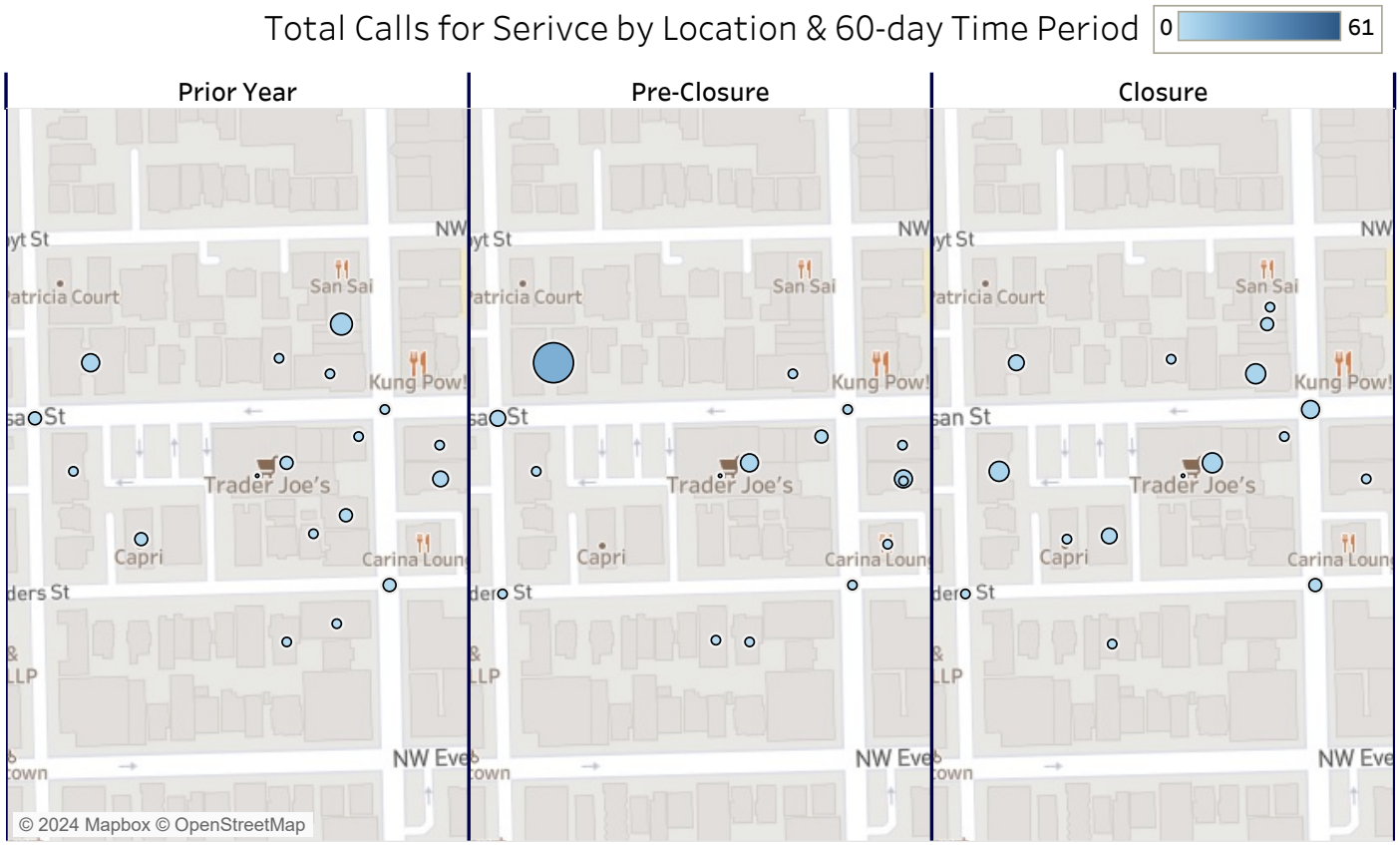
Total Calls per 60-day Period



The bottle return at the Trader Joe's on NW Glisan remained open during the 60-day closure period, which took place at the Jefferson St Safeway and Plaid Pantry sites. Calls for service in the Trader Joe's area decrease 18% during the closure period (36) compared to the the prior 60-days (44) but were slightly higher than the prior year (32).

Only a small proportion of the calls during each time period occurred at the address for the Trader Joe's location.

Total Calls for Serivce by Location & 60-day Time Period



Calls for Service by Call Type

Trader Joe's + 200ft Radius

Prior Year (March 2, 2023 - April 30, 2023), Pre-Closure (January 2, 2024 - March 1, 2024), Closure (March 2, 2024 - April 30, 2024)

Total Call Volume by Time Period and Call Type

	Prior Year	Pre-Closure	Closure
Disturbance	4	12	6
Unwanted Person	9	3	6
Welfare Check	5	6	7
Alarm	2	2	2
Harassment	2	2	2
Suspicious	2	2	2
Behavioral Health	1	2	1
Follow Up	0	4	0
Threat	1	1	2
Assist	2	1	0
Civil	0	3	0
Stolen Vehicle	1	0	2
Vandalism	0	1	2
Assault	1	1	0
Other	0	2	0
Sex Offense	0	0	2
Theft	1	1	0
Admin	0	0	1
Area/Premise Check	1	0	0
Burglary	0	0	1
Subject Stop	0	1	0
Grand Total	32	44	36

The chart to the left shows all call types in the Trader Joe's area. The bottle return at the Trader Joe's on NW Glisan remained open during the 60-day closure period, which took place at the Jefferson St Safeway and Plaid Pantry sites. Total calls decreased during the closure period compared to the prior 60-days.

The decrease from the prior 60 days can be primarily attributed to a 50% decrease in Disturbance calls (from 12 to 6). Other calls with notable decreases include Follow-Up (from 4 to 0) and Civil (from 3 to 0).

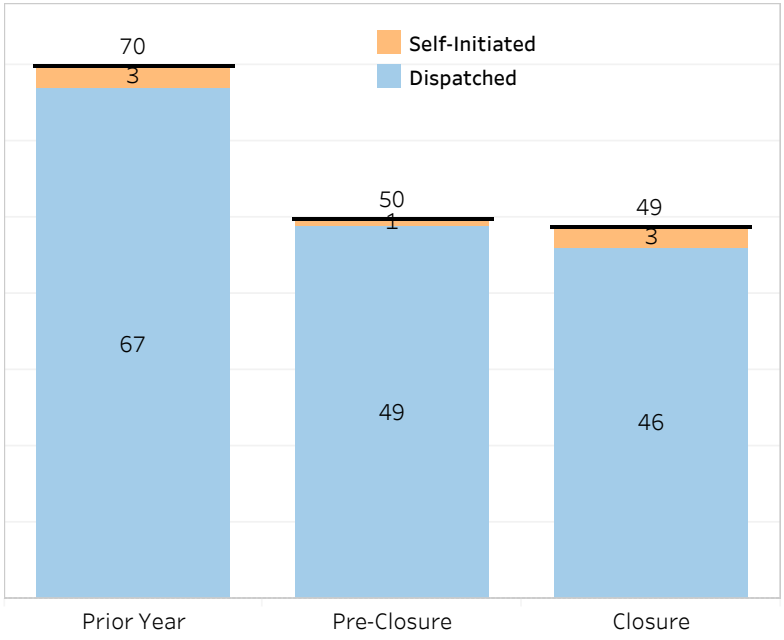
Unwanted Person calls increased by 100% during the closure period (6) compared to the prior 60 days (3).

Calls for Service

Whole Foods + 200ft Radius

Prior Year (March 2, 2023 - April 30, 2023), Pre-Closure (January 2, 2024 - March 1, 2024), Closure (March 2, 2024 - April 30, 2024)

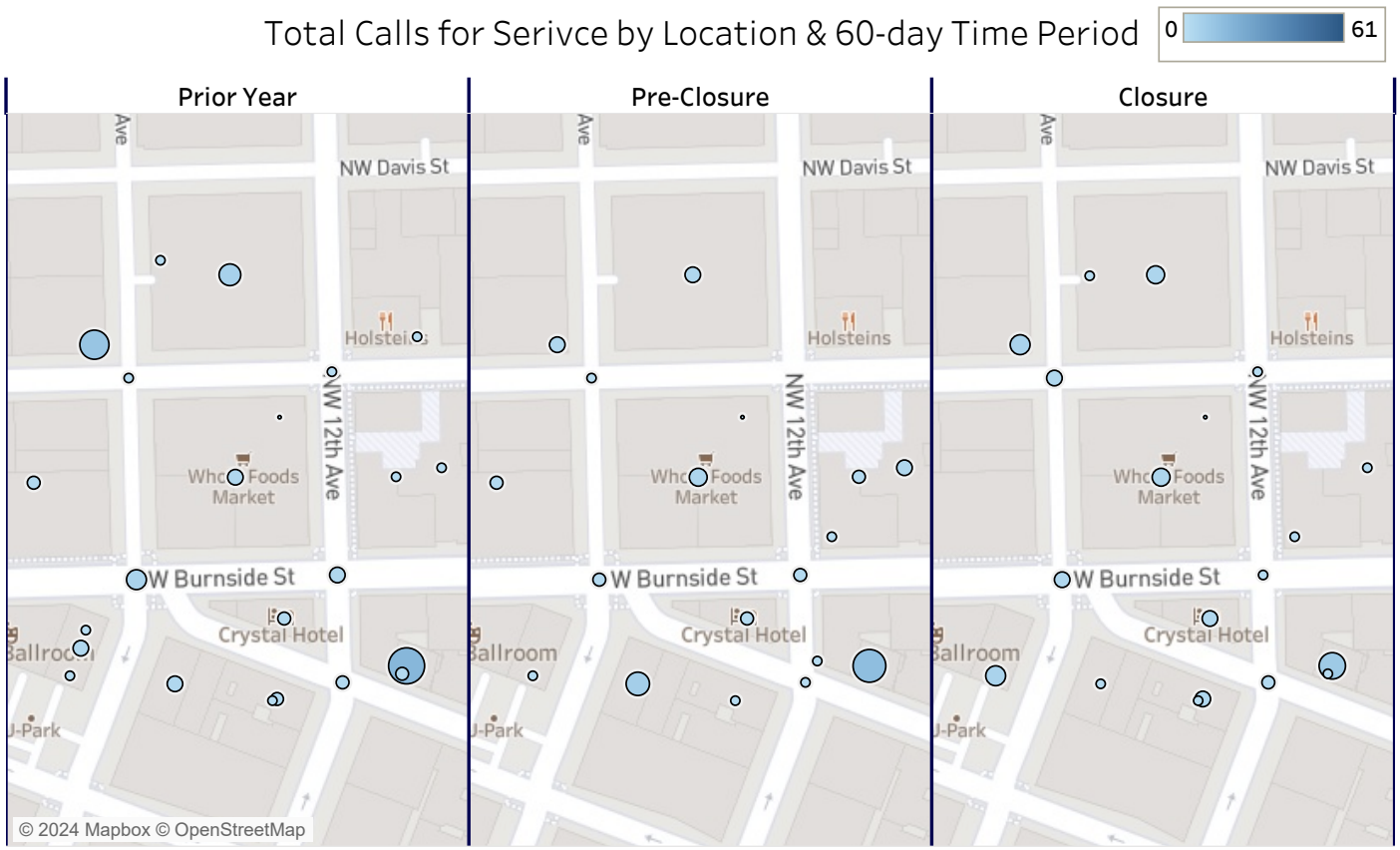
Total Calls per 60-day Period



The bottle return at the Whole Foods on NW Couch remained open during the 60-day closure period, which took place at the Jefferson St Safeway and Plaid Pantry sites. The Whole Foods area calls for service remained stable during the closure period (49) compared to the prior 60-day period (50), however, there was a 30% decrease from the same time frame the previous year (70).

Only a small proportion of the calls during each time period occurred at the address for the Whole Foods.

Total Calls for Serivce by Location & 60-day Time Period



Calls for Service by Call Type

Whole Foods + 200ft Radius

Prior Year (March 2, 2023 - April 30, 2023), Pre-Closure (January 2, 2024 - March 1, 2024), Closure (March 2, 2024 - April 30, 2024)

Total Call Volume by Time Period and Call Type

	Prior Year	Pre-Closure	Closure
Alarm	5	9	7
Welfare Check	5	9	6
Unwanted Person	12	2	5
Theft	10	3	1
Assault	2	5	4
Threat	2	4	5
Disturbance	6	3	1
Suspicious	4	3	1
Vandalism	2	2	4
Area/Premise Check	3	1	3
Assist	5	0	2
Follow Up	4	0	3
Harassment	0	2	2
Stolen Vehicle	1	0	3
Vice	2	2	0
Animal Problem	1	1	1
Flagdown	1	0	1
Admin	1	0	0
Arson	1	0	0
Civil	0	1	0
Parking Problem	1	0	0
Person Contact	0	1	0
Robbery	1	0	0
Sex Offense	1	0	0
Shots Fired	0	1	0
TriMet	0	1	0
Grand Total	70	50	49

The chart to the left shows all call types in the Whole Foods area. The bottle return at the Whole Foods on NW Couch remained open during the 60-day closure period, which took place at the Jefferson St Safeway and Plaid Pantry sites. Total calls during the closure period remained relatively unchanged compared to the previous 60-day time frame, however, there was a 30% decrease from the year prior.

While totals calls were stable compared to the prior 60-days, there were call types that experienced more significant changes. Unwanted Person increased 150% (from 2 to 5), Vandalism increased 100% (from 2 to 4), and Stolen Vehicle also increased (from 0 to 3).

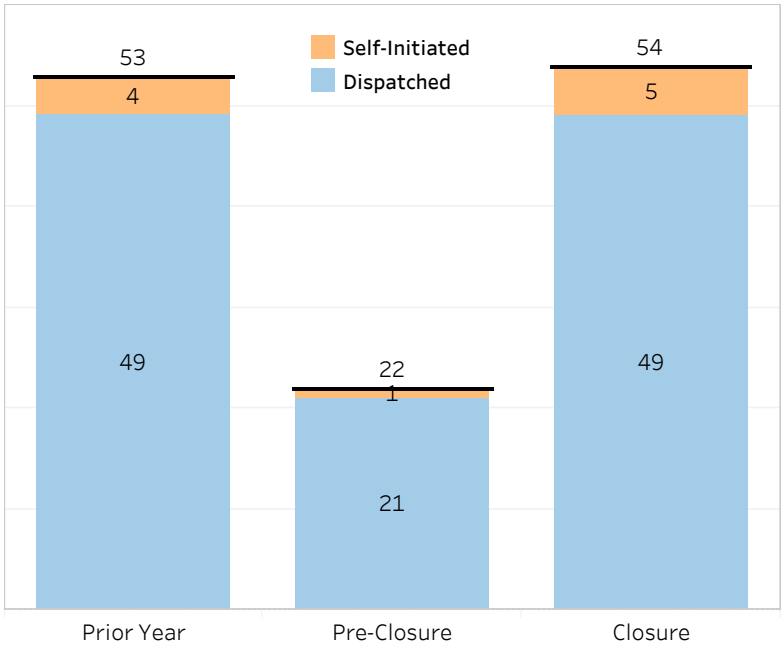
Notable decreases in calls from the prior year included Unwanted Person (from 12 to 5), Theft (from 10 to 1), and Disturbance (from 6 to 1).

Calls for Service

Safeway Lovejoy + 200ft Radius

Prior Year (March 2, 2023 - April 30, 2023), Pre-Closure (January 2, 2024 - March 1, 2024), Closure (March 2, 2024 - April 30, 2024)

Total Calls per 60-day Period

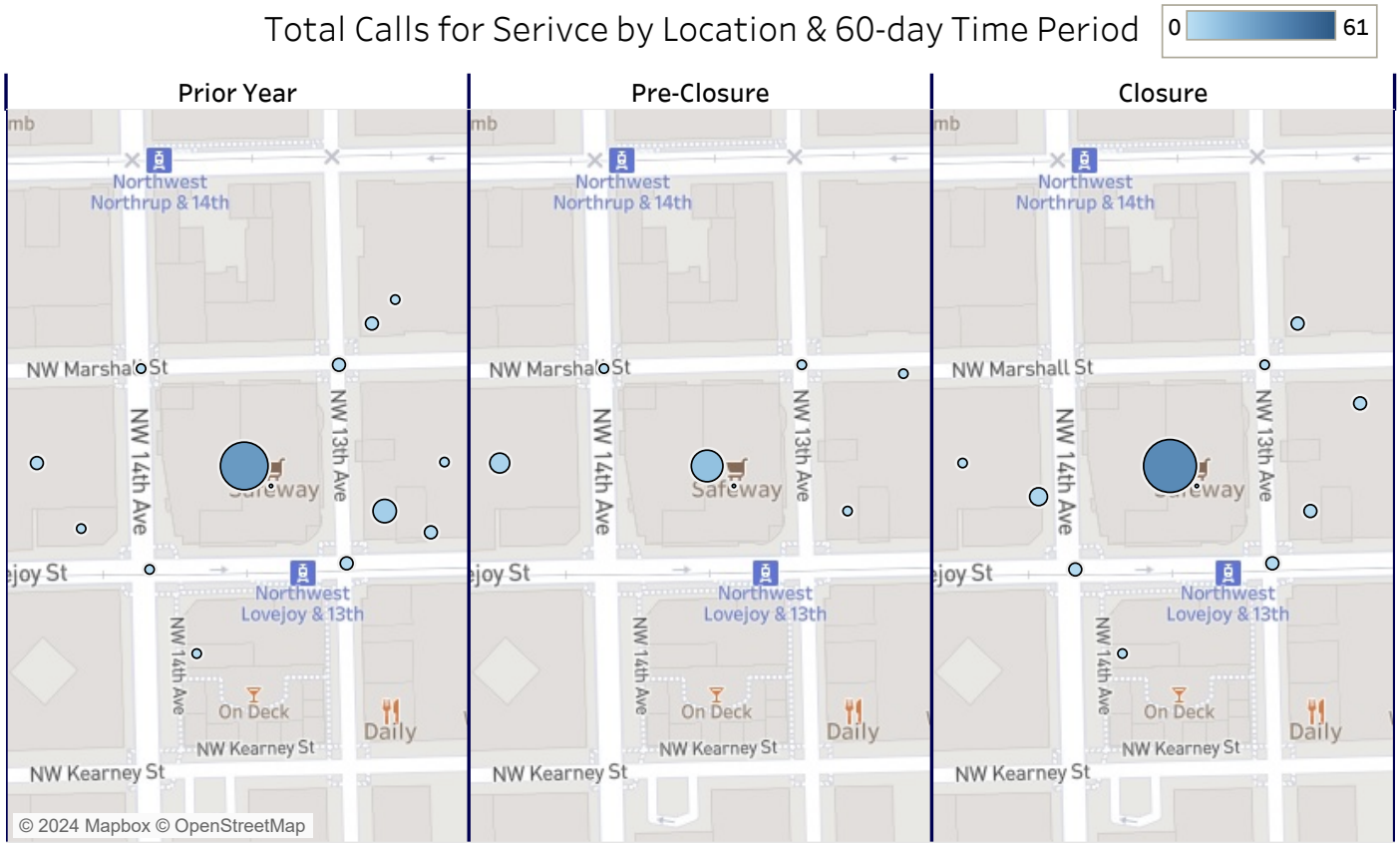


The bottle return at the Lovejoy Safeway remained open during the 60-day closure period, which took place at the Jefferson St Safeway and Plaid Pantry sites.

Calls for service in the Lovejoy Safeway area more than doubled during the closure period (54) compared to the prior 60-days (22). Calls during the closure period were almost identical to the same period in the prior year (53).

Calls specifically at the Lovejoy Safeway increased during the closure period (37) compared to both the year prior (30) and the 60 days preceding the closure (13).

Total Calls for Serivce by Location & 60-day Time Period



Calls for Service by Call Type

Safeway Lovejoy + 200ft Radius

Prior Year (March 2, 2023 - April 30, 2023), Pre-Closure (January 2, 2024 - March 1, 2024), Closure (March 2, 2024 - April 30, 2024)

Total Call Volume by Time Period

	Prior Year	Pre-Closure	Closure
Unwanted Person	7	3	9
Assault	6	3	6
Theft	4	2	7
Threat	7	4	2
Disturbance	3	1	6
Robbery	6	2	2
Alarm	1	0	6
Follow Up	3	2	2
Admin	1	0	4
Assist	2	0	2
Welfare Check	2	0	2
Suspicious	1	1	1
Vice	1	1	1
Area/Premise Check	1	0	1
Behavioral Health	0	2	0
Burglary	2	0	0
Harassment	1	0	1
Stolen Vehicle	2	0	0
Vandalism	1	0	1
Arson	0	1	0
Civil	1	0	0
Disorder	0	0	1
Restraining Order Violation	1	0	0
Grand Total	53	22	54

The chart to the left displays all call types in the Lovejoy Safeway area. The bottle return at the Lovejoy Safeway remained open during the 60-day closure period, which took place at the Jefferson St Safeway and Plaid Pantry sites.

Total calls increased during the closure period compared to the prior 60-day period but remained relatively unchanged compared to the prior year.

The calls which increased the most compared to the prior 60-days included Unwanted Person (from 3 to 9), Theft (from 2 to 7), Disturbance (from 1 to 6), and Alarm (from 0 to 6). These calls types also increased compared to the prior year.