OPAL | OREGON STATE UNIVERSITY Policy Analysis Lab

SUMMARY REPORT
SUBSTANCE USE DISORDER (SUD)

SUBSTANCE USE DISORDER TREATMENT IN BEHAVIORAL HEALTH & HOUSING

EXECUTIVE SUMMARY

1. Prioritize investments to increase SUD services across the board. [1]
2. Address the inadequate numbers of residential treatment beds. [2]
3. Address the lack of detox facilities and Medically Assisted Treatment (MAT). [3]
4. Lower barriers to existing residential treatment. [4]
5. Put more resources towards outpatient care, therapy, and counseling. [5]
6. Take seriously the extreme difficulty of maintaining treatment while experiencing homelessness. [6]
7. Provide more options to assist houseless people struggling with SUD than sober living. [7]
8. Direct resources to ongoing staff training and support. [8]
9. Educate the public and healthcare providers about substance use disorders. [9]

OVERVIEW

Gaps and difficulties in treatment for people with substance use disorders (SUDs) were ubiquitous across reports from the grantee partners. The limitations in SUD care were cited as a major shortfall in the behavioral healthcare and housing space. Below is a qualitative synthesis of grantee reports from RFGP 5250 of the systemic problems detailed by grantee partners for whom SUD treatment problems were detailed and/or of top priority in their community served. The report proposes recommendations to address these challenges. Please note that Portland-Metro area grantee reports are not included and will be part of a separate, upcoming report.

RECOMMENDATIONS

INCREASE RESOURCES AND SERVICES ACROSS THE BOARD

1. **Prioritize investments to increase SUD services across the board.** The most cited concern in the treatment of substance use disorders (SUD) is a **lack of services**.

    1.1. Every organization that listed SUD as a major concern in addressing Oregon's behavior health and housing crisis noted that there were not enough resources available to treat the need, be they available residential treatment beds, detox, and medically assisted treatment (MAT) programs, transitional care, out-patient counseling, or longer-term supportive housing.

> "I know where to go for drugs, but not where to go for support."
>
> -Focus-group participant suffering from SUD, Morrow County Health Department (Morrow County)

2. **Address the inadequate numbers of residential treatment beds**: this is the most-cited concern of the partner organizations who mention SUD in their reports.

    2.1. Many with treatment beds located in their service-area cite prohibitively long waitlists; sometimes stretching to close to a year; several have no public or low-cost treatment bed available at all within their service-areas. Long waitlists and geographical separation are major barriers for successfully treating patients suffering from substance use disorders: "Engagement in SUD treatment or residential treatment is an immediate choice: if beds are not available in that moment the client may not engage" says a consortium of providers in Klamath and Lake Counties, a sentiment echoed in other reports. "**Beds need to be available in the moment a client is in crisis**."

    2.2. Having treatment available when the client is ready for care is key to success in this field: key to treating relapses, and key to arresting longer-term downstream harm of a substance use disorder crisis.

    2.3. Partner organizations report the lack of beds resulting in patients ending up in emergency departments and jails that should have been in treatment, overwhelming these services and likely compounding trauma associated with SUD. With all of this in mind, more treatment beds, more funding, and more personnel are crucial.

"We see our clients in a cycle of recidivism and relapse because they have to leave the county to get treatment."

-LiFEBoat Services (Clatsop County)

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3. **Address the lack of detox facilities and Medically Assisted Treatment (MAT)**. Along with a lack of residential treatment beds, which often house patients for medium-duration substance abuse treatment, very rural frontier-areas of Oregon especially lack any medically assisted detox and crisis centers at all that are capable of serving patients in their local area.

    3.1. Prescription opioid abuse and fentanyl use is widespread and on the rise across Oregon, and the lack of MAT detox available to treat this kind of addiction is a major barrier to patients seeking help, particularly when withdrawal symptoms from this type of addiction can be extreme, and standard emergency departments are likely to turn away patients seeking care through this period as "drug-seeking behavior". This is the same with alcoholism-related withdrawals, which on top of discomfort can create medically dangerous situations.

    3.2. Oregon currently ranks 5th in the nation for percentage of individuals with Alcohol Use Disorder (12.3%), according to recent data from the Centers for Disease Control and Prevention. The inability to seek MAT in the local area may thwart patients in their first steps towards seeking treatment.

4. **Lower barriers to existing residential treatment**. Many people who need substance use disorder treatment are deterred by complicated intake, evaluation, and eligibility procedures, and often discouraged by bureaucratic complexity.

4.1. Intake and evaluation are also a site of stigma and shame that discourages clients from seeking treatment. Lowering eligibility barriers for entry into residential programs and especially into medically assisted treatment would be beneficial, as would prioritizing the hiring of people with lived-experience of SUD at the intake and navigation steps of the process.

4.2. Grantee-partners also note that interviewees with experience navigating publicly available programs were often frustrated or discouraged by the lack of communication from staff about the process of being admitted, their expected time on the waitlist and other aspects relating to the bureaucratic process of intake. Greater transparency starting at the first contact would help encourage the potential client to stick with the program and foster trust instead of a feeling of paternalistic exclusion from decisions involving their own care.

5. **Put more resources towards outpatient care, therapy and counseling**. Robust medical literature on addiction shows that the average person suffering from SUD goes through multiple rounds of treatment and relapse during recovery and will likely need continuing out-patient counseling and resources after being discharged from a residential treatment facility.

5.1. Grantee-partners note that this step-down service is missing in many places following detox and residential stays (where these are available), often due to a lack of resources in the client's home area, or, where those exist, lack of coordination between the acute stages of treatment and the maintenance phases.

5.2. These might come in the form of bureaucratic gaps – these programs don't communicate, have different levels of available funding, the client is eligible for one but not the other, etc. – or practical ones, including long travel distances to appointments, lack of transportation, lack of childcare, and others.

5.3. Often private groups such as AA or NA fill this gap, which is helpful but often not sufficient, especially in rural frontier areas where transportation is an issue. The gap of post-treatment outpatient services is noted as a major barrier to assisting people with SUD and leads to further pressure on demand for residential treatment services.

MEANINGFULLY ADDRESS THE INTERACTION OF SUD AND HOUSELESSNESS ACROSS THE STATE

6. **Take seriously the extreme difficulty of maintaining treatment while experiencing homelessness**. Interviewed individuals and focus groups convened by the grantee-partners repeatedly cited homelessness as a major barrier towards treating their substance use disorder and maintaining sobriety.

6.1. The interaction between these two challenges were strong and lasting, including but not limited to the ability to keep important documents and prescriptions; difficulty with unpredictable needs and schedules (including sweeps) interfering with the ability to make it to appointments and meetings; and the aggravated stresses and traumas of daily life without housing adding to much higher likelihood of relapse. **For those without stable housing, housing needs to be considered a part of SUD treatment.**

> "Sobriety, employment and mental health stability cannot be prioritized before shelter and basic needs."
>
> -LiFEBoat Services (Clatsop County)

7. **Provide more options to assist houseless people struggling with SUD than sober living**. Many grantee-partners noted that while sober-living options can be an extremely important piece of the SUD-treatment program, and in fact imperative for some struggling with both homelessness and addiction, they also miss populations: When they are the only option, they are seen to create a catch-22 for people struggling with both houselessness and SUD. A consortium of Klamath County of grantee-partners explains:

> "Many key informants and focus group respondents told us about the difficulty of maintaining sobriety while homeless, **and even that [street] life may be easier to cope with during active substance use**. One informant told us the general idea of sober crisis housing was to **'get clean on your own, and then we'll help you get clean'** "
>
> -Klamath County CFTC

TRAIN STAFF, EDUCATE THE PUBLIC, AND WORK TO REDUCE THE STIGMA ASSOCIATED WITH SUD

8. **Direct resources to ongoing staff training and support.** Helping people from a wide variety of backgrounds is complex and nuanced and requires intimate knowledge of SUDs and experience in treating people struggling with this disease.

    8.1. Grantee partners recommend directing resources towards ongoing staff trainings, including in cultural competency and intrinsic bias, and also resources towards staff-retention, recognizing that highly-trained staff with experience are invaluable in the success of SUD treatment.

    8.2. Staff-support resources include paying a family-wage, benefits, adequate vacation and supports that recognize that staff are often experiencing secondary trauma. Staff with lived-experience of SUD themselves are also cited by focus-groups and surveys as particularly important for the success of trust-creation within a program.

9. **Educate the public and healthcare providers about substance use disorders**. Misconceptions and prejudice about SUD discourage treatment, inhibits both individuals from seeking treatment and service-providers from offering it.

    9.1. Misconceptions result in siloed care that should otherwise be integrated for wrap-around care. For example, emergency departments should be better educated and equipped to treat and refer

patients suffering from untreated SUD to local providers; groups offering housing and homelessness services should be closely coordinating with SUD-treatments.

9.2. The stigma greatly discourages the appropriate provision of care and makes people who could benefit from it hesitant to seek it. Grantee-partners found extreme examples of this, with people going to great lengths to avoid medical situations, including a woman who refused to go into a medical setting after maggots were found in an untreated wound. This is an example of just how badly she was treated at standard medical establishments as someone suffering homelessness and simultaneous SUD.

> "Lack of public and professional education about addiction, treatment and recovery has resulted in persistent and dangerous myths around SUDs and mental health."
>
> -Intercommunity Health Plans (Benton, Lincoln, Linn)

REFERENCED GRANTEE PARTNERS

Please note: More information on this subject is required from Tribal grantee-partners about the specific needs of their communities surrounding substance use disorders.

Grantee-Partner	Primary Counties Served	Contact Address(es)
Bridgeway Recovery Services	Marion, Polk	3325 Harold Dr NE, Salem
Clatsop Behavioral Healthcare	Clatsop	65 N. Highway 101, Suite 204 Warrenton
Columbia Community Mental Health	Columbia	58646 McNulty Way, St. Helens
Community Counseling Services (CCS)	Gilliam, Grant, Morrow, Umatilla, Wheeler	550 W. Sperry St, Heppner
EUVALCREE	Malheur, Umatilla	67 SW 2nd Avenue, Ontario 210 E. Main Street, Hermiston
Homestead Youth and Family Services	Umatilla	816 SE 15th St, Pendleton
Intercommunity Health Plans	Benton, Lincoln, Linn	2300 NW Walnut Blvd, Corvallis
Jackson Care Connect	Jackson	33 N. Central Ave #320, Medford
Klamath Basin Behavioral Health	Klamath	2210 N. Eldorado Ave, Klamath Falls
Klamath Lake Community Action Services	Klamath, Lake	2316 S. 6th St C, Klamath Falls
LiFEboat Services	Clatsop	1040 Commercial St, Astoria

Morrow County Health Department	Morrow	65 W 3rd St., Ione
New Directions NW	Baker	3425 13th Street, Baker City
Red is the Road to Wellness	Klamath	921 E. Main St., Klamath Falls
Umatilla County	Umatilla	216 SE 4th St. Pendleton
Wasco County	Wasco	511 Washington St, The Dalles
Willamette Family	Lane	195 W. 12th Avenue, Eugene