DECEMBER 2024

Multnomah County

LONES MANAGEMENT CONSULTING

Multnomah County

Sobering & Crisis Stabilization Center Plan

Table of Contents

Section 1

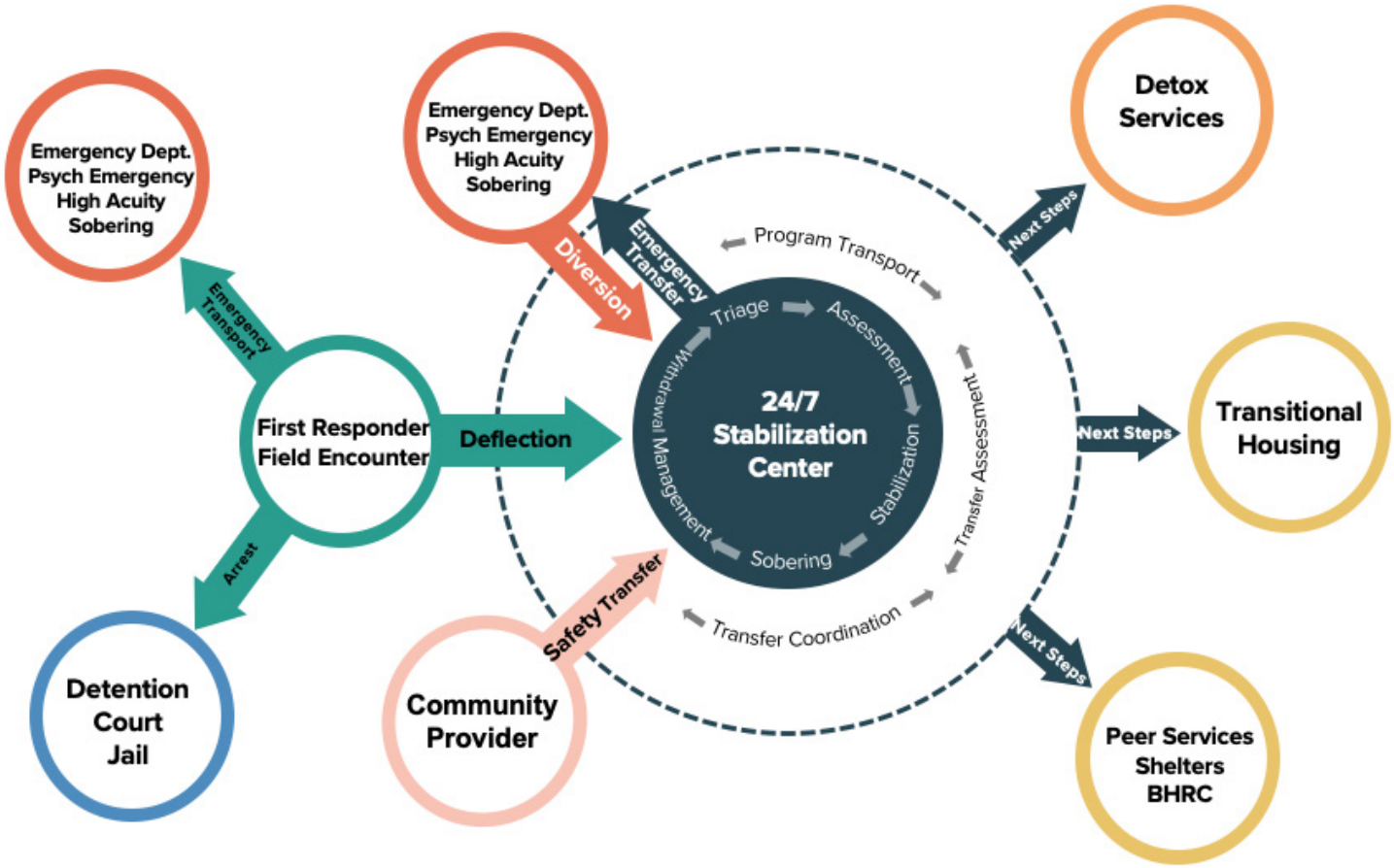
Executive Summary

The plan for a 24/7 Sobering & Crisis Stabilization Center was informed by over four years of community planning, drawing on input from first responders, the City of Portland, including ongoing work by the Multnomah County Health Department and community partners. It represents a community safety priority, improves Multnomah County's behavioral health continuum, and is based on best practices and clinical guidelines established by the American Society of Addiction Medicine.

Once opened the 24/7 Sobering & Crisis Stabilization Center will provide:

- A low barrier first responder approach to behavioral health crisis care that aligns with SAMHSA's national guidelines and Multnomah County's first responders' call for an alternative to emergency departments and jails.
- A patient-centered approach that aims to quickly engage patients in services to avoid traumatizing or re-traumatizing them, including:
  - A multidisciplinary care team that will provide trauma-informed, culturally responsive services
  - Rapid intake, triage, and assessment
  - 24/7 access to sobering and withdrawal management services for alcohol, stimulants, opioids, and other substances
  - Peer provider support, care coordination and transfers to other providers in the care continuum such as residential detox and withdrawal management providers, psychiatric emergency services, day centers, and transitional housing

Figure 1: Summary 24/7 Sobering & Crisis Stabilization Center Flow



Section 2

Background

In 1977, Portland began providing sobering services and a community transport model as a means of offering a safe place for individuals experiencing acute intoxication, primarily from alcohol, to sober under supervision. In 2019 the City's Sobering Center was shut down and first responders no longer had an alternative to jail or the Emergency Department. While a variety of reasons were identified for closure of the center, one of the key reasons was a marked increase in opioid and methamphetamine use.

On September 28, 2023, the Multnomah County Board of Commissioners voted to allocate $150,000 of Supportive Housing Services unanticipated revenue towards the "design, planning, and project development" of a sobering center to be led by Commissioner Julia Brim-Edwards. Commissioner Brim-Edwards convened the Sobering Core Project Team Group, comprised of leaders from across the behavioral health crisis continuum, law enforcement, the judiciary, Multnomah County Health Department, and Commissioner Meieran.

The "Multnomah County 24/7 First Responder Drop-Off Sobering Center Plan" was transmitted to the Multnomah County Board of Commissioners on March 1 for consideration in the County's 2024-25 budget process and shared during the 2024 Oregon Legislative Session. As part of the County budget process, a Sobering Leadership Team was established that included Chair Jessica Vega Pederson, Commissioner Julia Brim-Edwards, City leadership, internal County departments, and other experts as needed.

To incorporate a public health approach that addresses community safety needs, Multnomah County Health Department and Lones Management Consulting have updated the Sobering Core Group's plan to further integrate best practices in addiction medicine and the current service landscape, including the addition of Multnomah County's Coordinated Care Pathways Center Plan. The result is a clinically appropriate 24/7 Sobering & Crisis Stabilization Center that achieves the public safety goal it was designed to meet.

Section 3

Community Trends

3.1. Trends in Overdose Rates & Emergency Department Visits Related to Substance Us

Emergency department data from 2019-2021 indicates that methamphetamine, alcohol, and opioids, in that order, are the top three substances attributed to substance use related ED visits in Portland, Oregon.[1]

Of reported overdose deaths in 2023, fentanyl was attributed to 622 of 777 (80%) deaths in Multnomah County (see Figure 2).[2] Separate data from 2023, suggest that in approximately 61% of fentanyl overdose deaths a psychostimulant was involved, primarily methamphetamine.[3]

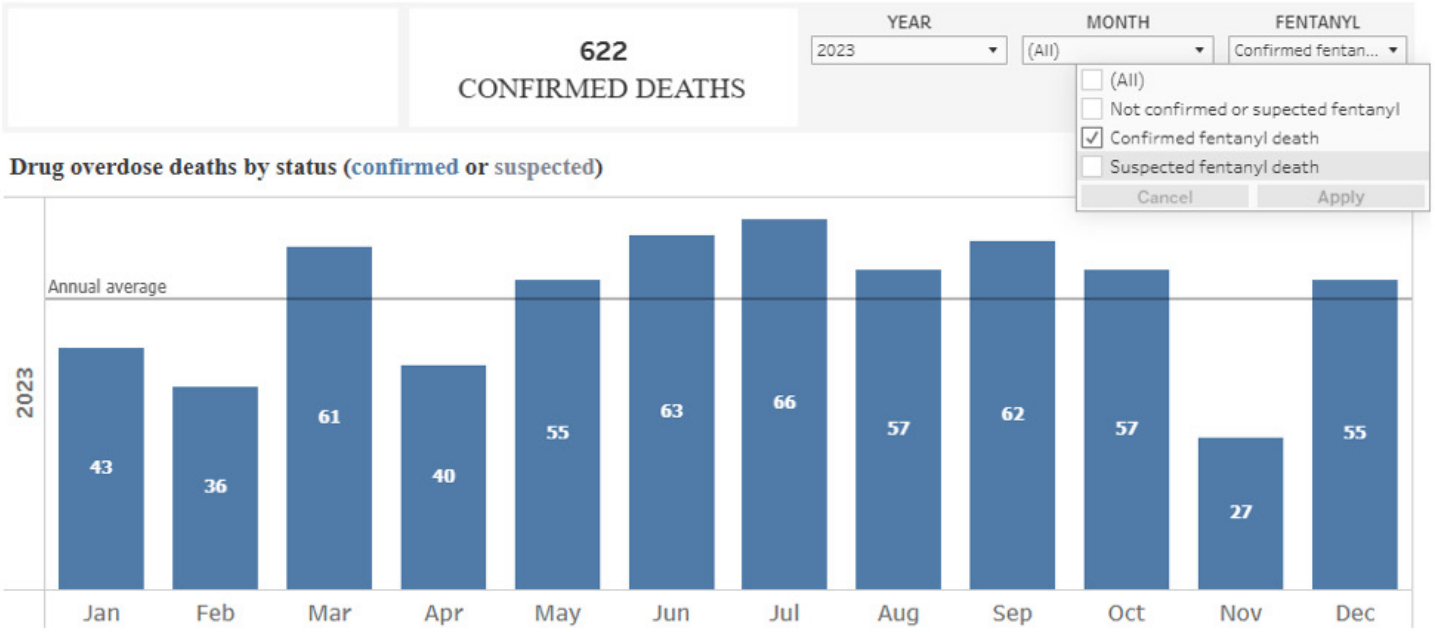
While neither study examines polysubstance use comprehensively, the combined use of methamphetamine and fentanyl suggest that polysubstance use (the use of two or more substances concurrently) may be a significant factor leading to increased mortality from use of these substances.

In response, on February 1, 2024, Multnomah County declared a 90-day State of Emergency, "to direct coordinated efforts to address fentanyl use."[4]

Multnomah County, the City of Portland, the State of Oregon, and local Coordinated Care Organizations (CCOs) have made significant investments aimed to expand capacity and improve coordinated efforts to address the crisis.[5] [6] [7] [8] [9] [10] [11]

The 24/7 Sobering & Crisis Stabilization Center will divert intoxicated individuals from local jails and emergency departments by offering a low-barrier first responder drop-off that doesn't leave individuals in crisis on the streets. The program components at the Center will include sobering, crisis stabilization, and withdrawal management services. These services will best serve the target population, address community safety priorities and the needs of first responders. This will help fill a critical gap in the continuum of crisis care.

Figure 2: Drug Overdose Deaths by Status (confirmed fentanyl death)



1. Oregon Mental Health Archive. (2022, July 23). Addiction & Emergency Room Statistics for Portland, 2019-2021. Retrieved from: https://www.oregonarchive.org/addiction-emergency-room-statistics-for-portland-2019-2021/

2. Multnomah County Health Department – Communicable Disease Services. (Retrieved 2024, October 25). Multnomah County Overdose Dashboard. Retrieved from: https://public.tableau.com/views/MultnomahCountyOverdoseDashboard/Starthere?:language=en-US&:sid=&:redirect=auth&:display_count=n&:origin=viz_share_link

3. Multnomah County Health Department. (2024, May 14). Fentanyl Overdose Deaths in Multnomah County: 2018-2023. Retrieved from: https://multco.us/news/multnomah-county-releases-fentanyl-overdose-mortality-report

4. Multnomah County Health Department. (2024, February 1). Overdose Prevention and Response. Retrieved from Multco.us: https://www.multco.us/overdose-prevention-and-response#:~:text=Emergency%20Declaration,use%20in%20Portland's%20Central%20City.

5. Mayor Ted Wheeler. City of Portland to Allocate $2M for 70-bed Behavioral Health Treatment Center in Central City. Retrieved from Portland.gov: https://www.portland.gov/wheeler/news/2024/1/4/city-portland-allocate-2m-70-bed-behavioral-health-treatment-center-central

6. Oregon Public Broadcasting (2024, January 4). Oregon's Medicaid insurers will redirect $25M in profits to youth mental health needs. Retrieved from OPB.org: https://www.opb.org/article/2024/01/04/oregon-medicaid-insurers-redirect-profits-youth-mental-health-needs/

7. Oregon Secretary of State LaVonne Griffin-Valade. (2023, December). Oregon Health Authority: Funding and Delivery of Measure 110 Substance Use Disorder Shows Progress, but Significant Risk Remains. Retrieved from Sos.oregon.gov: https://sos.oregon.gov/audits/Pages/audit-2023-39-Measure-110.aspx

8. Oregon Public Broadcasting. (2022, March 28). Portland Street Response expands citywide, with new answer for mental health, addiction-related 911 call. https://www.opb.org/article/2022/03/28/portland-street-response-oregon-mental-health-crisis/#:~:text=The%20program%20will%20answer%20calls,for%20the%20Portland%20Street%20Response.

9. Multnomah County. (2023, October 10). Multnomah County announces investments in Behavioral Health Emergency Coordinating Network (BHECN). Retrieved from Multco.us: https://www.multco.us/multnomah-county/news/multnomah-county-announces-investments-behavioral-health-emergency

10. Koin 6. (2022, September 28). Portland behavioral health center to focus on mental health and homelessness. Retrieved from Koin.com: https://www.koin.com/local/multnomah-county/portland-behavioral-health-center-to-focus-on-mental-health-and-homelessness/

11. Oregon Public Broadcasting. (2023, March 9). Portland Mayor Wheeler unveils first location for city-run homeless camp. Retrieved from OPB.org: https://www.opb.org/article/2023/03/09/portland-oregon-homelessness-camping-ted-wheeler-encampments-city-run/

Section 4

Project Equity Statement

24/7 Sobering & Crisis Stabilization Center project collaborators understand that meaningful community engagement takes time and continuous nurturing to build trusting relationships. The project is committed to this work, connecting with communities of color, LGBTQIA2S+ and other marginalized communities to create an accessible and responsive model that ensures individuals have access to intersectional, culturally, and linguistically specific and responsive services.

The 24/7 Sobering & Crisis Stabilization Center project recognizes the importance of developing an equity lens and process by which the community will be continuously engaged in its design. The following framework for decision-makers has been created to center equity and inclusion considerations and impacts; and to hold decision-makers accountable to diversity, equity and inclusion values and vision.

DEI Definitions

Use the definitions related to diversity, equity and inclusion as a means to work through communication differences; misalignment; conflict; and misunderstandings. Allow the definitions to provide clarity and cohesion for those making decisions and engaging partners.

Diversity

Voices, perspectives, and wisdom of peoples from communities that have been historically marginalized, colonized, or enslaved are present in a particular environment. Simple presence, however, does not necessarily mean that these voices, perspectives, or wisdom are included in the discussion. *(Source: Southwest Washington Accountable Communities of Health (SWACH))*

Inclusion

Integrating and prioritizing the voices, perspectives, and wisdom of people from communities that have been historically marginalized, colonized, or enslaved into power structures, and into the decision-making process from beginning to end. Inclusion means that people from these communities are empowered and invested in them so that they can thrive. *(Source: SWACH, Oregon Library Association (OLA))*

Equity

Addresses systems and structures that prevent the just and fair distribution of and access to power and resources. Equity means actively providing resources and creating programs that uplift and empower folks who have not been seen, heard, protected, and respected as they deserve. *(Source: OLA, SWACH)*

Racial justice / Racial equity

Racial equity is when people have the chance to reach their full potential and are not more likely to encounter life's burdens or benefits just because of the color of their skin. Racial equity involves work to address the root causes of inequities, not only their manifestation. This work includes the elimination of policies, practices, attitudes, and cultural messages that reinforce adverse differential outcomes by race. *(Source: SWACH)*

Culturally responsive care development

Meaningfully including culturally responsive organizations to develop care services that are effective, equitable, understandable, and responsive to a diversity of cultural health beliefs, practices, and needs. *(Source: adapted from Oregon Health Authority)*

Trauma-Informed Care (TIC)

TIC is an organizational framework, an approach used not just on the path from staff to client but in all ways, including how the organization interacts with staff and the community. TIC is grounded in strengths of the individual, system, and community. It is striving to understand and support safety for everyone, both physically, psychologically and emotionally. It is a commitment to stop and examine the "way things are done" in the name of seeking the systemic nature of oppression and trying on a new way of doing things through hearing the voices of those involved. *(Source: Central City Concern)*

Multnomah County's Shared Language Guide

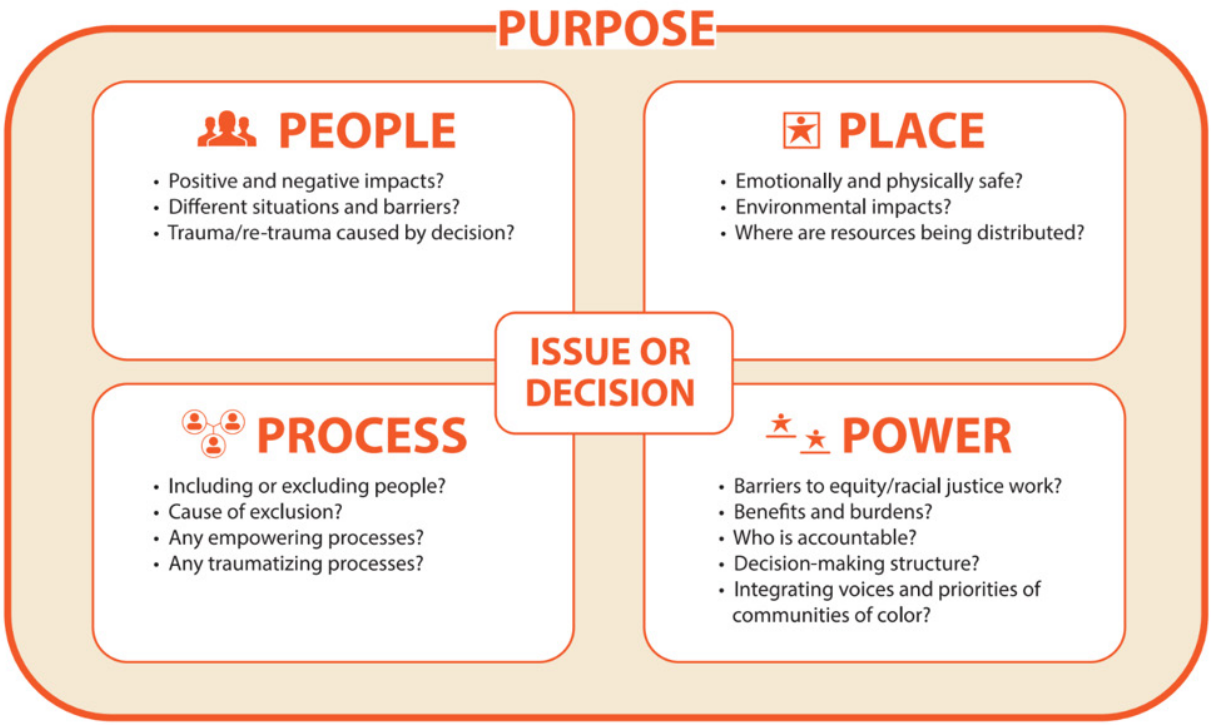
In addition to the sources provided with the definitions above, Multnomah County's Shared Language Guide includes frequently used terminology to promote a shared language for equity. The guide is intended to be a living document and is an attempt to unite our frameworks as Multnomah County continues to expand its equity infrastructure. It also serves as a reference for any staff that would like to learn more about equity work in the organization.

Revising the Shared Language Guide will be an ongoing effort because learning, language, and meaning evolve. The evolution of the guide will allow us to collect and incorporate feedback and continue to build with additional terms and definitions both now and into the future.

Multnomah County's Equity and Empowerment Lens

Multnomah County's Equity and Empowerment Lens lays out a rationale for practitioners. The Lens is a quality improvement tool beginning with "purpose" (captured in our strategies as overarching goals) and utilizes questions in four distinct areas: people (who is impacted and how); Process (how are those most impacted meaningfully involved in decisions that impact them; Place: (how is an issue or decision accounting for people's emotional and physical safety and their need to feel productive and valued); and Power: (how is the current approach shifting power dynamics to better integrate voices and priorities of communities of color). These sets of questions are the guiding frames for how strategies can address disparities within our organization.

This framework's focus has been creating a culture of practice when it comes to using the Equity and Empowerment Lens and what we consider when working through issues or making decisions.



DEI Approach and Supporting Questions

In addition to using the County's Equity and Empowerment Lens, pose these value-aligned questions at key decision points in the project design process, during ongoing operations or when processes feel confusing or not meeting expectations.

- What voices, experiences, and perspectives are present that help us fully understand conditions, needs, and realities?
- Who is missing, what are the barriers to their participation, and how do we remove those barriers?
- What relationships can we build and nurture to ensure that we have these voices, perspectives, and experiences in the future?
- Who will be responsible for ensuring this relationship building is done?
- Are we hearing the same voices, experiences, and perspectives?
- What are the barriers to bringing in different people and communities?
- How are we understanding and accounting for the impacts of our work?
- Where are these impacts beneficial and where are they burdensome, and in both cases, for whom?
- How do we know we're working with the right partners?
- What do we expect of our partners and what do they expect of us?
- What are our partners goals and needs?
- Where is our power greatest and what is our ability/appetite for using our power to invest in and support our partners and their work?
- How are we building power with and caring for our partners/communities through this program, initiative, process, or decision?

4.1. Community Engagement Framework & Neighborhood Commitments

Multnomah County provides social services for highly vulnerable populations and strives to be in good relationship with residential and business neighbors when and where the County provides those services. Community engagement and commitments are a critical component of identifying, evaluating, and confirming a site for the 24/7 Sobering & Crisis Stabilization Center. This section provides strategies for community engagement so there is a mutually understood process for engagement from site identification through opening.

Strategies

1. Provide clear roles and responsibilities for departments and staff involved in community outreach for potential sites through defined phases and processes.
2. Create an iterative process that allows for continual improvement of Multnomah County's engagement strategies.
3. Identify businesses, community-based organizations, behavioral health and medical providers, law enforcement, other elected officials, for outreach and engagement planning.

    a. Identify facilitation lead and support staff needed from departments for neighborhood engagement and development of shared commitments.

4. Outreach with providers and law enforcement on operational and program details to educate and agree upon how the facility will address community safety priorities and gaps in the behavioral health continuum of care.

Section 5

Recommendations

Recommendations in this section identify a program design for the 24/7 Sobering & Crisis Stabilization Center, articulate the basis for the design (including the clinical and non-clinical services that would be offered and the regulations that govern those services), and underscore the importance of planning for client and staff safety. This section is broken down by functional area and consists of:

1. Project Goals
2. Population of Focus
3. Facility Requirements and Other Considerations
4. Transportation Operating Model
5. Program and Operating Model Recommendations
6. Considerations for Involuntary Holds
7. Performance Management
8. Data Systems and IT

5.1. Project Goals

- 24/7 Sobering & Crisis Stabilization Center with adequate sobering and withdrawal management services that links into and supports the local crisis continuum, helping divert individuals from jail and hospital emergency departments
- Intake, triage, assessment, transfer, sobering, crisis stabilization, and withdrawal management capabilities
- Transportation capability with on and off-ramps to enable rapid step-up and step-down with tightly scoped care coordination
- Evaluation, continuous quality improvement and data sharing to drive performance, transparency, and accountability

5.2. Population of Focus

The programming available and clinical services at the Sobering and Crisis Stabilization Center shall be appropriate for the following target population:

- Adults 18+
- Experiencing substance use disorder including polysubstance use
- Experiencing acute intoxication from drugs and alcohol
- Not experiencing a physical health emergency
- Voluntary or meet the criteria for involuntary sobering admission and discharged within 24hrs (per ORS 430.399 section 3).

5.3. Facility Requirements and Other Considerations

The physical requirements of a facility that would house the services and programming available at the center will be based on the OARs applicable to crisis stabilization services and withdrawal management services. Due to business and building permits, the structure will need to have two areas, one for crisis stabilization services, including to support sobering, and one for withdrawal management.

When evaluating facilities for purchase, it will be important to consider whether it would allow for an appropriate ratio of sobering space to withdrawal management beds and space allocable to other reimbursable crisis stabilization services. The ratio will need to take into account 1) the needs of law enforcement for drop-off, which can be determined from data collected from the deflection program and from data collected in other jurisdictions related to sobering capacity needs and 2) the amount of potential revenue that could be generated from reimbursable services offered. The ratios should enable community needs to be met and to offset the ongoing operational costs of the facility. In Oregon, withdrawal management and crisis stabilization services are reimbursable, while sobering is not.

Considerations beyond what regulations require may include:

- Location in Multnomah County that all first responder jurisdictions can efficiently access, within a specific search boundary (North: Killingsworth Street; South: Highway 26; West: the Willamette River; East: 162nd Avenue);
- Documented policies and protocols to mitigate safety issues in the local neighborhood
- Access to a monitored outdoor space that includes a space for tobacco use
- Proximity to a hospital emergency department
- Space sufficient to house some combination of 50 sobering sleeper recliners and withdrawal management beds (taking into account regulatory requirements in applicable OARs regarding space allocation for these services);
    - Phasing of construction may be required so that a portion of the facility can be opened and begin serving clients while construction is being completed.
- Occupancy that allows for service delivery beyond 24 hours for withdrawal management services;

- Be county owned or, alternatively, leased with an option to purchase
- Be more than 1,000 feet from a daycare, school or career school that primarily caters to minors per ORS
- Be an existing structure, not a new build. Preference for sites built or renovated in the last 25 to 30 years. The goal is to acquire this property, and then complete design, permitting, and renovations, in time for operations to begin in 2026.
- Trauma-informed and welcoming design
- A separate entrance for first responder ease of egress, drop-off, and rapid engagement
- A separate entrance for staff use and deliveries
- Two separate intake/triage areas with adjacent exam rooms to support intake and assessment
- Office space adjacent to intake for first responders to log drop-off/complete paperwork
- Space for quiet rooms that will enable monitored seclusion from the main milieus
- Rooms for individual and group counseling
- Bathrooms and showers for male, female, and gender neutral
- A storage area for patient and staff personal possessions
- A dedicated project team of decision-makers and subject matter experts will be assembled. The team will consistently engage in weekly stand-up meetings to rapidly make decisions, mitigate risks, and clear barriers.

To complete acquisition, construction, program standup and launch within the planned timeline, the following assumptions must apply. Failure to achieve these assumed requirements may result in an extended timeline.

- Costs for improvements to the acquired facility will be higher than average per square foot due to the speed of construction (purchase of long-lead building materials prior to design completion, work on nights and weekends, higher frequency of change orders, etc.).
- A dedicated project leadership team will run the project, manage the project team and other key workgroups that are identified, provide technical assistance to the selected facility operator and transportation team, and operate as an owner's representative for design, construction, and program implementation.
- Accelerated inspection, permitting, waiver and approval process will be actively supported by assigned State, County and City decision-makers who can clear barriers.
- Any prospective facilities must be evaluated through a due diligence process that at minimum includes:
  - Compliance with the requirements stated in the subsequent "Facilities Requirements" section of this plan
  - Inspection by certified commercial building inspectors and bonded commercial specialty contractors, as necessary, to determine the existing state of repair

- Evaluation by architects, engineers, and land use planners to:
  - Determine if the facility's intended use meets zoning requirements and if a request for conditional use is required
  - A study of building code requirements considering prospective improvements to the interior and exterior of the facility
  - A "test fit" study conducted by architects to verify program and code requirements align
  - Evaluation of existing Fire, Life, and Safety systems in collaboration with Authorities Having Jurisdiction (AHJ) and the scope of any required improvements
  - A study by land use planners to assess any nonconforming upgrades required
  - ADA, parking, and traffic studies to identify if the facility's use will exceed code minimums
  - Early assistance meetings with any building/planning departments having jurisdiction, and the Oregon Health Authority to determine assessment criteria for design review, building permits, and inspections
  - Title review, and if necessary, consultation with a real estate attorney
- If there are delays in construction, the opportunity may exist to launch the program while construction is being completed on another part of the facility.

5.4. Transportation Operating Model

Transportation will be a key element of programming. Transportation plans will align with the needs of the Center operators, first responders and law enforcement, and clients. Possible options and considerations include:

- Transport of intoxicated individuals from the street to the 24/7 sobering & crisis stabilization center
- Inclusion/exclusion triage and safety protocols for first responders to bring individuals to the 24/7 Sobering & Crisis Stabilization Center
- Coordination of transportation to the 24/7 sobering & crisis stabilization center with local dispatchers, first responders, and community providers (this may include a future vision to expand to receive direct transfers from Emergency Medical Services and Mobile Crisis Intervention Teams)
- After clients receive crisis stabilization services (including sobering and/or withdrawal management), support further care coordination by transporting individuals to their next step or a designated location
- As needed, support rapid transfer of clients who are triaged with a high acuity medical or behavioral health need that the 24/7 sobering & crisis stabilization center is not scoped to provide

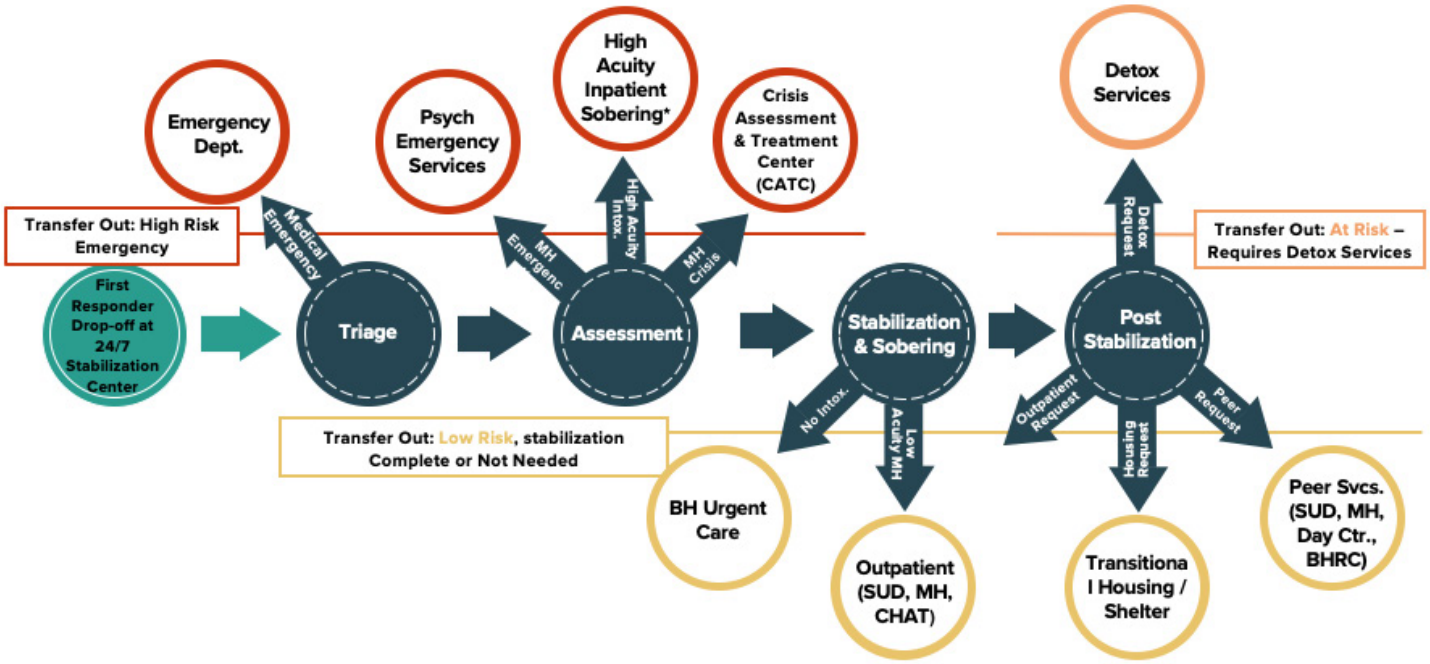
See Appendix 6 for additional transportation considerations, including safety standards and protocols for transportation to and from the 24/7 Sobering & Crisis Stabilization Center.

5.5. Program and Operating Model Recommendations for 24/7 Sobering & Crisis Stabilization Center

Essential operating model components include (see Figure 3 for a visual depiction of client journey flow):

- Sobering
- Crisis stabilization
- Withdrawal management
- Care team with medical and behavioral health staff
- Low barrier drop-off for first responders and referral, reliable drop-off engagement model capable of rapid triage, intake, assessment, and initiation of care
- A critical determination will be the timing and procedural details of the alignment between deflection of individuals at the point of arrest and first responder utilization of the 24/7 Sobering & Crisis Stabilization Center and transportation capability.
- Measurable capacity to safely and rapidly triage, assess, and transfer care to the most appropriate setting (see Figure 3 below)
- The ability to provide quality sobering care, withdrawal management (including MAT/MOUD) and associated observation as appropriate and clinically necessary
- Level of acuity as determined by ASAM and other clinical tools as appropriate for each of type of care
- Specific medical protocols developed to support sobering and withdrawal management by SUD, i.e. protocols for opioid use, methamphetamine use, alcohol use, etc.
- Designed and staffed to safely care for clients who are agitated, combative, or experiencing psychosis

Figure 3: Example 24/7 Sobering & Crisis Stabilization Center Client Journey Flow



Effective Response to High Acuity

This diagram shows one of many potential transfer pathways. There must be timely and appropriate transfer and transportation to step-up facilities for clients who do not meet inclusion criteria due to acuity.

*High Acuity Inpatient Sobering" includes beds at Providence Portland and Unity Center of BH

**Following field assessment, first responders may take high risk individuals to Psych Emergency or High Acuity Inpatient Sobering

5.5.1. Medical Acuity and Transfer Of Care[12]

- A blended staffing model (medical/behavioral health) capable of triaging, assessing, and providing care during sobering and withdrawal management
- The ability to deliver patient centered, trauma informed care
- Sufficient clinical expertise in the facility team to safely and effectively triage, assess, and transfer clients at the right time
- Appropriate safety and quality policies, procedures, and clinical protocols
- A sustainable and repeatable training approach

5.5.2. Safety and De-Escalation[12]

- Maintain ratio of clients relative to appropriate staffing ratios
- As needed, ability to separate voluntary and involuntary clients in order to maintain a safe milieu[13]

Proposed security infrastructure to maintain a safe milieu:

- A facility environment and culture of safety that model trauma-informed practices and fosters productive relationships with first responders and the justice system
- A no weapons policy with appropriate procedures, signage, and staff training
- Security personnel and other staff with training and ability to assess threat, and when needed, call on law enforcement resources to keep staff and clients safe
- Specific and repeatable training for law enforcement and other first responders in inclusion/exclusion protocol and the drop-off process
  - Request for proposal and facility operator contract language that articulates inclusion/exclusion criteria for:
  - First responder transport to the Sobering & Crisis Stabilization Center
- Facility operator intake, triage, and assessment of clients
- Acknowledgement in facility operator RFP and contract language:
  - Prevent facility operator from creating additional exclusion criteria based on client behavior during intake without the consulting contract holder(s) consent.

12. For further considerations related to Safety Protocols and Medical Guidelines that will be evaluated during project implementation, see Appendix 7.

13. For a definition of relevant holds see Appendix 5.

5.5.3. Holds – Transportation and Length Of Stay

Holds may be used to ensure patients achieve stability and have the mental clarity required to make informed decisions about their next steps in treatment post-sobering. This aligns with the changes made by HB 4002 to ORS 430.399 (Intoxication Welfare Holds). In principle, voluntary pathways and 'no force first' principles should always be the primary means of connecting people to treatment. The use of these statutes must balance harm reduction, the welfare of the individual, and a person-centered, trauma-informed approach to services. **Further considerations about length of holds are under review and subject to change.**

For more information on holds, see Appendix 5.

5.5.4. Care Coordination

The 24/7 Sobering & Crisis Stabilization Center staffing model includes care coordinators to ensure that clinical staff have the support they need to facilitate rapid transfers to step-up and step-down facilities. Care coordinators will also be essential for program evaluation through the 'quality connection check' function, which will ensure the provision of services by downstream step-up and step-down facilities or document other outcomes.

- Have clinical policies, procedures, and protocols for effective transfer
- Transfers both to and from the 24/7 Sobering & Stabilization Center:
    - Coordination with City of Portland Bureau of Emergency Communications, 988, and Multnomah County Crisis Intervention Call Center dispatchers
    - Use of the Oregon Hospital Capacity System to enable first responders/ dispatchers to know if/when the 24/7 Sobering & Crisis Stabilization Center is at capacity
- Low-barrier drop-off for first responders with standardized intake process
- Regular evaluations will be performed to assess outcome(s) of client transfers
    - Transfer verification will be a metric of success for the center's care coordination team
    - Client transfers will be verified, documented, and evaluated for performance and program evaluation. This will inform quality improvement efforts, training, and investment in the crisis continuum and must be considered during workflow development.
    - Have a process for effective communication, learning and improvement between Sobering Center/24/7 Drop-off and transportation staff, first responder agencies, providers, the criminal justice system, and other key stakeholders
- Data-informed and governed processes to round on the high utilizer SUD population, and adjust tactics and strategies as needed

5.6. Performance Management

The 24/7 Sobering & Crisis Stabilization Center project is focused on the creation and effective use of evaluative tools to improve community safety and safety for individuals receiving the Center's services. The existence of a 24/7 "front door" for the crisis system will enable a focused approach to the collection of criminal justice and health data. This data will be cross walked to create key performance indicators.

A critical component of the contract with the facility operator will be the ability to adhere to performance standards and engage in continuous quality improvement. A set of measures and reporting expectations will be compiled as part of preparation for the facility operator procurement process. See Appendix 4 for metrics that have been identified for review.

5.7. Data Systems and IT

Requirements

- 42CFR Part 2/HIPAA-compliant and secure
- Policies and procedures for HIPAA compliance, data security, personally identifiable information, and uses and disclosures of client protected information.
- Data use agreements with other organizations, including but not limited to the State of Oregon, Multnomah County, and the City of Portland

Systems

- Oregon (Hospital) Capacity System (recommended use by non-clinical admin staff to show bed availability)
- EHR (Electronic Health Record)

Technology

- Printer/copier access (with wi-fi or air card, for law enforcement to use on-site and in advance of arrival)
- Radio(s) (for communication with EMS, PPB, and MCSO)
- Cell phone(s)/land line(s) (for PPB and MCSO to communicate status before arriving)

Other systems to consider

- Emergency Department Information Exchange (EDIE)/Collective

Section 6

Funding

It is the intention to create a program that balances the needs of the community with sustainable funding models to minimize the use of general funds or temporary funding. At the outset, the 24/7 Sobering & Crisis Stabilization Center will most likely need to rely on County General Funds and/or leverage State and CCO funding to underwrite operations (a reality for similar efforts in other jurisdictions across the state).

The ultimate goal for this service facility is to be funded exclusively through state reimbursement. The County should be able to generate enough revenue from reimbursable services to fund non-reimbursable services such as sobering. Once a facility is identified, the County can develop a detailed plan for funding based upon the number of beds allocated for each type of service.

Section 7

Implementation & Cost

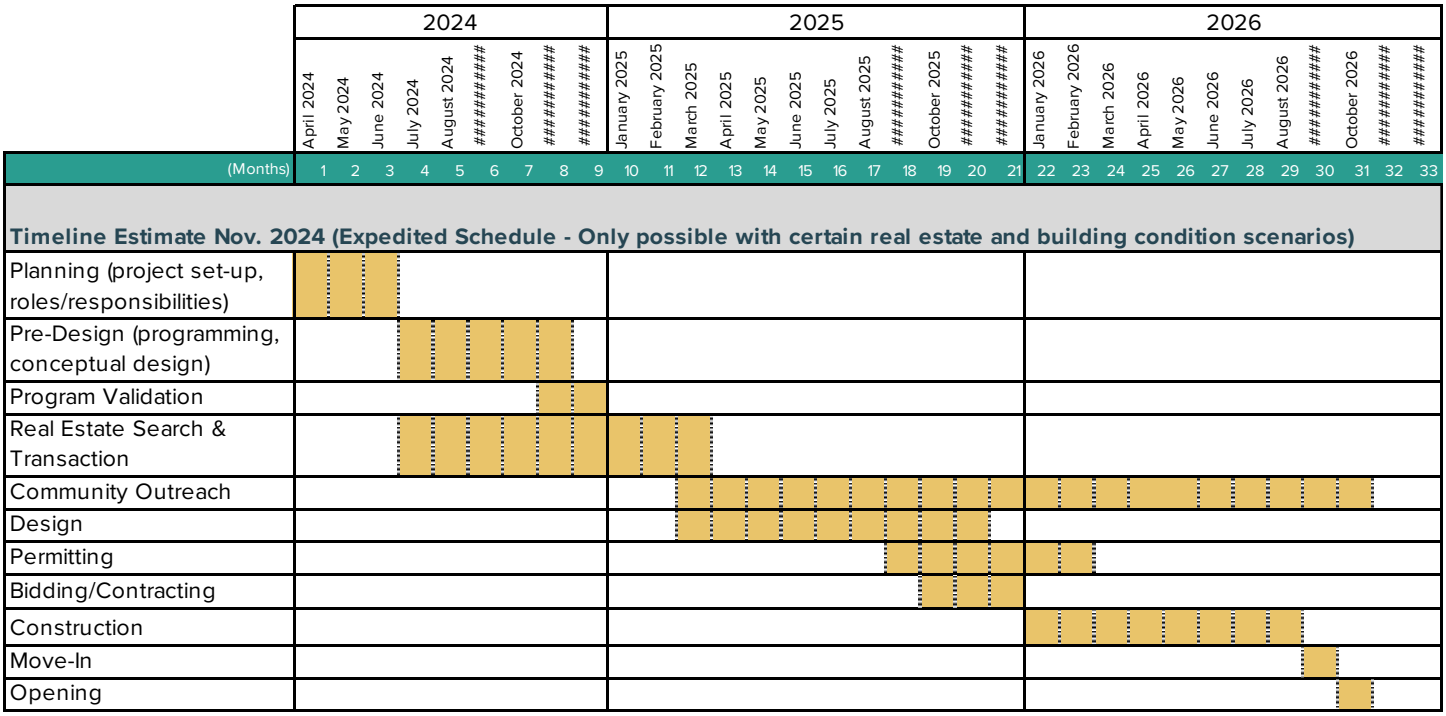
7.1. Project Timeline and Approach

Due to the urgency of community need, the following facility development timeline is aggressive. Facility development will likely need to be aligned with a phased approach to facility operator procurement and program launch to ensure there is no gap in sobering services provided by Multnomah County. Project stakeholders and the Department of County Assets' Facility and Property Management team created an expedited schedule that is only possible with certain real estate and building condition scenarios. If these conditions are sufficiently met, the 24/7 Sobering & Crisis Stabilization Center is anticipated to open in Fall 2026 (see Table 4: Project Timeline). Updates to the timeline will be issued as needed.

Alongside moving quickly towards a permanent facility, Multnomah County has prioritized funding sobering and withdrawal management services with our existing partners: In August 2024, The Unity Center for Behavioral Health added nine emergency substance use disorder beds; in January 2024, Providence added eight emergency substance use disorder beds.

Through Multnomah County's Coordinated Care Pathway Center and the advocacy of Commissioner Brim-Edwards, sobering services will be offered in Phase 2 of the County's deflection program, scheduled to begin Spring 2025.

Table 4: Project Timeline



7.2. Budget

Critical information for the plan's budget, such as site location, licensure, and procurement of facility operator(s), will influence amounts and calculations. This section is therefore conceptual and will change. One critical consideration is developing an operating model that is sustainable not only for this project but others like it in the state.

Multnomah County 24/7 Sobering & Crisis Stabilization Center Suggested Budget

Estimated Annual Operating Budget

A. Personnel

Personnel Costs:

	Suggested FTE	Amount	Notes
Admin/Support Staff, Clinical Staff, and Behavioral Health Staff	82.4	$6,591,520	Roles and FTE estimates will be refined through the procurement and planning processes. Wages were based on usual and customary market rates for the Portland area.
29.2% Fringe		$1,924,724	7.65% FICA, 13.65% Health/Life Insurance, 6% Retirement, 1.12% Workers Compensation, 0.78% Regional Transit Payroll Tax
10% Evening and 15% Night Shift Differential		$429,312	Excludes day shift and management roles.
Credentialing, Training, and Travel Costs (including trauma-informed care, HIPPA trainings, de-escalation, etc.)		$178,000	Estimate $2500 per year, per FTE Also includes travel, lodging, and conference expenses for leadership roles.
Total		**$9,123,566**	

B. Services, Supplies, & Equipment

Services, Supplies & Equipment Costs:

	Suggested FTE	Amount	Notes
Services & Equipment Costs (IT, phone, facility furniture replacement, office equipment, meal service, etc.)		$427,195	This could be more or less depending on existing agreements.
Insurance (general, malpractice, liability)		$55,000	Will be based on FTE and licensing of the facility.
Supplies (pharmaceuticals, medical supplies, food, office supplies, client basic need supplies, cleaning supplies)		$689,200	Over-the-counter drugs, MAT, Narcan, and other medications deemed appropriate for the safety and care of patients.
Maintenance (repairs to facilities and equipment not covered by warranty		$50,000	
Total Operating Cost		**$1,221,395**	
Additional Administrative Overhead		$122,140	Legal, finance, HR, etc. at 10% of Total Operating.
Total Operating with Admin. Overhead		**$1,343,535**	
Total Personnel & Operating Costs		**$10,467,101**	

Estimated Capital and Equipment Outlay:

	Suggested FTE	Amount	Notes
Acquisition Costs (Purchase of Facility, Inspections, Appraisal, Insurance, etc)		$6,600,000	Will vary based on actual building, assuming $155 cost per sq. ft.
Facility Improvements (Architects, Engineering, Construction, etc)		$10,000,000	Will vary based on scope of improvements, assuming $350 per sq. ft
Furniture and Equipment (recliner chairs, beds, kitchen equipment, office equipment, medical equipment)		$314,000	
Contingency (10% of all Capital Costs)		$1,691,400	
Total Capital Outlay Cost		**$18,605,400**	

7.3. Facility Operator Request for Proposals

Multnomah County Health Department will develop a Request for Proposals for the necessary services and operating models to ensure that individuals accessing the 24/7 Sobering and Crisis Stabilization Center have access to services that support treatment and recovery and that enhance community safety.

The Health Department will follow Multnomah County's standard Request for Proposal (RFP) process, in order to foster a process that garners the best quality applications from a wide range of applicants. The RFP process is expected to take 6 months, which allows time for early engagement with potential applicants to support the development of a practical RFP. Educational outreach (to help attract interest) and the release and closure of the RFP are also included in the process.

Section A

Appendices

- Appendix 1: Sobering Core Project Team
- Appendix 2: Multnomah County Sobering Leadership Team
- Appendix 3: Research and Literature Review
- Appendix 4: Performance Measures
- Appendix 5: Holds
- Appendix 6: Transportation
- Appendix 7: Medical Guidelines and Clinical Safety
- Appendix 8: Gap Analyses

Appendix 1: Sobering Core Project Team

Meetings:

Eight weekly Core Group meetings held January 24 - April 10, 2024; weekly briefing to the Commission Chiefs of Staff and Policy Advisors, several Commission meetings/work sessions, ongoing consultation with Key Advisory Group members.

Core Group Members

Name & Title	Affiliation
Julia Brim-Edwards, Commissioner Eric Zimmerman, Chief of Staff Michelle Rogelstad, Budget and Policy Director	Multnomah County, District 3
Sharon Meieran, Commissioner	Multnomah County, District 1
Tabitha Jensen, Director, Budget & Strategic Projects Renee Huizinga, Policy Advisor	Multnomah County, Chair's Office
Rachael Banks, Director Adelle Adams, Policy and Communications Manager Barbara Snow, Interim Senior Manager of Safety Net Services	Multnomah County Health Department
Nicole Morrisey-O'Donnell, Sheriff Carey Kaer, Chief Deputy, Law Enforcement Division	Multnomah County Sheriff's Office
Bobby Lee, Chief of Staff Skyler Brocker-Knapp, Senior Policy Advisor	City of Portland, Mayor's Office
Bob Day, Chief Mike Frome, Deputy Chief	Portland Police Bureau
Travis Gullberg, Chief	Gresham Police Department
Kyle King, President Adam Lee, Operations Executive	Adventist Health Portland
Andy Mendenhall, President and CEO	Central City Concern
Devarshi Bajpai, CEO Jessica Gregg, Chief Medical Officer	Fora Health
Nan Waller, Multnomah County Judge, Position 2	Oregon 4th Judicial District Circuit Court

Appendix 2: Multnomah County Sobering Leadership Team

The following Budget Note was adopted by the Board of County Commissioners on June 6, 2024 and created the Multnomah County Sobering Leadership Team, composed of Commissioner Brim-Edwards, the Chair's office, County leadership, City leadership, internal County departments, and other experts as needed.

24/7 Drop Off Receiving and Sobering Services; HB 4002:

Multnomah County is implementing House Bill 4002, which made significant changes to Measure 110 with a focus on the timelines in the legislation. These changes will affect many systems within the county and among jurisdictional partners. The County is also working to open sobering services as a part of a new 24/7 drop off receiving and sobering center.

HB 4002 Investments in the FY 2025 budget will support the County's work to implement a deflection program by September 1, 2024, and collaborate with inter-governmental partners and law enforcement to share definitions, eligibility, and expectations.

Multnomah County will clearly articulate the phasing of its response to this new law and ongoing need for sobering services and connections to withdrawal management, treatment, recovery, and other services. Implementation will happen through partnership with justice and law enforcement partners, behavioral health providers, other jurisdictional partners, and internal County departments.

The FY 2025 budget appropriates $26.9 million of State and City funding for the development of a 24/7 drop off receiving and sobering center. Activities funded under this program will aid in the coordination of the many systems designed to address the region's severe drug and alcohol abuse crisis.

These funds, along with additional State dollars, will also support initial tracking and assessment of the impacts of this new law on the community, with particular regard to racial disparities and disparate impacts for historically marginalized groups.

The Health Department will work in collaboration with the Department of Community Justice and County leadership to develop the necessary services and structures to ensure that individuals have access to resources that support treatment and recovery and that enhance community safety.

This budget note requests the following:

- The County creates a Sobering Services Leadership Team to provide oversight and direction to the creation of sobering services at the 24/7 dropoff receiving and sobering center. This team should include the District 3 Commissioner, the Chair's office, County leadership, City leadership, internal County departments, and other experts as needed.
- County departments move forward to open a permanent 24/7 drop off receiving and sobering center in alignment with timelines and programmatic elements outlined in the draft Multnomah County 24/7 First Responder Drop off Sobering Center Plan.
- Work with inter-governmental partners to provide public education about how the County is implementing HB 4002.
- Provide one or more Board Briefings no later than August 15, 2024 addressing the following topics:
    - The elements of HB 4002 and how they impact County operations and our community
    - Overview of deflection programs
    - Overview and status of phased launch activities
    - Determination of ongoing annual operating expense for comprehensive 24/7 drop off and receiving center with sobering services, transportation, and security

Provide the Board with quarterly updates on the opening of sobering services in or around October 2024, January 2025, March 2025, and June 2025.

Appendix 3: Research and Literature Review

Operational sobering facilities visited by Commissioner Julia Brim-Edwards:

- Buckley Detoxification Center, Eugene, Oregon (Tour Date: 12/29/23)
- Tuerk House, Baltimore, Maryland (Tour Date: 01/11/24) with Chair Vega Pederson staff
- SoMa RISE, San Fransico, California (Tour Date: 01/22/24)
- Houston Recovery Center/Houston Center for Sobriety, Houston, Texas (Tour Date: 10/10/24) with Commissioner Stegmann
- National Sobering Collaborative Meetings with Commissioner Stegmann

Literature and publications reviewed:

- *Receiving Center Clinical Rubric*. Dr. Andy Mendenhall. January 2024.
- *Emergency Department Referral Criteria*. Dr. David L. Murphy Sobering Center Sobering Center. March 2021.
- *Sobering Centers & Day Habilitation*. CalAIM Community Support Webinar. June 2022.
- *Program Specifications*. Neighborhood-based Drug Sobering Center, San Francisco, California.
- *Drug Sobering Center Issue Brief*. Mental Health San Francisco Implementation Work Group -San Francisco Department of Public Health. April 2021.
- *Oregon Drug Sobering Shelters vs. Crisis Stabilization Units Comparison of Solutions*. Central City Concern. December 2019.
- *180 Jones Program Description*. HealthRIGHT 360. January 2020.
- *Utilization of a Sobering Center for Acute Alcohol Intoxication*. Smith-Bernardin, S. Et. Al. February 2017.
- *LA Sobering Protocol*. Dr. David L. Murphy Sobering Center. April 2019.
- *Identification and Practice Patterns of Sobering Centers in the United States*. Warren, O., Et. Al. November 2016.
- *Sobering Centers Explained: An Environmental Scan in California*. Smith-Bernardin, S., September 2021.
- *Sobering Centers Explained: An Innovative Solution for Care of Acute Intoxication*. Smith-Bernardin, S., July 2021.

- *Medical Protocols*. Dr. David L Murphy Sobering Center. May 2019.
- *Standard Operating Procedures*. Huston Recovery Center, Huston Center for Sobriety. January 2018.
- *Behavioral Health Emergency Coordination Network (BHECN) Project Status Report Phases I&II*. Lones Management Consulting. October 2022.
- *Sobering Center Medical Protocols*. San Francisco Dept. of Public Health, San Francisco Sobering Center. August 2016.
- *EMS Can Safely Transport Intoxicated Patients to a Sobering Center as an Alternative Destination*. Smith-Bernardin, S., Et. Al. July 2019.
- *National Guidelines for Behavioral Health Crisis Care -A best Practice Toolkit*. Substance Abuse and Mental Health Services Administration. 2020.
- *Crisis Reliability Indicators Supporting Emergency Services (CRISES): A Framework for Developing Performance Measures for Behavioral Health Crisis and Psychiatric Emergency Programs*. Balfour, M. Et. Al. September 2015.
- *National Hospital Ambulatory Medical Care Survey: 2018 Emergency Department Summary Tables*. Santo, L. Et. Al. December 2021.
- *Why is there comorbidity between substance use disorders and mental illnesses?* National Institute on Drug Abuse. April 2020.
- *Snapshot of Behavioral Health Crisis Services and Related Technical Assistance Needs Across the U.S.* Substance Abuse and Mental Health Services Administration. May 2023.
- *Does Mandating Offenders to Treatment Improve Completion Rates?* Coviello, D. Et. Al. November 2012.
- *HB 2417 Report: Statewide Coordinated Crisis System.* The Oregon Health Authority. January 2022.
- *Methamphetamine*. Saadabadi, A., Et. Al. National Library of Medicine. May 2023.
- *National Prevalence of Alcohol and Other Substance Use Disorders Among Emergency Department Visits and Hospitalizations: NHAMCS 2014–2018*. Suen, L. Et. Al. National Institute for Health. Aug 2022.
- *Patient and Provider Perspectives on Emergency Department Care Experiences among People with Mental Health Concerns*. Navas, C., Et. Al. July 2022.
- *Hospital Data Trends to Inform BHECN Design: 2019-2021*. Henderson, R, et al. 2022
- *Alternative Payment Model APM Framework Health Care Payment Learning & Action Network*. 2017

Oregon Statutes and Administrative Rules Reviewed:

- Oregon Statutes:
  - 414.025 *Definitions for ORS Chapters 411, 413, and 414*
  - 426.074 *Investigation*
  - 426.127 *Outpatient Commitment*
  - 426.130 *Determination of Mental Illness*
  - 426.150 *Transportation to Treatment Facility*
  - 426.200 *Duties Following Emergency Admission*
  - 426.210 *Limit of Detention After Commitment in Emergency Proceedings*
  - 426.217 *Change of Status of Committed Patient to Voluntary Patient*
  - 426.220 *Voluntary Admission*
  - 426.228 *Custody*
  - 426.231 *Hold by Licensed Independent Practitioner*
  - 426.232 *Emergency Admission*
  - 426.233 *Authority of Community Mental Health Program Director and of Other Individuals*
  - 426.234 *Duties of Professionals at Facility Where Person Admitted*
  - 426.236 *Rules*
  - 426.237 *Prehearing Detention*
  - 426.238 *Classifying Facilities*
  - 426.295 *Judicial Determination of Competency*
  - 430.210 *Rights of Persons Receiving Mental Health Services*
  - 430.262 *Registration of Sobering Facilities*
  - 430.357 *Minimum Standards*
  - 430.397 *Voluntary Admission of person to Treatment Facility*

- 430.399 *When a Person Must be Taken to Treatment Facility or Sobering Facility*
- 430.401 *Liability of Public Officers, Providers, Treatment Facilities, and Sobering Facilities*
- 430.460 *Consent to Evaluation*
- 430.465 *Referral for Evaluation*
- 430.626 *Definitions*
- 430.627 *Statewide Coordinated Crisis System*
- 682.062 *County Plan for Ambulance and Emergency Medical Services*

- Oregon Administrative Rules:
  - 309-023-0100 through 309-023-0180 *Psychiatric Emergency Services*
  - 309-035-0100 through 309-035-0220 *Residential Treatment Facilities and Residential Treatment Homes for Adults with Mental Health Disorders*
  - 309-072-0100 through 309-072-0160 *Mobile Crisis Intervention Services and Stabilization Services*
  - 410-136-3120 *Medical Transportation Services*
  - 415-012-0000 through 415-012-0090 *Licensure of Substance Use Disorders and Problem Gambling Residential Treatment and Recovery Centers*
  - 415-20-0000 through 415-020-0096 *Standards for Outpatient Opioid Treatment Programs*

Appendix 4: Performance Measures

Below is a list of possible measures to assess 24/7 Sobering & Crisis Stabilization Center program performance. This list was created from literature and publications on the subject and community input (see Appendix 2, Literature and Publications Reviews above).

Program Performance Measures

Intake	Treatment	Transfers Out	Quality/Safety	Community
• Transfers in by type (first responders, criminal justice, providers, walk-in) • Number of minutes it takes a first responder to complete drop-off • Number of minutes from arrival to complete assessment • Medical, MH, SUD acuity upon presentation to the 24/7 Stabilization Center • SUD Diagnosis stratified by SUD • Number of clients with positive drug screenings – by substance/ polysubstance use • Number of clients with negative drug screens • Number of clients with positive pregnancy tests	• Length of stay – stratify by SUDs • Number of clients requiring wound care • Symptom reduction • Medication restarted	• Transfers out by triage or assessment status • Number of clients requesting connection to treatment • Number of clients declining connection to treatment • Rate of success of transfer and staying connected to care, and if not, why not • Successful transfer of care plan to next level of care provider • Where possible, follow-up w/ clients to determine outcome (stratified by mental health and SUDs diagnoses)	• Client experience with culturally appropriate and peer services • Chart reviews (adherence to clinical protocols) • Rate of incident report by incident type • Adherence to Continuous Quality Improvement schedule • Number of issues identified • Number of issues resolved • Number of clients requiring physical and/or chemical restraint • Utilization of seclusion spaces • Average duration of holds • Conversion from hold to voluntary status • Hours of physical restraint use • Hours of seclusion use • Independent panel review of incident reporting • First responder experience • Evaluation of inclusion/ exclusion protocol utilization • Successful data entry and exchange (continuous training, verification, validation) • Client experience	• Equitable access and treatment • Community impact survey • Percentage of time on facility divert • Number of arrests deflected • Number of ED visits deflected • Number of jail booking diverted • Provider/staff satisfaction • Likelihood to recommend • Number of individuals who approve/decline staff to attempt to contact family or other support

Appendix 5: Holds

Several types of civil holds are used by first responders and health care providers to transport and evaluate individuals who are intoxicated or may be a danger to themselves or others. Additionally, arrest deflection, jail or court diversion, and jail population review are used to connect people in custody to sobering and treatment centers or other healthcare providers. This section details each type of hold and their relevance for the 24/7 Sobering & Crisis Stabilization Center.

Civil Holds –Public Intoxication

- Summary: In Oregon, police officers and sobering or treatment facilities can hold an intoxicated individual for a limited duration of time. Police officers may only hold an individual who is intoxicated in a public place to transport them to a sobering or treatment facility. Per statute, the police officer must bring the person to the facility themselves. A sobering facility shall discharge admitted individuals within 24 hours. A treatment facility shall discharge admitted individuals within 48 hours unless the person has applied for voluntary admission to the treatment facility.
- Relevance for 24/7 Sobering & Crisis Stabilization Center:
  - Law Enforcement: Each law enforcement agency in Multnomah County must set a policy for the use of civil intoxication holds and issue directives to their officers accordingly.
  - Facilities: The 24/7 Sobering & Crisis Stabilization Center's ability to hold an intoxicated individual will depend on facilities licensure.
- Selections from Oregon Revised Statute § 430.399
  - (1) Any person who is intoxicated or under the influence of a controlled substance in a public place may be sent home or taken to a sobering facility by a police officer. [Continues]
  - (2) When a person is taken to a treatment facility, the director of the treatment facility shall determine whether the person shall be admitted as a patient, referred to another treatment facility or a sobering facility or denied referral or admission. If the person is incapacitated or the health of the person appears to be in immediate danger, or if the director has reasonable cause to believe the person is dangerous to self or to any other person, the person must be admitted. The person shall be discharged within 48 hours unless the person has applied for voluntary admission to the treatment facility.

- (3) When a person is taken to a sobering facility, the staff of the sobering facility shall, consistent with the facility's comprehensive written policies and procedures, determine whether the person shall be admitted into the sobering facility. A person who is admitted shall be discharged from the sobering facility within 24 hours.

Civil Holds –Mental Health

Summary: In Oregon, the community mental health program director or their designee can notify a police officer to take a person into custody and direct the officer to take the person to a hospital or non-hospital facility approved by the Oregon Health Authority (OHA). Additionally, a police officer may take into custody a person who the officer has probable cause to believe is dangerous to themselves or any other person and is in need of immediate care, custody, or treatment for mental illness. The officer must then transport them to the nearest hospital or non-hospital facility approved by the Oregon Health Authority for evaluation by a Licensed Independent Practitioner.

- Relevance for 24/7 Sobering & Crisis Stabilization Center:
  - The 24/7 Sobering & Crisis Stabilization Center will not be a licensed mental health treatment facility and therefore will not be eligible to receive Mental Health Director or Police Officer holds for mental health.
- Selections from Oregon Revised Statute § 426.233
  - 1(b) The community mental health program director or designee under the circumstances set out in paragraph (a) of this subsection may:
    - (A) Notify a peace officer to take the person into custody and direct the officer to remove the person to a hospital or nonhospital facility approved by the Oregon Health Authority;
    - (B) Authorize involuntary admission of, or, if already admitted, cause to be involuntarily retained in a nonhospital facility approved by the authority, a person approved for care or treatment at a nonhospital facility by a licensed independent practitioner under ORS 426.232 (Emergency admission);
    - (C) Notify an individual authorized under subsection (3) of this section to take the person into custody and direct the authorized individual to remove the person in custody to a hospital or nonhospital facility approved by the authority;

- (D) Direct an individual authorized under subsection (3) of this section to transport a person in custody from a hospital or a nonhospital facility approved by the authority to another hospital or nonhospital facility approved by the authority as provided under ORS 426.235 (Transfer between hospital and nonhospital facilities); or
- (E) Direct an individual authorized under subsection (3) of this section to transport a person in custody from a facility approved by the authority to another facility approved by the authority as provided under ORS 426.060 (Commitment to Oregon Health Authority).

- Selections from Oregon Revised Statute § 426.228
  - (1) A peace officer may take into custody a person who the officer has probable cause to believe is dangerous to self or to any other person and is in need of immediate care, custody or treatment for mental illness. As directed by the community mental health program director, a peace officer shall remove a person taken into custody under this section to the nearest hospital or non-hospital facility approved by the Oregon Health Authority. The officer shall prepare a written report and deliver it to the licensed independent practitioner who is treating the person. The report shall state:
    - (a)The reason for custody;
    - (b)The date, time and place the person was taken into custody; and
    - (c)The name of the community mental health program director and a telephone number where the director may be reached at all times.

Arrest Deflection

Summary: Arrest deflection is a policy created by a district attorney's office that allows police to take someone to a treatment facility, sobering center, or crisis receiving/stabilization center when they have made an arrest, typically for a lessor offense such as a non-person misdemeanor committed by an intoxicated person. The person is charged with a crime and is issued a citation in lieu of transport to jail. Often these policies are accompanied by a policy to review and, if appropriate, dismiss the charges if they participate in services once deflected.

- Relevance for 24/7 Sobering & Crisis Stabilization Center:
  - In the prior iteration of planning, prosecutors from the Multnomah County District Attorney's Office participated in a workgroup to develop recommendations for arrest deflection. The Law Enforcement Assisted Diversion (LEAD) program was piloted several years ago before it was discontinued.

Booking, Jail, or Court Diversion

Summary: Booking or Court Diversion is a policy created by a jail or court to divert someone in the custody of a jail to a treatment facility or crisis stabilization unit. As defined by the Sequential Intercept Model (SIM) diversion may occur at several key intercept points including booking/initial detention, initial hearing(s), during a jail population review, reentry into jails, or through community corrections.[14]

- Relevance for 24/7 Sobering & Crisis Stabilization Center:
  - Recommendations have been developed for booking diversion, however they require further development prior to integration into the 24/7 Sobering & Crisis Stabilization Center model as they require conducting additional safety assessments and special transportation considerations as the people held did not qualify for arrest deflection and categorically represent a higher level of risk.

Table 3: In and Out of Scope Transportation and Facility Holds

Type of Hold	Applies To	In Scope	Out of Scope
Intoxication Welfare Hold	Transport/ Facility	Up to 24 hours for the 24/7 Sobering & Crisis Stabilization Center	
Mental Health Director's Hold (Mental Health)	Transport/ Facility		Specific to mental health transport and evaluation; out of scope for the 24/7 Crisis Stabilization Center.
Civil Commitment (Mental Health)	Facility		Specific to mental health evaluation and ongoing custody; out of scope for the 24/7 Sobering & Crisis Stabilization Center.
Arrest Deflection	Transport	The ability for Peace Officers to transport someone under arrest to a sobering or treatment facility in lieu of jail.	

14. Substance Abuse and Mental Health Services Administration. (2022, September 27). The Sequential Intercept Model (SIM). Retrieved from: Samhsa.gov: https://www.samhsa.gov/criminal-juvenile-justice/sim-overview

Appendix 6: Transportation

See Tables 1 and 2 below to view protocols designed to meet safety standards for transportation to and from the 24/7 Sobering & Crisis Stabilization Center.

Table 1: First Responder Field Evaluation Protocol for Transport To 24/7 Sobering & Crisis Stabilization Center

First Responder Evaluation	Entity for Additional Evaluation	Disposition*	Secondary Disposition
1. Needs ALS**		• Ambulance to ED	
2. Unconscious and cannot be roused		• Ambulance to ED	
3. Probable cause for potential crime	LE	• Shall arrest*** - LE transports to jail • Deflection: LE transports to 24/7 Sobering and Crisis Stabilization Center • Deflection: Transportation to 24/7 Sobering and Crisis Stabilization Center	• Booking assessment or pretrial screening
4. Requires civil hold	PR, EMS, LE	• Director hold: Ambulance transports to ED with LE assistance • Safety hold: LE**** or transportation to 24/7 Sobering and Crisis Stabilization center	
5. High acuity SUD and/or MH	Transportation team	• Check 988, County Crisis Line for ACT/FACT	• Ambulance to ED • PSR to community provider or stabilization center • Transportation to 24/7 Sobering and Crisis Stabilization Center
6. Suspected intoxication, cooperative, low acuity MH		• Other partnerships or resources • Cab ride or rideshare to 24/7 Sobering and Crisis Stabilization Center • Transportation to 24/7 Sobering and Crisis Stabilization Center	

*Disposition refers to destination after evaluation

**Triage by first responders is subject to all policies and requirements of Multnomah County EMS

***Not all 'shall arrest' cases will require transport to jail and may be eligible for 24/7 Stabilization Center services

****LE transport to the 24/7 Stabilization Center piloted by Enhanced Crisis Intervention Trained (ECIT) officers or officers that have BH training/credentials

Glossary of Terms

ALS: Advanced Life Support

ED: Emergency Department

EMS: Emergency Medical Services

LE: Law enforcement

PSR: Portland Street Response

PR: Project Respond

MH: Mental health

SUD: Substance use disorder

NEMT: Non-emergent medical transportation (Medicaid benefit)

Assumptions:

1. Location of client in the community, the availability of transportation resources, level of acuity/urgency will be the primary factors for determining mode of transportation.
2. NEMT network will not be used as a means for transportation to the 24/7 Sobering & Crisis Stabilization Center due to prior authorization requirements.
3. The 24/7 Sobering & Crisis Stabilization Center will be secure and will be able to accept holds.
4. Evaluation conducted in the field.

Table 2: Triage or Assessment for Transport FROM 24/7 Sobering & Crisis Stabilization Center

Sobering Center Triage or Assessment	Status	Disposition*
7. Medical or MH emergency	Pt requires evaluation	Ambulance Drop-off to ED or PES
8. Medicaid established	NEMT approves prior auth	NEMT to appropriate services or home
9. Client wants "next step" services	Needs warm hand-off and peer connection	Transportation to appropriate services
10. Independent transfer	Stable for independent transport	Rideshare to shelter, home, or choice of destination
11. All other transfers	Requires supported transport	Transport to shelter, home, or choice of destination

*Disposition refers to destination after discharge.

Glossary of Terms

ALS: Advanced Life Support

ED: Emergency Department

PES: Psychiatric Emergency Services

MH: Mental Health

NEMT: Non-emergent medical transportation (Medicaid benefit)

Assumptions:

1. Not all clients will have Medicaid established or qualify for Medicaid.
2. Some clients will choose not to participate in services after sobering.
3. NEMT will be utilized only if the client stays more than approximately 36 hours (prior authorization required)
4. General Fund dollars will be used to support this model.

Appendix 7: Considerations - Medical Guidelines and Safety Protocols

The following medical guidelines and safety protocols are for consideration only and will be evaluated during project implementation.

Medical Guidelines

Key Area	Considerations	Assumptions
Personnel	• 24/7 licensed provider (LPC, NP, MD, PA, PMHNP) • RN staff • Pharmacist (PT or FT) • LCSW • Specialized SUDs Care Coordinators • Peer Providers • Safety / Security • Milieu Management • Medical Director and Associate Medical Director/s • CADC	• Must include skill set and licensure that allows 24/7 Sobering and Crisis Stabilization Center to monitor, maintain and lift holds and can perform complex medical management • Staff who is adept at motivational interviewing • Possibly a peer provider/social work duo • Important to bake in low barrier connection to longer term treatment AND know some people will not want it • Medical Directors should include psychiatric and SUDs expertise.
Standard community practice around sobering and withdrawal from alcohol and other substances	• Utilize current standards of care from hospitals and residential settings • Access to point of care testing (incl drug testing, CBG, public health screenings, pregnancy) • Focus on Oral Medication and Injectable medication • Observation, monitoring, supportive care, withdrawal management if needed • Referral to higher level of care • Onsite Behavioral Health support incl social support to help after 24-48 hours, after they've stabilized, or withdrawal has happened	• Exclude intravenous medication • Don't anticipate having easy access to lab technology outside of point of care testing – (Impacted if adjacent to a hospital or higher level of care that already has one?) • Consideration for routine or screening EKG for medication management

Medical Guidelines

Key Area	Considerations	Assumptions
Utilize current Standards of Care around early treatment for methamphetamine intoxication	• Oral Antipsychotics • Benzodiazepines • Calm environment (rest, hydration, nutrition) • Injectable antipsychotics may sometimes be necessary	• Commercial kitchen for nutrition needs
Holds management	• Regular evaluation and assessment of legal status at least daily • Daily consideration of appropriate level of care • This section ties to the Facilities Workgroup deciding upon location.	• Must include skill set and licensure that allows 24/7 Sobering and Crisis Stabilization Center to monitor, maintain and lift holds and can perform complex medical management • Once a hold is lifted, we can continue to support folks voluntarily
Pharmacology	• On-site Pharmacy or access to pharmacy services is recommended (with capacity for quick turnaround of several hours in some instances) • Oral or injectable medications that do not require continuous monitoring • Stock medication you store and dispense • Ability to store and administer personal medications	• Formulary to provide: • Oral and injectable antipsychotics • Benzodiazepines • Oral phenobarbital • Medications for comfort and adjuncts for withdrawal (i.e., gabapentin, antiemetics, anxiety medications like clonidine, hydroxyzine • Medications for common co-occurring conditions (wounds, soft tissue infections, etc.) • Constipation • Less acute than hospital, but more in line with subacute facility capabilities
Facility requirements as non-pharmacologic interventions	• Observation up to 72 hours • Quiet, safe environment • Areas of decreased stimulation incl safe seclusion rooms • Comfortable and safe places to rest with beds • Places for low key recreation (TV, puzzles, coloring, etc.) • Space for therapy and group meetings • Access to outdoor space and smoking area?	• Effective and compassionate non pharmacologic interventions are essential • Storage and procedure around personal belongings (policy on weapons)

Safety Protocols

Key Area	Considerations	Assumptions
1. During intake process	• Personal Belongings	• Contraband check • Remove shoes • Change into facility socks • Catalog valuables while patient is changing into scrubs and undergoing skin check in a private area
	• Medical Recommendations	• Skin check (same sex RN)-check skin folds but no cavity checks • Staff required to change into facility scrubs • Perform best practice medical assessment and mental health assessment • Initiate actual detox treatment program for alcohol, opiates, or poly-substance use
2. Other safety considerations	• Facility Recommendations	• Managing animals • Managing what to do if no improvement in 48 hours on public safety hold • Decide if PD needs to be involved in conversation about custody discharges • Plan for walk-in portion • Protocol around Weapons and contraband (and storage) • Considerations for designated smoking areas • Alcohol –free products • Clear communication of approved and restricted items • Establishing trauma-informed spaces by centering around equity, specifically racial equity

Safety Protocols

Key Area	Considerations	Assumptions
3. Staff training during agitation	• Verbal de-escalation training (i.e., therapeutic options and CPI) for all staff • Physical de-escalation and containment training (i.e., safety clinch) for BHTS and BHA staff • Contraband • Allowable items	• Safety starts at the door! • Initial and annual training for ALL staff • Establishing trauma-informed spaces by centering around equity, specifically racial equity
4. Managing Agitation: Multipronged approached	• General guidelines to managing agitation in a trauma informed manner	• Clear expectations and boundaries-what is acceptable or not • Expectations need to be consistent and apply equally to everyone • If someone is acting it, it is because they have a need that is not being met • When someone visibly upset, engage with them to figure out what need they have that is not being met • Meet that need if possible: more food, more blankets, a quiet room • Offer comfort medications-the person is in detox after all • Utilize peers to engage the person, as well, but any team member can engage the person and the more contacts and efforts the team has trying to rectify this person's experience, the more successful team will be at establishing rapport and avoid major blow outs if possible • Strategically engage with patient after the RN gives medications to help direct the narrative • Establishing trauma-informed spaces by centering around equity, specifically racial equity
	• Managing agitation with medications	• Use case: when medication is required based on response to other interventions • Two pathways: stimulant vs. depressant • Protocol for treatment of agitation. BZN (benzodiazepine), EPS (extrapyramidal side effects; ETOH (alcohol); IM (intramuscular)

Safety Protocols

Key Area	Considerations	Assumptions
	• If agitation persists beyond these measures	• Having a staff presence may head off violent aggression but in someone intoxicated could also exacerbate it; this is where behavioral health is so nuanced and there is no cookie cutter approach • Recommend taking the person away from main milieu to avoid upsetting other patients and making the event bigger than it needs to be (take into an office if the person is safe enough to engage in that manner) • Decrease stimulation-taking out of main milieu or to quieter area with less distractions and more one on one attention • Establish clear expectations: no yelling, no throwing items, and inform when these expectations are not being met gently
5. Managing Agitation: Multipronged approached	• Extreme DTS (self-harm)	• Restraint pathway if all else fails • Ensure medications are offered or given if indicated at this point. It Is how the symptoms will improve if someone is truly psychotic • If necessary, subdue the person physically so they can be transferred to a safe place where they cannot injure themselves • Have patient assist in own transfer if possible • If they refuse to assist, engage transport equipment like transport blanket or taco • Only use restraint chair if the patient will not refrain from harming themselves and make sure that medications are given at this time. This is the therapeutic intervention part above merely keeping the person safe • Person must be observed by a 1:1 through entirety of restraint • Constant observation with 15-30 min checks of restraint equipment, circulation, breathing, etc. • Containment should be as brief as possible – it can be traumatizing • Do not forget to debrief after any event! What went well? What did not? Should be multi-disciplinary conversation

Safety Protocols

Key Area	Considerations	Assumptions
	• Agitation/Aggression DTO	• Seclusion pathway • Make sure to utilize medications rather than just locking someone in a room two "cool off" – must be a therapeutic measure • Once in seclusion, 15 min checks and frequent vital signs – generally every few hours and seclusions need to be continually reassessed for ongoing need – containment should be as brief as possible • Have patient assist in own transfer or utilize transfer equipment – bring to seclusion room • Provide PRN medications and set very clear expectations to have seclusion discontinued – let the person know what you need to see before they can be released from the room • Continue to assess for patient's needs, perhaps the person was too agitated to even articulate their needs – keep your eyes and ears open! • Leave seclusion room one at a time after administering medications • 15-minute checks, 2–4-hour vitals while in seclusion • Release as soon as release criteria are met and continue to clearly communicate expectations of release – this is a trauma informed measure

Appendix 8: Gap Analyses

Operating Model

Staffing Model

Recommendation: Implement a staffing model with the capabilities to support medically/behaviorally complex sobering clients.

Current State	Recommendations	Future State
• Multnomah County has limited providers offering 24/7 sobering and crisis stabilization capacity that is appropriately staffed to receive individuals experiencing acute intoxication, psychosis, and co-occurring disorders.	• Implement a staffing model that combines medical and behavioral health staff to quickly triage, assess, and initiate care for sobering and manage early withdrawal symptoms. • Staff may include a combination of providers (MD, PA/NP), nurses (RN/LPN), EMTs, peers, LMHPs, QMHAs, SUDs Care Coordinators, CADCs, and support staff.	• A blended staffing model (medical/behavioral health) capable of triaging, assessing, and providing care during sobering and early withdrawal management. • The ability to deliver patient centered care. • Sufficient clinical expertise in the 24/7 Sobering & Crisis Stabilization Center team to safely and effectively refer and transfer clients at the right time.

Reliable and Rapid Engagement Capability

Recommendation: Implement a reliable and rapid engagement model that can quickly triage, assess, and initiate care.

Current State	Recommendations	Future State
• Portland lacks a dedicated non-ED/jail setting to receive first responder's drop-off that can quickly triage clients and transfer care or custody. • First responders are unable to determine the cause of psychosis in the field i.e., mental health, SUD, or co-occurring.	• Each first responder agency should receive specialized training on the 24/7 Sobering & Crisis Stabilization Center services and service population. • First responder transfers should happen timely and at minimum be comparable to transfers to jail or the ED. • Non-admission to the 24/7 Sobering & Crisis Stabilization Center should be closely monitored, and follow-up training should be conducted regularly to improve the intake process.	• First responders are well trained and can determine which clients are eligible for 24/7 Sobering & Crisis Stabilization services. • 24/7 Sobering & Crisis Stabilization Center transfers happen quickly so first responders can return to work in the community.

Psychosis, Agitation, and Combative Behavior

Recommendation: Prioritize safety and security of staff, first responders and clients.

Current State	Recommendations	Future State
• First responders frequently encounter individuals experiencing psychosis and agitation who may be combative. • First responders have three choices: the ED, jail, or disengage the client leaving them in the community. • Aggressive behavior associated with meth/polysubstance withdrawal causes many providers in Multnomah County to exclude this population from care.	• Modify a facility to be physically capable of receiving clients experiencing psychosis. • Create robust safety protocols that place staff and client safety first. • The operating model must prioritize safety, client centered care, trauma-informed care, and client choice. • Pathways for seclusion, physical and chemical restraints must exist with well-defined protocols and procedures.	• A safe place for first responders to take clients exhibiting psychosis, agitation, or combative behavior. • Trauma-informed, client centered care are the core principles with a "no force first" model of care. • Voluntary seclusion is an option for clients; involuntary seclusion available, when necessary, per protocol. • Medications for psychosis and agitation are available and align with standards of care with well-defined protocols and procedures.

Referral Pathways and Transfer of Care

Recommendation: Develop agreements with programs and services across the crisis continuum so care can be quickly transferred to the most appropriate setting post triage, assessment, or sobering.

Current State	Recommendations	Future State
• The current SUD crisis is beyond our system's capacity to manage. • There is high demand for and limited access to immediate SUD/MH care. • No "front door" exists for first responder drop-off. This drives inappropriate utilization of jail, EDs, and treatment provider services. • In the absence of a front door, accurate measurement of referrals to existing programs' impact on client outcomes and public safety is tricky at best. This creates an accountability gap.	• Prioritize triage and assessment capabilities so the 24/7 Sobering and Crisis Stabilization Center can quickly evaluate and admit or triage to another level of care. • Options should be available for a triage up (ED, Unity, Jail), triage sideways (other crisis services), triage down (referral to outpatient care). • Agreements should be in place with providers in the continuum for reserved beds or program slots to receive clients leaving sobering. • 24/7 Sobering & Crisis Stabilization Center should have metrics in place to evaluate outcomes post-referral or transfer.	• Clients not admitted to the 24/7 Sobering & Crisis Stabilization Center have appropriate and timely access to care. • Clients assessed post intake who are experiencing a mental health crisis are connected and transported to an appropriate level of care. • Clients who sober up are connected and transported to programs and services that can help them work toward lasting recovery. • Reduced impact of dysregulated/unstable SUD utilizing ED, jail, and treatment provider services. • Ability to evaluate the outcome of referrals/transfers to other providers.

Transportation

Transportation

Recommendation: Develop a dedicated in-house transportation resource.

Current State	Recommendations	Future State
• Current OARs provide very limited roles and guidance on how an individual in crisis can be transported to sobering, stabilization or other appropriate settings of care.	• Implement a discrete mobile crisis outreach transportation resource to support first responders. • Advocate for changes to OARs to clarify mobile crisis outreach transportation and reimbursement rules.	• Transportation supports first responders by transporting intoxicated or low-to-moderate acuity co-occurring patients to appropriate settings of care. • Transportation capability is a reimbursable service for OHP members without prior authorization. • EMS continues to transport high acuity mental health patients.

Emergency Medical Services (EMS)

Recommendation: Develop an alternative transport protocol.

Current State	Recommendations	Future State
• AMR, the county's only ALS emergency medical services contractor, can only transport patients to emergency departments per ordinance § 21.416 (H).	• Establish an alternative transport protocol to allow EMS to transport individuals experiencing acute intoxication or low-to-moderate co-occurring disorders to the 24/7 Sobering & Crisis Stabilization center or other appropriate settings of care.	• ALS patients and mental health holds are transported to behavioral health emergency / emergency departments per the existing protocols. • Patients experiencing acute intoxication that meet medical criteria established by a new alternative protocol are transported to the 24/7 Sobering & Crisis Stabilization Center or another appropriate setting of care.

Law Enforcement

Recommendation: Law Enforcement Transport to 24/7 Stabilization.

Current State	Recommendations	Future State
• No discrete transportation resource exists to support law enforcement with transport of individuals placed on civil intoxication holds. • AMR transports people placed on mental health civil holds by PPB to emergency departments.	• Advocate for change to existing ORSs and OARs, so law enforcement can delegate civil hold authority to a discrete transportation resource for civil intoxication holds. • Implement an arrest diversion model based on the recommendations in the appendix for those charged with certain offenses; law enforcement would then transport to the 24/7 Sobering & Crisis Stabilization center.	• Law enforcement transports intoxicated individuals who are being diverted from arrest, DA's office will review charges and dismiss charges when appropriate. • Transportation capability with transport holds for intoxicated individuals. • AMR continues to transport mental health holds.

Care Coordination

Effective Care Coordination

Current State	Recommendations	Future State
• Care Coordination is often seen as a panacea. "We just need more...case managers (etc.)" • There are many forms of care coordination, e.g., specialty navigation, intensive case management, etc. • The level of resourcing, i.e., salary, education level, training, and management support for care coordination varies widely.	• Specific to 24/7 Sobering & Crisis Stabilization Center coordination staff – focus on keeping the scope of their work focused and measurable (consider calling the role "Transfer Coordinator"). • Establish an intensive and consistent training and support program for transfer coordinators. • Where possible, establish service line agreements with providers to reserve treatment beds, shelter space, etc.	• Transfer Coordinators are well trained, resourced, supported, and focused. • Service line agreements for reserved beds, shelter space, etc. are in place with providers. • Wherever possible, client transfers will be verified, documented, and evaluated for performance. This will inform quality improvement, and training efforts.

Effective Care Coordination

Current State	Recommendations	Future State
• It is difficult to measure the effectiveness of care coordination in a fractured system. This drives a more relational approach, often at the expense of efficiency and equity. • There is no unified or standardized capability to evaluate effectiveness across the many providers who receive clients.	• Where possible, set-up a data sharing agreement with CJ partners to identify justice involved individuals so transfer coordinators can help them access focused programs/resources. • Establish a "Quality Connection Check" protocol to drive visibility into care coordination effectiveness and transfer outcomes.	• Justice involved clients will be identified so the 24/7 sobering & crisis stabilization center's impact to the justice system can be evaluated and their care journey better supported. • The 24/7 Sobering & Crisis Stabilization Center team will create visibility into the effectiveness of transfer outcomes; this may help to better pinpoint where investments are best used for building capacity in the crisis continuum.

Intake, Medical Acuity, and Transfer of Care

Current State	Recommendations	Future State
• The population who uses fentanyl, meth, and poly-substance can present with a high level of medical acuity. • This acuity poses a risk to safety at any facility providing care. • Some providers exclude the population, leaving two options – the emergency department or doing nothing. • Some communities have demonstrated success with a third option – facilities like what we are scoped for in this project. • This third option can only be successful if safety is prioritized with proper staffing, infrastructure, transportation capability, training, policies, procedures, clinical protocols, and communication.	• The ability to deliver patient centered care. • Sufficient clinical expertise in the 24/7 Sobering & Crisis Stabilization Center team to safely and effectively triage, assess and transfer clients at the right time. • Policies, procedures and clinical protocols for effective triage and timely transfer of individuals with medical acuity that is not safe for the 24/7 sobering & crisis stabilization facility. • Support a sustainable and repeatable training module for transport staff, care coordinators, dispatchers, and first responders to learn the inclusion/exclusion criteria for drop-off at the facility.	• The risk of using illicit street drugs is higher than ever; some individuals who use these substances will experience harm from them. • There is no ideal solution. • Proper staffing, infrastructure, transportation capability, training, policies, procedures, clinical protocols, and communication will enable the 24/7 Sobering & Crisis Stabilization Center to exist as a third option to the ED or doing nothing. • These measures will mitigate, to the greatest extent possible, safety risks for 24/7 Sobering & Crisis Stabilization Center facility clients.