Budget Note 14_Adult Addictions Treatment Continuum

Introduction

In June 2025, District 2 Commissioner Singleton introduced a Budget Note (#14) requesting the Chair direct the Adult Addictions Treatment Continuum (Behavioral Health Division PO 40085) and Homeless Services Department (HSD) staff to provide recommendations to:

- Increase referral access for homeless service providers to addictions treatment programs, regardless of the provider's ability to diagnose clients.
- Align publicly funded resources to provide a pathway for people from detox/sobering to:
    - clean and sober shelter and outpatient treatment
    - transitional recovery treatment programs / inpatient treatment
    - permanent housing with supports for recovery either through Permanent Supportive Housing (PSH) in home services or outpatient treatment.
- Collect housing and homelessness data and enter data into the Homeless Management Information System (HMIS) for those experiencing homelessness. Data to include:
    - Required HMIS data elements, as determined by the HSD
    - Housing outcomes, as determined in partnership with HSD, to include but not be limited to:
        - Number and % of people exiting transitional recovery treatment to permanent housing
        - Number and % of retention (stably housed)
            - 6 months post subsidy
            - 12 months post subsidy.

Budget Note 14 further requested that the assessment be heavily influenced by front line providers, those with lived experience, and current consumers of services. In April 2026, Commissioner Singleton agreed to accept this report in lieu of holding a separate briefing during the busy FY27 Budget season.

The following represents a collaboration between the Behavioral Health Division (BHD) and HSD to gather existing research on these topics, and provide insights and recommendations as requested.

Existing Research

BHD and HSD have conducted local studies in recent years to understand provider and end-user experience navigating across health and homeless systems. These studies offer a foundational framework to help the County understand barriers in cross-system referrals, and inform recommendations to homeless service providers to improve access to addiction treatment beds, and provide pathways out of programs into secondary treatment options, such

as substance-free shelter with abstinence-based recovery services and permanent housing with treatment supports.

In Fall 2024, as part of the Comprehensive Local Plan + (CLP+), BHD's System Transformation project, the Division worked with the Health Department's Performance Design and Evaluation Services team to conduct a cumulative Substance Use Disorder (SUD) data review and a survey of SUD provider experiences. Though not specifically linked to homelessness per se, the resulting data demonstrated a strong need for additional Level III (supervised), Level II (monitored), and perhaps some Level I (peer run) SUD facilities at that time. A summary of levels of support can be found on page 6 of this report developed by the Substance Abuse and Mental Health Services Administration (SAMSHA).

Recommendations from these data review efforts include:

- Streamline the Behavioral Health Care Model (slide 8 of data review)
- Develop stronger behavioral health workforce (slide 9)
- Invest in physical infrastructure (slide 10), and
- Develop data systems (slide 12)

In addition to conducting these studies, BHD also held a series of convenings in the fall of 2024 with more than two dozen providers of mental health and SUD services. Cross-cutting themes among providers included:

- System complexity creates a huge burden to access
- The importance of housing and other social determinants of health: housing-related needs are urgent, specifically for detox, residential, level II and III housing, stabilization housing, and recovery housing longer than six months
- Funding for medical services in SUD residential programs to support medically complex patients is critical
- "No wrong door" is great, but it is unclear how to do it without over-assessing people.

Data such as this strongly points to a need — particularly in the context of highly constrained resources — to find practical, intermediate solutions and connections between behavioral health and housing efforts.

The Pathways Study, a collaboration of Portland State University's Homelessness Research and Action Collaborative (HRAC) and HSD, surveyed over 500 respondents with current or recent experience of homelessness to understand how people navigate the road from homeless to housed. The survey and findings were developed in tandem with a lived experience research advisory committee, and focused on, among other things, what services people sought while currently or recently homeless, which services were helpful, and what service needs were unmet.

Services provided by the adult addiction treatment continuum were frequently mentioned as an unmet need:

- People with SUD challenges reported actively seeking and using recovery services, including support from certified recovery mentors and peers.
- Addiction recovery services were among unmet needs for a quarter of the sample.
- Survey participants also identified mental healthcare as one of the most desired housing supports (ranked #9 out of 38, selected by 43% of respondents). People with disabilities ranked it even higher.

People who identified having a SUD also reported experiencing barriers to housing supports that differed from people without a SUD:

- Examples included longer service wait-times for those experiencing SUD challenges, more difficulty accessing other services, and ineligibility for specific housing programs.
- People with SUDs also reported wanting services to manage and treat their substance use, but did not want their housing to be contingent on their use of and success with these services. While 27% of respondents desired “sober” housing, an equal share (around 30%) indicated they would decline housing with sobriety requirements.
- The study concluded that housing stability and recovery are closely connected, but making one conditional on the other creates additional barriers to both.

Central City Concern (CCC) released a brief in September 2025 called Engaged Supportive Housing that explores the critical juncture of access to behavioral health supports. This paper asserts that insufficient capacity of behavioral health services statewide, coupled with the large number of people struggling with SUD who have high-acuity behavioral health conditions and are experiencing homelessness or are recently housed, is creating an untenable situation for PSH providers. It echoes several common points regarding the divide between these two systems:

- It makes it difficult to ensure those in subsidized housing (including PSH) have access to and engage in services they need to stay stable (including BH services),
- It undermines the housing first principle by making follow through with critical services difficult to facilitate or ensure, and
- It results in negative outcomes at individual, program, and systems levels, including: poor housing stability for underserved individuals, financial and social destabilization of entire buildings, and increased operating costs for affordable housing providers.

To counteract the untenable situation the Engaged Supportive Housing brief outlines, the authors argue for a coordinated process that prioritizes those recently engaged in stabilizing treatment settings. This might include prioritizing those discharged from inpatient behavioral healthcare or justice settings, and those exiting interim housing programs, to maximize the impact of that treatment and ensure greater treatment access following move-in date by pre-establishing behavioral health services connections. HSD is working with the Homelessness

Response System to pilot a similar concept for folks with Behavioral Health needs, by prioritizing housing placement for people leaving the Unity Center. If successful, we could consider a similar pilot linked to SUD treatment, but given the limited number of Permanent Supportive Housing openings we would want to be mindful of the impact on the system of multiple specific set-aside programs.

Much of the data in this research project was the foundation for the new ongoing data partnerships between Health Share and Multnomah County and is directly linked to the current focus on High Acuity Behavioral Health in that partnership. While certain policy points are clearly echoed in the Pathways Study — e.g., people want access to housing and treatment at the same time — other recommendations should be considered in context to a message we have heard repeatedly: while individuals want access to treatment to be available, they do not want success in such services to be an independent requirement in order to access or retain housing.

Current Links: Homeless Service Providers and Addictions Treatment Programs

By the end of FY 2026, HSD will have opened two new adult shelters with abstinence-based recovery services, in addition to over 400 units of County-funded shelters with sobriety requirements. The Thayer Family Foundation Veterans Motel Shelter serves exclusively veterans in 17 units of the former Kenton Hotel, and the Harrison Community Village (opening late Spring 2026) will add 38 units of alternative style shelter, supporting all identities, including, but not exclusive to those who identify as Veterans. Participants have either been discharged from a treatment facility or do not meet the threshold necessary to require residential or in-patient treatment. Both programs, run by Do Good Multnomah, were created to provide essential clinical and recovery support during weekend and evening hours, bridging the gap between participants' primary treatment providers and the structure available during the standard workweek. Certified drug and alcohol counseling will be onsite, as well as housing placement services.

The City of Portland has also added recovery-oriented shelter options to the system in FY 2026, such as the SE Grand Recovery Overnight-Only Shelter run by Transition Projects. The Grand Recovery Shelter offers a safe, structured, substance-free environment with 140 units. Guests are expected to arrive at the shelter sober and shelter staff offer light touch service navigation. When it opened in January 2026, the City broadcast the new resource, sharing in provider circles, such as Care Oregon's SUD provider support meeting. Some of the City of Portland's alternative shelter sites also have demarcated "wellness" areas purposefully separated to make sobriety more approachable and accessible, with programming like peer support, addiction counseling, recovery-oriented care coordination, and Medication Assisted Treatment.

Many housing to treatment connections also occur within the provider community, without formal facilitation of County or City programming. With homeless service provision occurring entirely at a community level, it can be difficult to quantify such informal pathways. Agencies like Central City Concern, New Narrative, NARA, Outside In, and Cascadia offer both treatment and housing options and often have internal referral mechanisms and inhouse case management software

which allow referrals to occur, bypassing privacy and security concerns present in agency to agency communications.

Barriers within these linkages

While there are some discrete linkages that have worked to formalize pathways between housing and SUD services, there are barriers writ large in crossing systems in the continuum of services.

The most apparent barrier is that housing and SUD services are structured with different "front doors." The certification process for intake is different and there often is misinformation or misunderstanding of what is needed or how to access services when crossing these systems. This gap of education effectively means housing navigators do not understand what is available to their clients and what the qualifications are to access addiction treatment services, and vice versa. These barriers are further amplified by the clinical documentation standards that occur across behavioral health provision, including SUD services. In Health Care Services, consistent and detailed documentation standards are essential for proper reimbursement and liability prevention. Conversely, homeless services are not subject to these stringent requirements and do not rely on fee-for-service documentation.

Another barrier is administrative. Each system has their own set of regulated privacy and security measures that can result in complicated communication. Oregon laws hold a very high standard for involuntary intervention related to behavioral health needs; this can result in significant misunderstanding between providers in different systems trying to serve the same people.

And finally, co-occurring, high acuity mental health and SUD continues to be something that current system resources' regulatory standards struggle to effectively intervene with.

Recommendations

The following are recommendations to increase/resolve linkages between BHD and housing service referrals in the adult addiction treatment continuum, in no particular order. Some of these recommendations would require a lower threshold of resources, such as ensuring outreach to provider partners regarding networking opportunities and developing basic onboarding materials. Other recommendations, such as expanding case management practices and increasing PATH referrals and care coordination options, will require a higher level of funding that can be explored to inform longer-term decision making.

In an environment characterized by significant resource constraints, the County must adopt a highly strategic and data-driven approach to its public health initiatives and support greater coordination among the provider community. Central to this strategy is ensuring that the PATH team concentrates its invaluable care coordination efforts on the most vulnerable and high-risk populations. By prioritizing individuals with the most complex health, housing, and social needs, the PATH team can achieve the greatest measurable improvement in individual health outcomes and overall system efficiency. Successfully stabilizing these individuals and connecting them to

ongoing community-based care significantly reduces the need for more intensive, costly, and higher levels of care.

Increase cross system networking and education

- Integrate a diverse range of participants into current community partner forums, including the virtual Multco Networking Breakfast, the Homeless Alcohol and Drug Intervention Network (HADIN)—which regularly convenes local behavioral health and recovery specialists—and culturally-specific meetings for African American and Latino providers. These sessions are designed to facilitate community resource Q&A, provide program updates, and offer networking opportunities, alongside featuring a presentation or spotlight on a specific community partner. Incorporating housing education into these forum sessions could offer a valuable chance to identify and comprehend the obstacles involved in securing housing for individuals with behavioral health needs. Such a space would facilitate shared learning and the creation of coordinated strategies aimed at better supporting the housing and behavioral health requirements of these individuals.

- Furthermore, these meetings represent a vital networking opportunity that housing case managers and specialized staff could utilize during onboarding and as a recurring professional development activity. Attendance would help personnel expand their understanding of behavioral health services and improve their ability to secure resources for the individuals they assist. This initiative could be realized through collaboration between HSD and BHD: BHD would develop a meeting resource guide containing descriptions and organizer contact details, while HSD would manage the distribution of this guide to housing providers.
- Utilize provider level forums, such as Health and Housing Innovation (HHI), to understand what is currently occurring, what could bear replication and expansion, and where documentation of such referrals could help the care continuum better coordinate access. HHI, in particular, is seeking funding from Metro to support its mission. BHD/HSD could support their proposal with recommendations to provide more structure, such as having a recurrent and ongoing focus on the addiction treatment continuum.
- Support bringing new participants of provider forums and community partner meetings up-to-speed by developing a brief “onboarding” process and encouraging regular attendance of existing community partner meetings.
    - Expand cross-functional learning tools, such as the resource cafe, and identify or produce publicly accessible "101" guides for every system. Develop instructional materials including one-pagers, slide decks, or videos. To ensure these resources are impactful, we can collaborate with current departmental communications experts to design compelling content.
        - Disclaimer: Historical constraints on infrastructure and staffing have made it difficult to keep these materials current. To guarantee that future communications remain relevant and accurate, we suggest a commitment

from leadership to provide dedicated support for the ongoing production, maintenance, and iterative updating of these resources.

Facilitate coordination of services across systems

- Strategic coordination between the BHD and HSD must be purposeful and sustained to be successful. This involves establishing shared objectives for mental health/SUD and housing integration, securing necessary assets—such as joint personnel roles—and maintaining a consistent review of collaborative milestones.
- Based on insights from BHD convenings of mental health and SUD community partners, the need for housing support was a key theme, especially looking toward a centralized resource to coordinate housing needs across systems. The Board could consider creating a dedicated position whose primary responsibility is to develop strong, intentional coordination between the BH and housing communities that focus on identifying and resolving barriers to post treatment housing, maintaining an inventory of housing options (including detox, Level I, II and III options, recovery housing, supportive housing and permanent placement).
- Broaden and finance the PATH care coordinator role to concentrate specifically on the housing continuum in FY27 budget. These coordinators will assist housing case managers who may lack expertise in navigating the SUD system, thereby improving client access to withdrawal management, residential, and outpatient treatment. Additionally, this effort will support the cross-training of housing staff regarding the admission criteria for these specialized services.
    - To enhance the proficiency of housing case managers, this proposal advocates for a specialized, highly-skilled staff member who possesses a deep understanding of Substance Use Disorder (SUD) continuum of care workflows, including facility screening and admission requirements. As the existing PATH infrastructure is not currently equipped for this specific function, adding this role is intended to streamline and improve access to both essential housing and behavioral health services.
- Utilize the established Multco Cross Sector case conferencing meeting available to shelter providers to present cases on individuals requiring assistance—including medical, housing, SUD, and mental health services—particularly before they face the risk of housing instability. This process currently involves proactive pre-coordination between HSD and BHD personnel, who represent SUD, mental healthcare coordination, and crisis support systems, and features the use of asynchronous documentation to prepare for client discussions within each case conference session.
- Within the Multco Cross Sector case conferencing framework, participants frequently examine historical provider-to-provider linkages to collectively design service arrays tailored to an individual's immediate presentation and clinical needs. These sessions further analyze systemic barriers that have hindered past housing stability, identifying specific interventions necessary for long-term retention. To bolster this process, we

recommend designating a dedicated staff member to conduct formal trend analyses on emerging themes, such as system utilization patterns, re-enrollment requirements, and broader behavioral health needs identified during conferencing.

- To maximize the clinical expertise of current participants—including BHD care coordination, SUD/PATH personnel, HSD staff, and CCO representatives—it is essential to address sub-optimal attendance levels. Participation should be broadened through active outreach to housing providers not yet integrated into the forum, inviting them to present complex cases and leverage the multi-disciplinary support available to improve client outcomes.

System engagement and providing formal guidance

- Advocate with treatment providers to streamline referrals into other Levels of Care within their internal organizations. For example, enrolling individuals to outpatient services or Medication Assisted Treatment (MAT) while in detox and prior to discharge, or detox to residential services.
- Create a listing of "preferred providers/partnerships" for each treatment agency as potential pathways once a participant is enrolled in services. Many providers have connections to resources they utilize when available, or have funding partnerships that may help with costs while transitioning into specific programs.
- Identify clients' community supports as they are admitted to receiving homeless or SUD services; if available, request ongoing care conferencing meetings. Build in time for discussions about potential barriers and resources each program provides for next steps and discharge planning. If a client is not connected to community partners, encourage enrollment while engaging them in services (e.g., health plan specific resource navigators, mental health/SUD peer support services, PATH, medical case management).

Data Management

This budget note also requests the collection of housing and homelessness data and enter data into the HMIS in the context of the adult addiction treatment continuum. All homeless service providers funded by HSD, including those with transitional recovery housing, already track required data elements that include housing outcomes, as determined in partnership with HSD, to include but not be limited to:

- Number and % of people exiting transitional recovery treatment to permanent housing
- Number and % of retention (stably housed)
    - 6 months post subsidy
    - 12 months post subsidy

However, HMIS is not an appropriate or legal system to track data related to engagement in SUD treatment. Service Point, Multco's current HMIS provider, is not HIPAA compliant, and more critically, not compliant in 42CFRpt 2. While it is possible our upcoming new HMIS system (Bitfocus) can be configured to be HIPAA compliant, 42CFRpt 2 is a more complicated question. Although this is less a legal issue for housing providers who can discuss treatment, healthcare

providers are held to more stringent provisions and entering clinical notes, diagnosis, or even involvement in a treatment program is not legal in HMIS. Similarly, divulging treatment involvement with case managers without explicit consent from their client is not in compliance with 42CFRpt 2.

With these restrictions in mind, it does not make sense for the majority of SUDS providers to have access to HMIS. In an effort to facilitate accurate data collection in homeless services on housing status, it is recommended that formal partnerships are pursued in which housing providers are updated on the status of their client and HMIS entry is a natural byproduct of that case management. This would be further facilitated by ensuring behavioral health providers initiate conversations to obtain essential Release of Information (ROI) forms from clients to coordinate care and transact coordination verbally, documenting care outside HMIS and asking housing providers to track housing data elements in HMIS. These formal partnerships can be encouraged through the various recommendations under cross system networking and education. BHD will explore the option of contracts with providers emphasizing the inclusion of ROIs for clients who may need housing assistance post treatment, with the intent to include gathering the most comprehensive data possible.

Further, data coordination (and efficiency) could be pursued by identifying distinct hubs, such as the Deflection Center, in which providers play a dual role, and are formally trained in entering HMIS data, along with their training in providing housing services. These hubs should exist in spaces where providers provide both housing and SUDS care, rather than granting access to HMIS broadly However, ongoing training to message that housing status and only brief notes documenting connection would be appropriate in HMIS. Documentation of treatment provision would be far more appropriate in an Electronic Health Record (EHR) or case management module in order to ensure compliance.

To support that alternative, the County/HSD, in partnership with HealthShare CCO, is continuing to explore holistic case management spaces, such as cross sector case conferencing and “office hours” which offer brief connections to data and services. These areas are ideal to explore how we transact, legally and ethically, conversations described above and identify what data elements are most critical in existing across both HMIS and EHR systems.This partnership is further supported by Community Solutions, which is helping to develop an evaluation criteria across multiple pilots, and meets to provide ongoing support and recommendations on scalability and refinement.

Summary

As this report, and other recent briefings and conversations have shown, homeless services and behavioral health systems are complex. They contain myriad intersections, parallel paths, and require that both internal and external partners play critical roles for some of our most vulnerable populations. There is no “one size fits all” solution at this time, but with continued conversation, collaboration, and intent, we can collectively move toward more cohesive and measurable outcomes for more people in Multnomah County.