Fentanyl Summit Report

03.13.2024 || 8:30am - 11:30am
The Redd: 831 SE Salmon, Portland, OR

Hosted by the Multnomah County Health Department

Fentanyl State of Emergency 2024
Multnomah County • City of Portland • State of Oregon

Multnomah County
Health Department

Executive Summary

On March 13, 2024, more than 150 community members, government staff, and clinicians gathered for the 90-Day Fentanyl Emergency Fentanyl Summit hosted by the Multnomah County Health Department. The Summit, requested by the Fentanyl Emergency Unified Command, convened partners for a facilitated dialogue about how to address the fentanyl crisis and to develop recommendations to inform work during and after the emergency declaration.

Community and government leaders provided a recap of previous opioid summits and an overview of the current situation to ground the discussion and build upon earlier good work. Partners then participated in multiple group breakout sessions on issues related to fentanyl addiction and treatment. The group discussions identified gaps in the community, approaches to addressing these gaps, and the resources needed to make those approaches successful.

RECOMMENDATIONS

Overall, there were hundreds of ideas discussed and considered by partners in the sessions. Their invaluable expertise identified critical needs in an effort to shape the broader response to this work. Some recommendations that rose to the top of the discussions included:

- Incorporating community wisdom, and especially people with lived and living experience, into discussions, policy decisions, and recommendations.
- Monitoring for and mitigating unintended adverse consequences during and around the Fentanyl Emergency interventions.
- Improving clinical, outreach, and behavioral health workforce recruitment and development, especially for culturally-specific care.
- Establishing a real-time database of substance use services and bed availability.
- Streamlining single access points for connecting communities with substance use services.
- Convening ongoing meetings to advance this work and address emergent concerns.
- Removing barriers for outreach services.
- Coordinating trainings for providers on medications for opioid use disorder.

These recommendations are intended to reflect key priorities identified by many of the participants, and especially emphasize the perspectives of those providing culturally-specific care and those with lived/living experience.

OVERARCHING CONCEPTS

Two overarching concepts emerged from the summit that provide foundational understanding to the recommendations outlined above:

We can't arrest or Narcan our way out of this crisis. No single solution can effectively address this complex issue. This crisis requires a robust, multi-modal response and strategy that reflects the communities' needs, removes barriers, and provides holistic care.

Some people use drugs, but no one should die from them. People deserve autonomy. Our systems should prevent people from dying and provide the needed support if and when they seek treatment/recovery. Centering humanity in all our approaches will yield the best outcomes.

"I made some new connections with folks that I needed to meet."

~ Summit Participant

Participants

- 4D Recovery
- Alcohol and Drug Policy Commission
- Behavioral Health Unit of Multnomah County Forensic Diversion
- Boulder Care
- Bridges to Change
- CareOregon
- Central City Concern
- City of Portland, includes Portland Bureau of Transportation and Shelter and Homeless Services
- Clackamas County Behavioral Health, Public Health
- Clark County Public Health
- CODA
- Columbia County Public Health
- Community Living Above
- Confederated Tribes of Siletz Indians
- Dept. of County Human Services Bienestar De La Familia
- Do Good Multnomah
- Fentanyl 90-Day Emergency Unified Command, Incident Management Team
- Fora Health
- Fortaleza Atravez Barreras
- Ground Score Association
- Harmony Academy
- Health Justice Recovery Alliance
- Health Share of Oregon
- Home Forward

- Iron Tribe Network
- Joint Office of Homeless Services (JOHS)
- Juntos
- Multnomah County Health Department (MCHD)
- Multnomah Education Service District
- Mental Health and Addiction Association of Oregon, Behavioral Health Resource Network
- Multnomah County Chair's Office and Office of Government Relations
- Multnomah County Circuit Court
- Native American Rehabilitation Association Northwest
- Native Wellness Institute
- New Avenues for Youth
- Northwest Family Services
- NW Instituto Latino de Addiciones
- Oregon Department of Human Services includes Child Welfare (Multnomah Co)
- Office of Governor Kotek
- Office of Congressman Blumenauer
- Oregon Health Authority
- Oregon Family Support Network
- Oregon Recovers
- Oregon-Idaho High Intensity Drug Trafficking Areas Program, Overdose Response Strategy
- Outside In
- Overdose Response Strategy, Centers for Disease Control Foundation
- PDX Saints Love
- Painted Horse Recovery
- Portland Drug Users Union
- Portland Fire & Rescue, including Community Health Assess and Treat (CHAT) team
- Portland Metro Chamber
- Portland Street Medicine
- Portland Street Response
- Portland People's Outreach Project
- Portland Public Schools
- Project Reduction Education Distribution (RED)
- Providence Health
- Quest Center for Integrative Health
- Recovery Works NW
- Rockwood CDC
- Solutions Group NW
- Song for Charlie
- Training to Impact LLC
- Transcending Hope
- Transition Projects, Inc
- Trillium Community Health Plan
- US Attorney's Office- District of Oregon
- UNIDOS
- Unity Behavioral Health
- Washington County Public Health, Behavioral Health, Health Officer
- WeShine PDX

Total confirmed: 43 community-based organization, 8 payer/health system, 83 government
Total invitees: 85 community-based organization, 15 payer/health system, 122 government

Format and Agenda

FORMAT

Event organizers approached the format and content of the event from the understanding that no one individual or organization has all of the answers; but that by convening, codiscovering, and collaborating we can bring a greater sense of equity to our discussions.

Small groups met throughout the space to discuss specific areas of focus related to addressing the fentanyl issue locally. A facilitator and notetaker, along with interactive maps and activities, gave each group the tools and grounding needed to encourage conversation and capture ideas. This report synthesizes those notes, along with feedback provided during and after the event.

"The conversation was so good I stayed too long and was late for my next meeting."

~ Summit Participant

AGENDA

- Centering, welcome, introductions, background
  - Song of welcome and centering by Donald Quenelle and Irvin Wilson, Painted Horse Recovery
  - Grounding and reflection statement, Haven Wheelock, Outside In

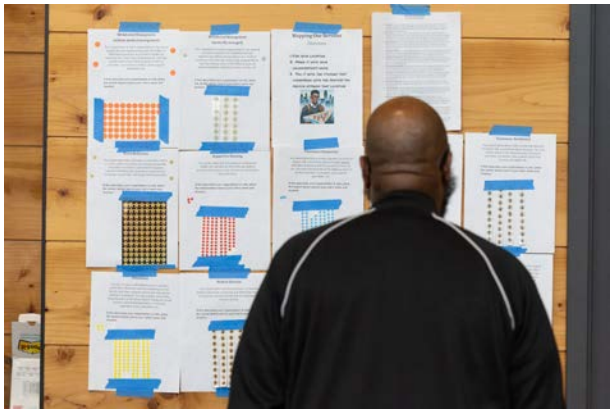
    - Welcome, appreciations, level-setting from Dr. Richard Bruno, Health Officer, Multnomah County Health Department
    - Message from 90-Day Fentanyl Emergency Unified Command Team, Dr. Jennifer Vines. Review of the impetus for the summit and 5 objectives
    - Greetings from Multnomah County, Jessica Vega Pederson, Chair
    - Greetings and recap of 2023 Fentanyl Convening by Oregon Attorney General Ellen Rosenblum
    - Greetings and recap of the National Tribal Opioid Summit Resource Hub's Summer 2023 National Tribal Opioid Summit, Candice Jimenez, Chief of Staff, Confederated Tribes of Warm Springs
    - Greetings and recap of OHA's Fall 2023 Overdose Response Team's Listening Sessions, Ebony Clarke, Behavioral Health Director, Oregon Health Authority
    - MCHD's Overdose Prevention & Response Plan and Tri-County Opioid Safety Coalition history, Dr. Tyler Swift, Multnomah County Health Department
    - Fentanyl-related Overdose Trends in Multnomah County, Dr. Emily Mosites, Multnomah County Health Department
- BREAK, participants encouraged to help construct a Local Services Map
- Large Group Brainstorming and Discussion
- Facilitated Small Group Breakouts. 3 breakout sessions, 20 minutes each. Topics:
    - Outreach
    - Prevention
    - Harm Reduction
    - Treatment
    - Reversals
    - Recovery
    - Supportive Housing
    - Justice System Involved
    - Withdrawal Management (Sobering/Stabilization)
    - Data
- Large Group Recap
- Closing Remarks, Dr. Bruno
- LUNCH, networking
- Press Q&A in Boardroom

LOCATION

The Redd in SE Portland provided a centrally located, ADA-accessible event space for the summit, with ready access by streetcar and bus and an adjoining parking lot. Breakfast, coffee, juice, water, snacks, and lunch were provided, and included gluten-free, allergy-friendly, vegetarian, and vegan options. A virtual space was

provided for individuals unable to attend in-person, but no individuals joined the virtual space. Honoraria were available to individuals/organizations with barriers to attendance.

Goals



- Key outcomes as requested by the Unified Command:
    - Identify rapid/direct pathways into existing clinical addiction treatment services.
    - Provide insight for multiple pathway (not one-size-fit-all) options post-90-day emergency.
- Other potential outcomes:
    - Highlight activities/gains during the 90-Day Fentanyl Emergency, including any new data tools
        - Share high level data trends
        - Share brief highlights of existing MCHD resources/activities
    - Identify short- and long-term health system and policy needs to address fentanyl and polysubstance use locally
- Discuss existing opportunities for streamlined connection to treatment and recovery services
- Create space for connection and support in this work
- Begin planning for future opportunities for connection and collaboration

"I have a better understanding of how big this issue is."
~ Summit Participant

Small group discussions

For each of the 10 small group discussion topics facilitators had prompts to begin and encourage conversation, but discussion was not limited to these prompts. When possible, notetakers gathered comments around 3 categories: existing gaps, possible approaches, and resources needed.

The following sections provide highlights from those discussions, but do not capture the entire range of information, experiences, and emotions shared during the event.

SELECTED QUOTES FROM PARTICIPANTS

- I feel inspired.
- I have a better understanding of how big this issue is.
- I know now you all are clearly working hard.
- I made some new connections with folks that I needed to meet.
- I am walking away with hope.
- I am now aware of options that I didn't know were out there.
- The conversation was so good I stayed too long and was late for my next meeting.
- What's next?

SMALL GROUP TOPICS

Outreach – Street-level community- or government-based efforts to engage people who may be interested in addressing their substance use concerns:

- Trust and relationship-building are key and often require many touch-points.
- The equity and inclusion lens focuses on giving people what they say they need.
- There are service gaps and other areas of overlapping outreach/duplicate efforts, which can be traumatizing to clients. Better communication, shared inventory of services and resources such as an electronic database can improve these issues.
- An overall need to understand and connect folks to immediately available resources.
- What "counts" in service provision needs a deeper look. There is inadequate or no credit for time spent on referring, coordinating care.
- Regular opportunity for outreach providers/collaborators to connect in-person, build relationships, work jointly on projects including grant and other funding opportunities

Prevention – Primary prevention efforts that address underlying trauma, racism, and other systemic drivers that may lead to addiction to fentanyl:

- There are many understandings of and approaches to *prevention* and a need for shared understanding.
- Primary prevention begins in early childhood through normalized/stigma-free conversation about mental health and substance use disorder, discussion of trauma causes and mitigating factors, self-care demonstration and teaching.
- Connection and community are pivotal to primary prevention.
- Primary prevention is most successful when accompanied by society meeting fundamental needs such as housing, food, physical and psychological safety, opportunities for education and employment, access to services and healthcare.
- Culturally- and linguistically-specific services are inadequate in our area.

Harm Reduction – Secondary prevention efforts to meet people where they are and give people the information and tools to decrease the negative impacts of fentanyl use. Examples include syringe exchange, wound care, and drug checking services:

- More client-responsive services are needed, such as extended hours, more mobile services, expanded drug checking, supplies that match patterns of use such as safer smoking supplies, overdose prevention sites and more post-overdose recovery services.
- People who use drugs should be informing, leading this work.
- More culturally-specific services are needed.
- Current funding is insufficient to address community needs.
- Policies and practices should reflect existing harm reduction science and best practice, and further support and advocacy (organizational, political, public) is needed for harm reduction programs to provide both reactive and proactive, science-based services that meet community needs
- Closer partnering with healthcare, law enforcement, and other agencies is needed.

Treatment – Medication for Opioid Use Disorder (MOUD) and other efforts to help change thoughts and behaviors, and manage physical dependence on fentanyl, including inpatient detox and outpatient programs:

- Ongoing barriers to accessing treatment include stigma, lack of

culturally- and linguistically-specific services; concurrently needed services are absent or uncoordinated (e.g., mental health, emotional skills).

- Opportunity to explore accountability of individuals and organizations providing no or inadequate services, including both healthcare and pharmacy.
- Net enough detox, MOUD, and residential services for youth, and not enough opportunities for education and training, technical assistance for potential clinicians and supporting staff and organizations.
- People with lived experience need to be better incorporated into the development and delivery of services.
- Better access is needed for long-term injectable MOUD, supportive housing, peer cohorts, and other resources supporting long-term stability and recovery.

Reversals – Tertiary prevention efforts to support reversing overdoses and saving lives:

- Safer use sites/overdose prevention sites are needed in areas of Portland with high rates of fatal and nonfatal overdose.
- Naloxone vending machines and other means of expanded, readily and publicly available naloxone are needed.
- More street-based peers and outreach workers, who not only have naloxone and can provide it to folks they meet, but who can also help connect folks to services.
- Further education and resources are needed around secondary reversals (risk of subsequent overdose when an individual uses again shortly after an overdose reversal).
- More options for real-time initiation of buprenorphine/MOUD after an overdose reversal, including virtual options.

Recovery – Holistic options via multiple pathways to help support people to reach their full potential and personal goals related to substance use, including therapy, counseling, and peer recovery support:

- Overdose receiving centers - more day centers/drop-in centers, more detox and recovery centers.

- More culturally-specific, culturally-responsive providers.
- Increased coordination needed between systems; a “no wrong door” model so providers at any step along the way know how to move an individual towards treatment and recovery. More warm handoffs.
- More youth-focused services, including detox services, treatment beds, clinicians comfortable with MOUD for youth.
- More recovery services for people with co-occuring mental health disorders - providers able to offer physical health, mental health, detox, and MOUD in one space. CCO and insurance provider requirements to reimburse adequately for these services.
- Less reliance on grant funding for addiction services providers - more annually renewed/available funding needed.

Supportive Housing – Addiction and recovery wraparound services embedded in housing buildings for people seeking recovery. These may or may not have alcohol and drug free policies:

- Not enough beds, especially for families, those with high-acuity mental health needs, individuals who do not want to be in a controlled environment, individuals with disabilities, individuals who speak other languages and would benefit from culturally-specific services, and/or those who are justice-involved.
- A platform is needed that tracks all resources and the availability of the resources, such as a live bed inventory and an agreed upon system for assigning beds. System would need to specify when the beds are able to meet specific population needs (language/culture, family housing, other specifics noted above).
- Rapid access is needed for when people are in their willing window.
- People don’t want treatment if they don’t have a safe place to be (during or after treatment).
- Not enough housing available after treatment. Landlords for available housing often need to be more trauma-informed. Ideally, discharge planning/planning for the next step would start at admission to addiction services.

- There are staffing issues, especially staffing shortage/high turnover. Needs to be addressed with resources like living wages and student loan forgiveness.

Justice System Involved – Pre-trial and jail-based options for treatment access, as well as post-release coordination and probation/parole connected services:

- Lack of services at all levels of care for youth, especially for residential, withdrawal management, and MOUD. Disrupt the school-to-prison pipeline with supports for youth and families.
- More staffing capacity across the spectrum of recovery services, including behavioral health, public safety, mental health, health, and people with lived experience/peer mentors. More incorporation of peers into parole and probation, jail, and reentry.
- Educate the community about decriminalization—where the money is going and what services it has improved. Extend short timelines to implement programs/expand one-time funding.
- Greater collaboration and connection between people doing this work. Better assessments at entry that inform enhanced case management, and wraparound services on release and discharge planning (connection to treatment, housing, OHP, MH, ESL, etc.). More transition centers and drug court programs. More transparency and build a system for sharing information more effectively (i.e., a shared electronic health record). More partnership with CCOs to increase funding.
- Improve culturally-responsive services. Better education about the system to clients, engage/fund/hire and listen to communities of color/non-English speaking clients. Work on inequitable charges for people of color. Understand impact of culture, poverty, trauma, rural communities, and language differences

Withdrawal Management (Sobering or Stabilization) – The medical and psychological care of patients who are experiencing withdrawal symptoms as a result of ceasing or reducing use of their drug of dependence:

- To “meet people where they are” we need to truly meet people where they are, meaning engage them on the street rather than requiring engagement in facilities.
- Meeting people where they are also means engaging when folks may be agitated, and doing so in a trauma-informed way.
- A coordinated access system is needed to ensure available detox beds are used (often one place full while another has plenty of availability) and to decrease the need for duplicate forms for each organization accessed. Ideally this would be

part of a universal SUD care system incorporating both behavioral and physical health records into a single health record.

Data – Data collection, sharing, and visualization to help provide transparency and accountability for the above efforts:

- Reporting is only as good as the data we capture, and there are opportunities for additional sources of information for this emergency response and beyond.
- Trust is a significant factor in data sharing between organizations, and there is often no incentive to do so.
- Hoarding data is hoarding power.

Observations, feedback and reflections from facilitators and organizers

STRENGTHS

- It came together quickly, so many details were put into place. I really appreciate the thoughtfulness around equity and trauma informed care.
- Great preparation - the agenda, the facilitator guide, the pre-planning meeting, and the printouts available.
- Energy was good, space was conducive. Overall positive feedback on the venue—people liked the space.
- Many community partners were able to make it and participate on short notice.
- People were glad to connect with each other--they felt like the right people were there.
- The tribal organization presentation was a highlight.
- Good model. Good design. Rich discussions. Great way to collect data and information and ideas in an efficient manner (facilitator + notetaker)
- Folks were able to speak their truth which at times appropriately included anger, mistrust.

- I appreciate that there was food. As a person with food allergies and sensitivities, I particularly appreciate that there was food that was safe for me to eat (and that didn't run out).

OPPORTUNITIES

- Fewer speakers/ more focus on folks providing direct services.
- More time for large/small group discussion, longer sessions at tables, less frantic pace.
- More streamlined processes around organizing discussion tables, explaining/encouraging voting (nonverbal input) on things.
- Table assignments for small groups were confusing, but we figured it out.
- Ensuring space is comfortable, convenient, useful for those who couldn't/chose not to participate. Some folks were nervous to come. Some attendees were nervous to share. Better opportunities to participate virtually and/or asynchronously for those not comfortable coming.
- Offers for collection of new data/information, potentially more meaningful data.
- Space for other culturally-specific leadership and organization, maybe a culturally-specific summit.
- Specific summits for other topics: Outreach, Direct Services, Policy
- Other ideas for collaborative discussion and problem solving:
    - "Data Rage" sessions.
    - Sharing policy-level information to lower barriers for clinicians to provide MOUD services to youth.
    - Bring back payphones? CBO's spending a lot on phones for folks.
    - More holistic approach desired for services - don't need to go to 5 different places for 5 co-occurring conditions.
    - Low-barrier housing yes, but also non-triggering recovery spaces for folks in recovery.
- More advocacy, bravery to push back at city/county/state level when important activities, policies, initiatives are threatened.

OTHER THOUGHTS

- Folks had a lot to say, they were glad to have an opportunity to participate.
- There was skepticism around actions resulting from this.
- There was a yearning for more conversation.
- Some people were nervous to share due to law enforcement being in the room. They didn't want to be called out as individuals.

- Some people expressed frustration with the focus of the data gathered, and the focus on data in general. Some don't trust data.
- The trust level went up in the end.

Common Themes and Takeaways

Takeaways and recommendations expressed here are presented through the lens of the Multnomah County Health Officers. This lens is a construct of the systems and structures we have been educated and employed in, and may have related implicit biases.

- **Communication and connection are important, but not enough.** Though we had desired to have this Summit be action-oriented, we had to do a certain amount of level-setting as a group and building upon previous work. We strove to avoid it being a performative space with too much talking and not enough action.
- **We can't arrest or Narcan our way out of this crisis.** It will take a multi-faceted, coordinated effort across sectors.
- **We need a single, up-to-date database of services** for better coordination and real-time meeting of needs.
- **We should continue to map available services** to ensure optimal matching of what is available to what is needed.
- **More culturally- and linguistically-specific services are needed** across categories of work.
- **More access to care and facilities are needed across the spectrum** of SUD-related services.
- **There is a lot of encouragement for people with lived and living experience** to lead the work.
- **Increased funding and workforce is needed** for organizations to meet goals, serve the community best.
- **There is a collective desire for more spaces to connect**, collaborate, and coordinate services.

Recommendations for 90-Day Fentanyl Emergency

Hundreds of ideas were discussed and considered by partners in the summit. Their invaluable expertise identified critical needs in shaping the broader response to this work. Some recommendations from the discussions included:

- Further incorporation of **community wisdom** into 90-Day Fentanyl Emergency efforts, not only consulting with community based organizations but specifically including people with lived- and living-experience into policy decisions and recommendations for post-90 day efforts.
- Explicit **monitoring for unintended adverse consequences** during the emergency event, analysis post-event, specifically around displacement of individuals from the focus area into other areas of the city.
- Workforce **recruitment** and **development** to provide more culturally-specific care and peer support, including scholarships, on-the-job training, hiring/retention bonuses, and competitive wages.
- Advocacy for a single, up-to-date **database of services and bed availability in real-time** for better coordination and real-time meeting of needs.
- Create **single access points** for individuals to access services across the spectrum of prevention, substance use, treatment, and recovery ("no wrong door" approach). Ensure organizations are supported, funded to provide and bill for coordination of care.
- **Ongoing convenings** (quarterly) of this group, including topic and group-specific meetings.
- Facilitate removal of permit and other logistical barriers for organizations providing **outreach services**.
- Coordinate **training** of substance use disorder providers on MOUD to improve access

Planned Follow-Up

“What’s next?”
~ Summit Participant

- ☑ Solicit participant feedback of event: 1 week
- ☑ Launch publicly-available dashboard on fentanyl-related overdoses
- ☑ Compile and share event report with Unified Command and participants: 2-3 weeks (when finalized)
- ☐ Other scheduled follow-up re: outcomes (6 months and as needed)
- ☐ Convene smaller group of planners: 1 month
- ☐ Next quarterly meeting/topic: 3 months

Appreciations

We hold a genuine appreciation for those with lived experience who keep showing up even when systems have failed them, for community-based organizations, communities of color, and participants for their time, and truth shared.

We’d like to express deep gratitude to the presenters - Donald Quenelle, Irwin Wilson, Haven Wheelock, Jessica Vega Pederson, Jennifer Vines, Ellen Rosenblum, Candice Jimenez, Ebony Clarke, Tyler Swift, and Emily Mosites.

We are also so thankful for the Unified Command-supplied organizational and administrative support for the event—all of the folks who helped plan, operationalize, and provide logistics support (especially Barry Zimmerman for leading the efforts). We’d like to thank Rachael Banks, MCHD director, for solidifying funding the space and food, and for the incredible MCHD staff and other agencies who served as greeters, facilitators, notetakers, and cleaners (Naomi Hunsaker, Lisa Emery, Jammel Rose, Andrea Hamberg, Andrew Campbell, Natalia Nikolaeva, Mario Cardenas, Kim Rhodes, Matt Spingler, Jennie Brixey, Pamela Deresh, Cesilee Fidler, Jenny Hampton, Trey Mueller, Lynn Bybee, Jeff Hagen, Patch Perryman, Valdez Bravo, Melissa Walker, Gayle Wilson, Heather Fara, Katie Thornton, and Ryan Yambra).

We’re thankful for The Redd for giving us a discounted rate on short notice. And lastly, to Gabriel Hernandez (MC EM), Carol Pinegar (CityNET) for assistance with note transcribing.

Report compiled by Dr. Richard Bruno, Dr. Teresa Everson, and Dr. Tyler Swift.
Photo credit all photos: Motoya Nakamura, Multnomah County Communications Office