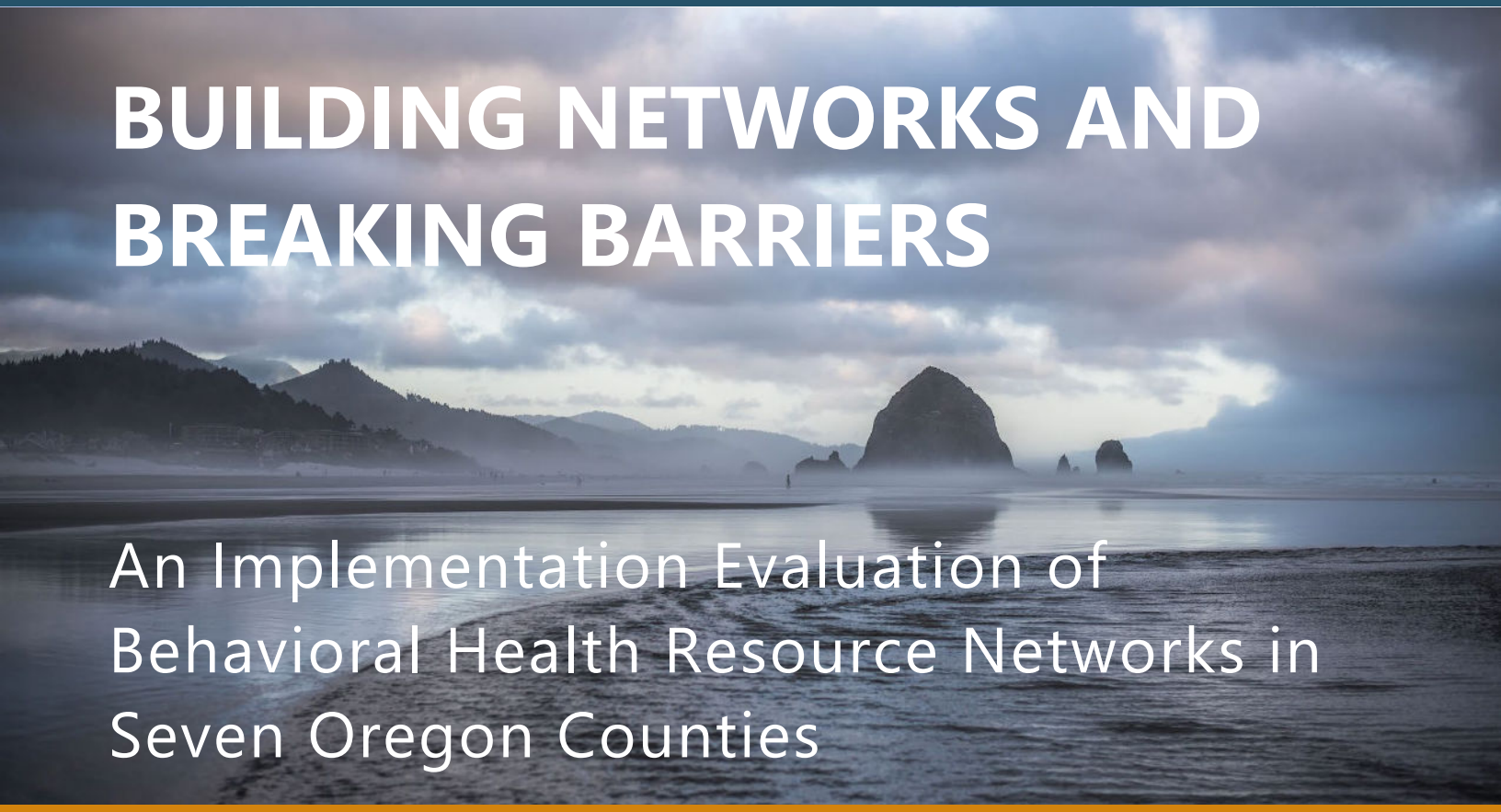

BUILDING NETWORKS AND BREAKING BARRIERS

An Implementation Evaluation of Behavioral Health Resource Networks in Seven Oregon Counties

December 2023

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EXHIBITS

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Comagine Health's Research and Evaluation Team focuses on projects related to the prevention and treatment of substance use disorders, harm reduction interventions, initiatives to promote community health and equity, and the development and testing of tools and interventions.

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EXECUTIVE SUMMARY

Oregon is the first state in the U.S. to decriminalize small amounts of drugs for personal use through a voter-initiated ballot measure, **Measure 110,** which passed with nearly 59% of the vote in November 2020. Measure 110 was enacted in February 2021 as the **Drug Addiction Treatment Recovery Act** with accompanying legislation.

Measure 110 ended arrests for personal possession, restructured penalties for larger amounts of drugs, and allocated over $300 million in the 2021-2023 biennium from cannabis taxes to substance use disorder treatment, harm reduction, peer support, housing, and other supportive services for people who use drugs. Funding was distributed between June and October 2022. **Oregon Health Authority (OHA) reports over 60,000 Oregonians received services through Measure 110 in the legislation's first two years.**

This study contributes to the comprehensive evaluation of Measure 110. We assess the early implementation of networked services called Behavioral Health Resource Networks (BHRNs) in seven predominantly rural counties. This report is structured around three goals from the local implementation evaluation of Measure 110:

- Explore BHRN models across counties.
- Share perspectives from Executive and Program Directors about the impacts of BHRNs on services like substance use treatment, harm reduction, and housing in their counties.
- Provide considerations to state agencies and policymakers about how to support BHRNs based on feedback from BHRN organizations.

Oregon decriminalized drugs and expanded services for people who use drugs through Ballot Measure 110.

These findings can inform decision-making to improve BHRNs and enhance the effectiveness of substance use-related services across the state.

This project draws from hour-long interviews with 27 program and executive directors of BHRN-funded organizations. We focus on seven predominantly rural counties around Oregon. Key findings and recommendations include:

- **BHRNs are unique in each county, reflecting the flexibility of the model and the distinct characteristics of communities.** Given the flexibility, variability, and novelty of BHRNs, we recommend additional support for BHRNs in future funding processes. Participants asked for more clear guidelines about BHRN expectations, and dedicated, trained staffing to support BHRNs.

- **BHRN providers envision peer-provided services as an important pathway into services.** Participants highlighted the importance of peer outreach for engaging individuals and guiding them through BHRN referrals. The training and resource needs of the BHRN peer workforce should be considered.

- **Administrative requirements for BHRN implementation and coordination were challenging and would benefit from funding support.** State agencies can consider employing centralized referral processes to facilitate better coordination among different organizations. In future BHRN funding opportunities, state agencies can consider funding for centralized administrative positions for the BHRNs.

- **BHRNs faced difficulties addressing housing needs, highlighting the ongoing struggle to meet this critical aspect of support for people who use drugs.** In light of this, housing initiatives, especially programs tailored to the needs of people who use drugs, should be considered and pursued.

BACKGROUND

Oregon is the first state in the U.S. to decriminalize small amounts of drugs for personal use through a voter-initiated ballot measure, Measure 110, which passed with nearly 59% of the vote in November 2020. Measure 110 was enacted in February 2021 as the **Drug Addiction Treatment Recovery Act** with accompanying legislation.

Measure 110 ended arrests for personal possession, restructured penalties for larger amounts of drugs, and allocated over $300 million in the 2021-2023 biennium from cannabis taxes to low-barrier substance use disorder (SUD) treatment, harm reduction, peer support, housing, and other supportive services for people who use drugs[1]. This report focuses on **local implementation of expanded services for people who use drugs.**

In combination with other statewide efforts, Measure 110 aims to address Oregon's history of underfunding SUD treatment and supportive services in the face of a deepening overdose mortality crisis. Proponents of Measure 110 argue that the criminalization of drug possession has not been effective in reducing drug use or drug-related harms and instead often exacerbates problems through a cycle of criminal consequences, especially for vulnerable populations and communities of color.

By treating drug use as a public health issue, Measure 110 aims to reduce the stigma around substance use and provide expanded, more effective pathways to health and recovery for people who use drugs. For more background on Measure 110 and the statewide implementation of the law, please visit www.DrugDecrimOregon.org.

MEASURE 110 WAS MODELED ON PORTUGAL

Measure 110 draws inspiration from Portugal's groundbreaking drug decriminalization model. Portugal decriminalized drug consumption while increasing investments in SUD treatment and harm reduction initiatives. Over the past twenty years, data from Portugal has shown a notable decrease in drug usage rates and related health issues[2]. Since this legislative change, drug consumption rates

[1] This report refers to people who use drugs as a person-centered way to include people using drugs across a spectrum of use. Accessing services through Measure 110 does not require a SUD.

[2] Hughes CE, Stevens A. (2012). A Resounding Success or a Disastrous Failure: Re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs. Drug Alcohol Rev 31(1),101-13. https://doi.org/10.1111/j.1465-3362.2011.00383.x.

in Portugal, especially among the 15 to 34 age bracket, have remained below the European Union (E.U.) average[3]. Moreover, drug-induced death rates in Portugal are impressively low at six deaths per million for those aged 15 to 64, in stark contrast to the E.U.'s average of 23.7 per million[4]. Over 50% of individuals grappling with opioid issues in Portugal participate in SUD treatments, a figure slightly surpassing the E.U. average[5]. Portugal's outcomes hint at the potential success of such a legislative stance in Oregon. Measure 110 offers a pivotal chance to determine whether this approach can be effective in the U.S.

MEASURE 110 PROVIDED NECESSARY FUNDING FOR SUBSTANCE USE TREATMENT, HOUSING

In 2022, Oregon Health and Sciences University researchers released a systematic statewide inventory of substance use services and gaps. In their assessment, researchers identified that 49% of needed SUD-related services were missing statewide. On the same assessment, service providers across SUD treatment, peer support, and harm reduction discussed their lack of capacity to meet the service demand[6]. In 2021, Oregon ranked ninth among states (including the District of Columbia) in SUD rates[7].

This mirrors broader gaps in SUD treatment access nationwide. While non-medication-based treatments such as cognitive behavioral therapy, contingency management, and motivational interviewing have a robust scientific foundation, these programs tend to be inadequately covered by insurance. Medications for opioid use disorder (MOUD), like methadone and buprenorphine, have proven effective in reducing morbidity and mortality associated with opioid use disorder (OUD). Methadone mandates daily clinic visits due to strict regulations, and while primary care doctors can prescribe buprenorphine, it historically also faced regulatory challenges, like the need for physician training and in-person patient visits. Some MOUD restrictions were relaxed during COVID-19, but those provisions may be temporary. In 2021, only 6% of individuals with a SUD received treatment nationwide, as indicated by the Substance Abuse and Mental Health Services Administration[8].

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[3] European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). *Statistical Bulletin 2020 -- prevalence of drug use.* (2020). https://www.emcdda.europa.eu/data/stats2020/gps_en.

[4] Ibid.

[5] Ibid.

[6] Lenahan, K., Ranier, S., Goren, R., and Waddell, EM. (2023). *Oregon Substance Used Disorder Services Inventory and Gap Analysis.* OHSU-PSU School of Public Health, Oregon Alcohol and Drug Policy Commission, and Oregon Health Authority, Health Systems Division and Public Health Division. https://www.oregon.gov/adpc/SiteAssets/Pages/gap-analysis/2023_January%2027_OHSU%20SUD%20Gap%20Analysis%20and%20Inventory%20Report.pdf.

In 2020, Oregon also ranked fifth among states (including the District of Columbia) in the rate of homelessness (34.7 per 10,000)[9]. Measure 110 provides unprecedented funding to expanded services for people who use drugs in Oregon, but against a long history of inadequate access to SUD treatment, harm reduction, and stable housing.

BHRNS HAVE SERVED THOUSANDS OF OREGONIANS IN THE FIRST TWO YEARS

Oregon Health Authority's BHRN Dashboard includes data regarding the number of funded BHRN organizations and BHRN funding allocation statewide[10]. To understand the early impacts of BHRNs in Oregon, this report highlights reporting from BHRNs in Q1 and Q2, which overlapped with the data collection and analysis timeframe for our study.

Across Oregon there are 42 total BHRNs. These 42 BHRNs include 160 partner organizations and 233 grant agreements. Organizations may have multiple grant agreements to serve multiple counties. The current total BHRN allocation is $264,146, 725, with $214,250,656 (81%) having been paid to date. Additionally, there are 11 Tribal Grant Agreements with an allocation of $11,372,556, with $9,966,471 (88%) having been paid to date. **Combined Measure 110 funding has reached more than 60,000 Oregonians in the legislation's first two years[11].**

Early Expenditures Were on Capital Improvement and Personnel

Oregon Health Authority also reported expenditures, clients served, client demographics, successes, lowering barriers, and challenges, statewide and for selected counties[12]. This report includes information collected in quarter 1 (Q1): July 1, 2022- September 30, 2022 and quarter 2 (Q2): October 1, 2022-December 31, 2022. In Q1 and Q2, BHRN partners spent most on Substance Use

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[8] Substance Abuse and Mental Health Services Administration (SAMSHA). (2023). *Results from the 2021 National Survey on Drug Use and Health.* Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/newsroom/press-announcements/20230104/samhsa-announces-nsduh-results-detailing-mental-illness-substance-use-levels-2021.

[9] National Alliance to End Homelessness. (2022). *State of Homelessness: 2022 Edition*. National Alliance to End Homelessness. https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness/.

[10] Oregon Health Authority (OHA). (2023). *Measure 110 Behavioral Health Resource Network Dashboard*. Accessed August 25, 2023. https://www.oregon.gov/oha/hsd/amh/pages/measure110.aspx.

[11] Oregon Health Authority (OHA). (2023). *Combined Measure 110 providers served more than 60,000 people during early implementation, preliminary reporting shows. https://content.govdelivery.com/accounts/ORDHS/bulletins/3465dc9.*

[12] Ibid.

Disorder Treatment (SUD Tx), Peer Support Services and Housing Services. Expenditure for all service areas increased between Q1 and Q2. Across counties, most expenditures were spent on capital (47%), personnel (30%), and services/supplies (15%).

Statewide BHRNs reported the number of clients they served, and the number of service encounters they had. For Q1 and Q2, the largest numbers of clients and service encounters were for Peer Support and Harm Reduction Services. There was a slight decrease in service encounters for Comprehensive Behavioral Health Needs Assessments (CBHNA), and Harm Reduction between Q1 and Q2. The largest increase in service encounters between Q1 and Q2 was seen for Housing Services (337% increase).

LOCAL IMPLEMENTATION EVALUATION IS ESSENTIAL TO UNDERSTANDING BHRNS ACROSS OREGON

This report is part of an ongoing effort to holistically evaluate Measure 110 in its early years, from the law's implementation to outcomes, from the perspective of researchers who know and work in Oregon. This local implementation evaluation is essential to understanding major, complex policy shifts like decriminalization.

Much of the media attention to Measure 110 since its passage has centered on the Portland metropolitan area, Oregon's largest population center. However, decriminalization occurred statewide with a focus on directing financial resources to every county. Rural regions of the state stand to see more significant shifts in their service landscape due to the funding requirements, which include support for lowering housing and SUD treatment barriers and expanded harm reduction offerings.

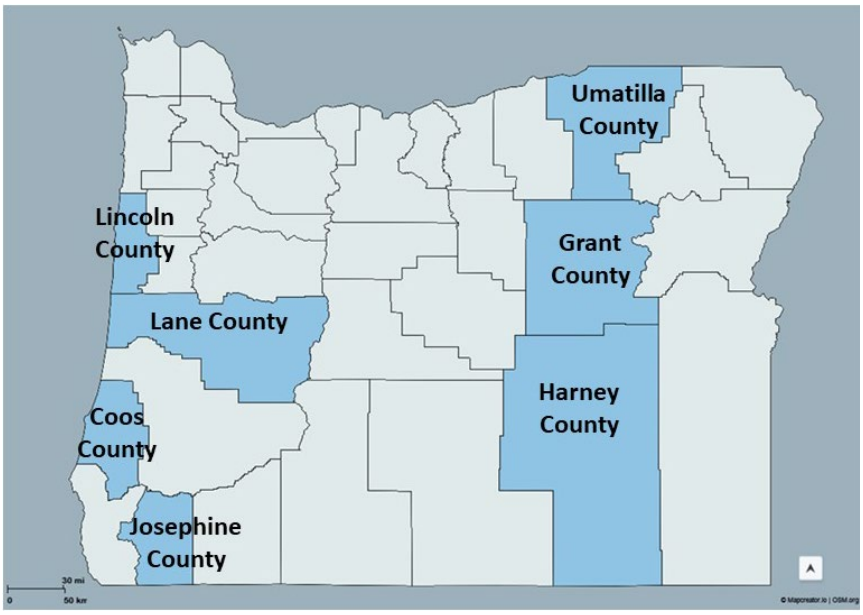
In line with the Fletcher Group's focus on rural access to evidence-based SUD treatment and recovery housing, this project team elected to focus on **rural counties.** To understand the differences between rural and urban BHRN implementation, this report includes Lane County (and the Eugene-Springfield metropolitan area, Oregon's second-largest population center) as an urban comparison.

EVALUATION DESIGN

This local implementation evaluation covers different BHRN models; strategies for engaging people who use drugs into services post-decriminalization; organizational and community cultures related to harm reduction, low-barrier SUD treatment, and supportive housing; and barriers and facilitators to implementation and service delivery.

COUNTY SELECTION

Figure 1: Map of selected counties: Coos, Grant, Harney, Josephine, Lane, Lincoln, and Umatilla.



This evaluation looks at BHRN implementation in Coos, Grant, Harney, Josephine, Lane, Lincoln, and Umatilla Counties (listed alphabetically). We sampled counties presenting a spectrum of opportunities and challenges for BHRNs, focusing on rural counties. Factors in our county selection process included:

- **Regional coverage of Oregon.** The regions we considered are defined infrastructurally through local economic and cultural ties and significant ecological and topographic features. We included a northern and southern coastal county (Lincoln and Coos, respectively) and a county on the Interstate-5 corridor (Lane County). In Southern Oregon, we included Josephine and Harney Counties. We included Umatilla and Grant Counties in Eastern Oregon.

- **Rural and urban representation.** We chose six rural counties, including five Health Resources and Services Administration-designated rural counties (Coos, Grant, Harney, Lincoln, and Umatilla)[13]. For urban representation, we chose Lane County with county seat Eugene. Eugene-Springfield is the urban center for services in Lane County, but the rest of the county is predominantly rural. Grant and Harney are both predominantly frontier counties with very low population density[14].

- **Demographic diversity in the county.** A crucial goal of Measure 110 was to reduce policing and health disparities among minoritized groups. We included counties with substantial Black, Indigenous, and People of Color (BIPOC) communities, especially Latinx populations and counties encompassing tribal nations (Coos, Harney, Lincoln, and Umatilla).

- **Substance use impacts.** To measure counties' current substance use landscape, we relied on EMS runs involving naloxone administration, overdose hospitalizations, and drug/narcotic offense rates before Measure 110 passed. We also included data on personal possession citations after Measure 110 (Class E violations). Finally, we included information on overdose-related services and projects across Oregon from Comagine Health's county service summary resources.

- **Other considerations.** We included varied county BHRN arrangements, including BHRNs with one organization and BHRNs with more than five partner organizations. Our sample included organizations founded with BHRN funding. We included one tribal-based program, a bilingual Spanish-speaking BHRN, and organizations focused on serving pregnant individuals, veterans, youth, and Lesbian, Gay, Bisexual, Transgender, Queer and Questioning, and Two Spirit (LGBTQ2S+) communities. Participants were sometimes involved in multiple BHRNs outside our selected counties, so we heard limited information about Benton, Douglas, Jackson, Linn, Morrow, and Union Counties.

[13] Health Services and resources Administration (HRSA). *Defining Rural Population*. Accessed November 3, 2023. https://www.hrsa.gov/rural-health/about-us/what-is-rural.
[14] U.S. Department of Agriculture Economic Research Service. *Frontier and Remote Area Codes*. Accessed July 7, 2023. https://www.ers.usda.gov/data-products/frontier-and-remote-area-codes/.

Table 1: Summary of Population, Demographics, and SUD Impacts in Study Counties.

County	Total Population	BIPOC Population (%)	Individuals 12+ with a SUD[15]	Class E Rate per 1000 People [16]	HRSA Designation[17]
Coos	63,315	18%	10,414	2.1	Rural
Grant	7,315	11%	1,158	-*	Rural
Harney	7280	10%	1184	-*	Rural
Josephine	86,569	17%	14,040	11.6	-
Lane	381,365	22%	61,585	.6	-
Lincoln	48,305	22%	8,233	2.1	Rural
Umatilla	81,495	36%	12,203	1.7	Rural

**Grant and Harney County had Class E violation counts under 5 individuals at the time of the study.*

[15] Substance Abuse and Mental Health Services Administration (SAMHSA). (2021). *National Survey on Drug Use and Health*. Rockville, MD: Center for Behavioral Health Statistics and Quality. Accessed July 20, 2023. https://www.samsha.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health.

[16] Oregon Judicial Department (OJD). (2023). *Measure 110 Class E Violations through 06/30/2023*. Accessed July 6, 2023. https://www.courts.oregon.gov/about/Documents/BM110Statistics.pdf.

[17] Health Resources and Services Administration (HRSA). (2019). *List of Rural Counties and Designated Eligible Census Tracts in Metropolitan Counties*. Accessed May 5, 2022. https://data.hrsa.gov/Content/Documents/tools/rural-health/forhpeligibleareas.pdf.

STUDY PROCEDURES

DATA COLLECTION

Comagine Health researchers identified eligible participants through email inquiries to every BHRN partner organization in the study counties listed on Oregon Health Authority's Measure 110 Dashboard[18]. Researchers contacted BHRN organizations by email and asked them to identify staff members who could speak knowledgeably about BHRN implementation in the invitation to participate.

Three trained qualitative interviewers conducted hour-long interviews on Zoom[19]. Interviews included obtaining verbal confirmation of informed consent. Interviews were completed between October 2022 and January 2023. For this report, we also include data from the BHRNs reported to OHA in the first two quarters of grant funding through December 2022. Participants were offered a $75 gift card for participation.

The interviews were semi-structured, led by a pre-defined discussion guide (see Appendix A). The research team developed the discussion guide with consultation with a subject matter expert familiar with SUD treatment, corrections, and social support service agencies in Oregon. All interviewers collaborated to collectively understand the guide and interview goal in advance of interviewing, and throughout the interview process.
The guide was organized in two main sections:

- How will the BHRN impact county services?

This discussion included an overview of changes to services including staffing, hours, delivery model, and capital investments. We also highlighted what participants felt the biggest impact to services in their county would be and remaining gaps in services.

- How is BHRN implementation going?

[18] Oregon Health Authority (OHA). *Measure 110 Behavioral Health Resource Network Dashboard*. Accessed August 25, 2023. https://www.oregon.gov/oha/hsd/amh/pages/measure110.aspx.
[19] Alexis Cooke, PhD; Danielle Good, PhD; Stephanie Pustejovsky, MHS

This discussion included discussion of coordination among organizations, barriers and facilitators to BHRN implementation, and support organizations would like to receive for implementation.

In addition to these primary goals, participants were also asked about the **broader community context**, capturing the dynamics and external factors that might influence the implementation and outcomes of BHRNs in their counties.

Participants

The research team conducted 27 hour-long interviews with representatives from BHRN organizations. We contacted 51 organizations for a response rate of 53%. Most interviews were one-on-one, but three interviews included multiple staff members. The participants predominantly were Executive Directors or Program/Site Leadership due to their strategic roles and knowledge of the implementation process and impacts of BHRNs.

Analysis

Two trained members of the research team (Alexis Cooke, PhD and Danielle Good, PhD) participated in qualitative analysis for this work. Interviews were audio-recorded with participant permission to capture the richness of responses. A professional transcribed audio recordings verbatim, ensuring the accuracy of the data. The transcriptionist and research team redacted any names or personally identifying information that could compromise participants' confidentiality.

Researchers analyzed the qualitative data using an adapted thematic analysis, based on Braun and Clark's widely accepted approach for identifying and interpreting patterns or themes within textual data[20]. Initially, both analysts independently conducted multiple readings of the transcripts. This allowed them to immerse themselves in the data, gain familiarity with the content, and develop a preliminary understanding of potential themes. Researchers then developed an initial code book guided by the data and the discussion guide, accompanied by code descriptions to organize interviews.

Following the initial readings, researchers used the qualitative data analysis software tool NVivo to code interviews. They systematically labeled and categorized segments of text to identify

[20] Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77-101.

patterns, concepts, or themes[21]. This process was both deductive, drawing from the initial interview guide, and inductive, allowing for themes to emerge directly from the data itself.

The analysts engaged in iterative coding, discussion, and refinement to ensure the reliability and validity of the identified themes[22]. This iterative approach helped refine themes and ensure that data was accurately interpreted and represented. Any discrepancies or disagreements between the analysts were resolved through discussion and consensus. In discussions of analysis, researchers looked for novelty and saturation of themes. Novelty refers to identifying new and unique information or insights from the data that have not been previously documented or explored. Saturation refers to the point where no new information or themes are emerging from the data, and continued analysis or data collection is unlikely to yield new information[23].

IRB Oversight

The study protocol was approved by WCG IRB (Western). WCG IRB is registered with OHRP/FDA; registration number IRB00000533, parent organization number is IORG0000432.

[21] Saldaña, J. (2021). The Coding Manual for Qualitative Researchers. Sage.
[22] Nowell, L. S., et al. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. International Journal of Qualitative Methods, 16(1), 1-13.
[23] Creswell, J. W., & Creswell, J. D. (2017). Research design: Qualitative, quantitative, and mixed methods approaches. Sage Publications.

FINDINGS: BHRN MODELS

BHRNs aim to provide a comprehensive range of services **across a continuum of care**, encompassing not only SUD treatment, but also harm reduction, housing, and employment services.

Furthermore, Measure 110 funding intentionally focused on services that were not billable to Medicaid or funded through other initiatives to supplement rather than supplant existing resources.

The community-led Oversight and Accountability Council (OAC) drafted and finalized administrative rules defining the BHRN services. These rules for Measure 110-supported services were established separately from other behavioral health definitions and administrative rules. The OAC specified the following services for BHRN funding in each county, but additional services may be included beyond these offerings[24]:

- **Screening** for substance use disorder, health, and social service needs available 24 hours a day, every day.

- **Low-barrier treatment services (SUD Tx),** or drug treatment absent of "programmatic barriers to service delivery, including practice-induced stigma." Low-barrier services might not require appointments, have little to no wait, are trauma-informed or culturally informed, encompass unique recovery trajectories, and are available regardless of finances, insurance, citizenship status, or transportation needs.

- **Harm reduction services,** or initiatives to "reduce the negative individual and public health outcomes of substance use." Harm reduction services include access to naloxone, sterile syringes, safer use and wound care supplies, infectious disease screening, sobering support, contingency management, drug checking supplies, and overdose prevention sites, which are currently prohibited in Oregon.

- **Peer support, mentoring and recovery services,** or "services, outreach, and engagement performed by a certified individual who has lived experience with addiction

[24] Oregon Secretary of State. (2021). *Oregon Administrative Rules, Chapter 944*. https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=6678.

and recovery and who has specialized training and education to work with people who have harm caused by substance use and/or substance use disorder."

- **Case management,** or "services to assist individuals to connect to and gain access to needed services and supports outlined in an individual intervention plan."

- **Comprehensive behavioral health needs assessments (CBHNA),** or "obtaining sufficient information, including a substance use disorder screening, to determine if a diagnosis is appropriate and to create a self-identified, individual intervention plan."

- **Housing,** or "options that serve populations at all points on the substance use continuum." BHRNs must include "gender affirming housing options including responsive housing and shelter options for those who are transgender, gender-nonconforming, and intersex" and family housing.

- **Supportive employment,** or "services that assist individuals with substance use disorder in obtaining and maintaining employment in the community." Some BHRNs included Peer certification or training as one form of supported employment.

- BHRNs were also directed to provide **culturally and linguistically responsive services** that are "effective, equitable, understandable, and respectful" of diverse communities.

BHRNS ARE FLEXIBLE, VARIABLE BY COUNTY

Measure 110 built **flexibility and inclusivity** into BHRN service definitions. BHRNs could be one organization that provides all the specified services, or multiple organizations networked together to provide the full range of services. This means that BHRNs look different from county to county, depending on the number of organizations funded and the decisions of Oregon Health Authority (OHA) and organizations about how BHRNs are organized within counties. For example, as illustrated in **Figure 2** some counties have multiple BHRNs, and BHRNs are not always co-located or centered in one shared space.

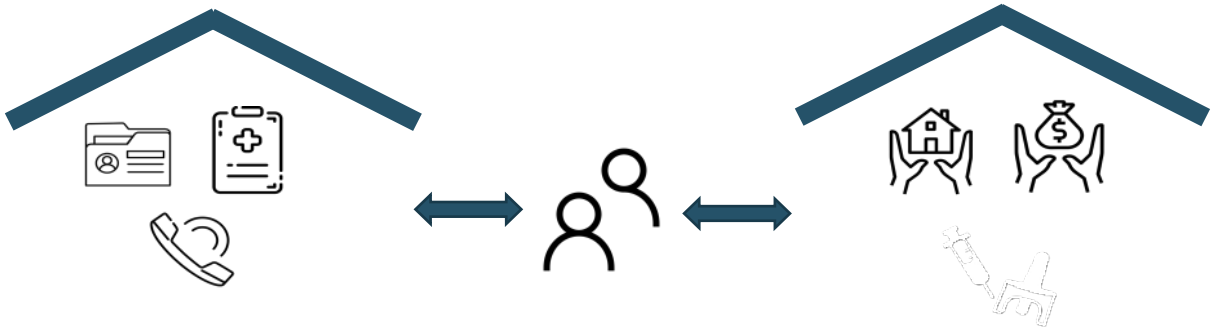
Flexibility is also reflected in BHRN expenditures. **Table 2** lays out funding allocations by county and **Figure 3** compares expenditures in Q1 and Q2 for the study counties. The largest service expenditure across study counties in Q1 and Q2 was **housing** for many counties, but spending allocations between capital investments, personnel, services and supplies, administrative and staff training varied.

Figure 2: BHRNs Can Be Organized Differently in Each County

Care can be coordinated across organizations in separate locations. Organizations **share information** so the participant doesn't have to repeat intake information with each organization.

Care can be **physically co-located,** with all services housed at the same location.

One organization may coordinate for the BHRN, or organizations all coordinate.



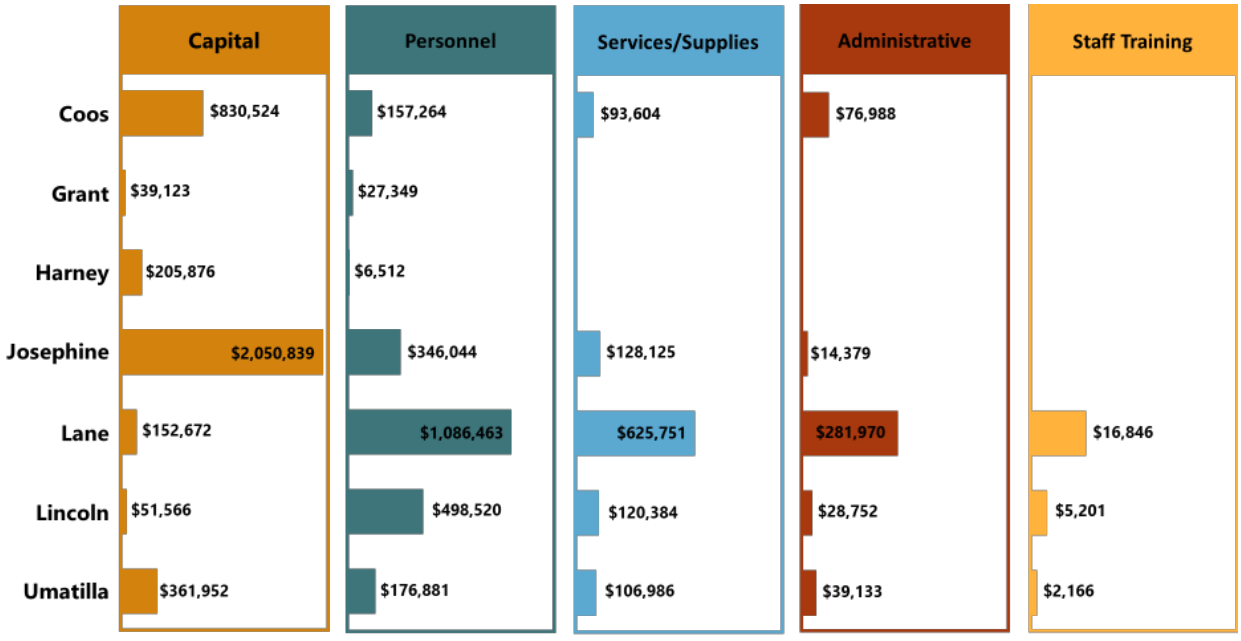
A majority of BHRNs include services at **multiple locations**. **Peers** or other system navigators may link services across organizations.

Table 2: BHRN Organization and Funding Allocations in Study Counties[25]

County	Number of BHRN Organizations	Total BHRN Funding Allocation	Funding Allocation Per Resident	Highest Combined BHRN Spending in Q1+Q2*
Coos	5	$4,670,105	$73	Housing
Grant	2	$750,000	$105	Housing
Harney	1	$857,712	$117	Supported Employment
Josephine	8	$10,753,658	$123	Housing
Lane	18*	$28,928,157	$77	Housing
Lincoln	8*	$4,655,401	$94	Peer Support Services
Umatilla	3	$5,324,524	$69	Housing

**Q1 and Q2 represent the study period with reported data overlapping with interviews.*

Figure 3: BHRN Expenditures Differed by Study County in Q1 and Q2



[25] Oregon Health Authority (OHA). *Measure 110 Behavioral Health Resource Network Dashboard*. Accessed November 3, 2023. https://www.oregon.gov/oha/hsd/amh/pages/measure110.aspx.

"I hope BHRNs make a **difference.**

I hope that we're **effective.**

Funding has always been tough, and here's an opportunity for our organization and other organizations in our community to, basically, **put on our best effort.**

I just hope it's **successful** because I think it's so **valuable.**

I hope it's **given enough time** because it's **not going to happen in the first 18 months**, I don't think, to reach its peak performance.

I hope it's effective because **I do believe it's going to be way better than what we had before**, which was incarceration, making people feel hopeless and helpless.

I feel like it's a huge responsibility.

There's really no excuse not to improve services."

FINDINGS: BHRN SERVICE IMPACTS

Key Findings

Participants highlighted several early impacts on services:

- Capital enhancements to boost the infrastructure for both care and housing,
- Recruitment of new program personnel and peers,
- Ability to initiate novel programs and care philosophies.

Participants pointed out gaps that Measure 110 funding could not address:

- Urban, rural, and frontier participants agreed that high housing costs, limited supply, and restrictive local ordinances present barriers to adding housing units,
- Participants looking to buy properties with Measure 110 funds faced a challenging real estate market and a lack of clarity in funding timeframes that impacted their ability to purchase properties,
- Participants noted a need for culturally and linguistically specific services across counties but felt that labor shortages and recruiting difficulties impacted their ability to meet those needs in substantive ways.

BHRN FUNDING IMPROVED PHYSICAL INFRASTRUCTURE

Statewide, the largest expenditures in the first two quarters of the BHRN funding cycle were focused on **physical infrastructure and capital improvement.** In our county sample, BHRN recipients discussed plans to use BHRN funding to help support the organizations' physical infrastructure for providing office/program space and new housing.

BHRN members discussed how a physical building would **facilitate service delivery** and help **cultivate community** for service recipients. Participants described housing as a significant need

across regions, and some organizations used BHRN funding to acquire more space. Organizations planning to use BHRN funding for housing specifically discussed how important and impactful the ability to expand or start housing services would be.

"Having a building, having all those spaces, what I also envision: **having a community room within the building.** A bigger space where we can **have the families of the clients come,** every so often, and we can have clients, who have already completed the program come and talk about how they're doing."

"Another thing that BHRN has provided—this is new to us—we have a motel that we converted into **transitional, well, kind of permanent housing.** We actually have another 40 units of a motel that we have, but we did take two of those units, and those are large rooms, some of them are one-bedroom [...] One of the things they allowed us to do **was open up some crisis beds.** Let's say that somebody they reach out for help on a Saturday night, and it's two o'clock in the morning or whatever."

Multiple Participants felt the BHRN funding was **challenging to put towards purchasing housing units.** They cited a limited real estate market and a lack of clarity about the timing and structure of payments early in the funding process as constraints on large purchases like housing.

"One of the things about [Measure] 110 was, really, **money wasn't given in the way that is could or should have been to purchase more housing.** Some counties did tap into that, some did not. For example, in [our county], we **have very little to purchase actual housing stock or develop housing stock.** [OHA] said there will be other money for this kind of purchase of properties and things, but it just hasn't really happened in the scale that we need.**"**

BHRNS EXPANDED HIRING OF PEERS AND PROGRAM STAFF

Among the counties we sampled, personnel were a large portion of Q1 and Q2 expenditures. In interviews, BHRN members discussed how BHRN funding would help support their staffing needs to expand and improve services. One participant noted that BHRN funding allowed them to pay staff higher wages. Participants discussed that having more staff would allow them to be more **responsive to service recipients and reduce wait times.** Participants discussed that this was particularly important for ensuring service recipients have an **initial point of contact** and **get connected to services as quickly as possible.** In interviews, BHRN roles for peers were often very broad or loosely defined, carrying high expectations of "gap filling" across many BHRN needs.

"If somebody needs an assessment and there's a week between that first point of contact and the assessment, **the peer will reach out to them and say: "Hey, I see you have an assessment scheduled in a week. Wondering if there's anything we can do to support you in the interim.** Are you wanting to check out local meetings? Do you need any help with housing?" Just those kinds of immediate needs that this new peer might be able to help. We couldn't offer that before because **that's not a billable service** because there's not an assessment or a treatment plan on file."

"This funding is going to allow for [peer] positions to be covered so that, **at any time, if anybody walks in, they can see somebody.** They don't have to wait for two days or something to see a counselor or even a peer. They can see somebody right away. They'll do the behavioral health comprehensive needs assessment look at all the barriers. What do you need? Housing? You need food. What do you need, and right away get a plan going for those people."

"Before Measure 110, we couldn't get a program that provided peer support within our SUDs program. Now with Measure 110, we **have four peer support specialists** who are working full-time, working with our clients on recovery services. Right now, I'm thinking maybe we need one more."

BHRNS OFFERED DEDICATED FUNDING AND ENHANCED INTEGRATION OF HARM REDUCTION

Measure 110 provided dedicated funding to harm reduction services, allowing organizations to plan for **more syringe exchange sites, staffing, and available hours.** Harm reduction organizations also emphasized their ability to purchase supplies, especially the **supplies their clients prefer.**

"For decades, we've been scraping in together to do syringe exchange in a lot of these places. That looks like individual donors, grant donors. I mean, just begging, have some money from the state, some from here. Some years you have it. Some years you don't. **There has never been a funding stream in Oregon that I'm aware of that identifies harm reduction as a priority for the funding.**"

"The actual **harm reduction sites—how many hours of that—will go up** in [our counties]. With the rural counties, [...] we're hiring an additional syringe exchange coordinator, so the number of hours will increase for [syringe exchange]. Another thing that we did in the BHRN was to **hire a harm reduction educator.** That person will do two things: One is to work with

the county to develop youth-appropriate harm reduction messaging that we can use in our HIV youth education program—doing a better job of incorporating that, so youth can understand how these things are related. Also, to do **community education around harm reduction.**"

The biggest part is that we can actually buy supplies. **We can buy the supplies that young people say they need."**

Several Participants highlighted that **BHRNs allow SUD treatment and housing agencies to host harm reduction programs like syringe exchange on their premises, and to adopt harm reduction principles into their programs**, even if they hadn't embraced such services or philosophies before.

"Well, one thing that I have seen—in terms of a **philosophical change that will impact the consumer for sure**—is a much more open-mindedness and embracing of harm reduction. Harm reduction as it's defined by the OAC—and harm reduction, in a broader sense, **in treatment centers developing a more harm reduction philosophy** and a more inclusive philosophy, a less rigid abstinence only "there's one way of defining recovery and this is it, and if you're not doing that, we can't really help you," that is probably one of the biggest things that I've seen."

BHRNS SUPPORTED NEW, INNOVATIVE SERVICES

BHRN funding allowed organizations to **implement pilot programs,** particularly for innovative services that may not have traditionally been covered by insurance. BHRN funding allowed organizations to try new treatment programs like Contingency Management that may have previously been cost-prohibitive. BHRN housing providers were excited to add agricultural therapy, cooking classes, and budgeting skills to their program offerings.

"It's a **pilot project** to do contingency management for stimulant use disorder, so folks will have a behavioral health provider. It's not a traditional treatment, so it's not like you're going to groups or that you have to stop using even. **If you don't use or you reduce your use, you get, basically, an incentive**, then you have access to our clinic, to our community health worker, and to a behavioral health specialist."

Contingency Management (CM) is an Evidence-Based Behavioral Intervention for Stimulant Use Disorder[26]

Participants in CM receive positive rewards for participating in treatment goals. **CM is more effective than other behavioral interventions and medications**, and evidence shows that **CM provides positive reinforcement, supports participant goals, encourages engagement, and self-motivation.** CM is included in SAMHSA's guide for the Treatment of Stimulant Use Disorders and is currently used by the U.S. Department of Veteran's Affairs[27].

[26] Brown, H.D., & Defulio, A. (2020). *Contingency Management for the Treatment of Methamphetamine Use Disorder: A systematic review.* Drug and Alcohol Dependence, 216, 108307. https://doi.org/10.1016/j.drugalcdep.2020.108307.
[27] Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). *Treatment of Stimulant Use Disorder.* 2020. https://store.samhsa.gov/product/Treatment-of-Stimulant-Use-Disorder/PEP20-06-01-001.

Organizations also discussed implementing services like **Medications for Opioid Use Disorder** (MOUD, also referred to as MAT) or **harm reduction** that may not have been innovative to the larger substance use field but were **new to their counties or organizations.** Through BHRN funding, they could offer these services that previously were not accessible to their clients.

"Tele-MAT [Medication Assisted Treatment] has been funded. **That is an innovative new thing. I think it's going to be really helpful in rural areas.**"

"We are using BHRN dollars to **stand up a MAT program in [four rural counties].** That's going to be really challenging."

Rural Counties Need Expanded MOUD Access

MOUDs are effective in treating opioid dependence and significantly reducing overdose deaths. **Coastal, rural, and frontier communities in Oregon are severely lacking in access to MOUDs**[28]. Rural communities often face barriers like large distances to clinics, shortages of trained healthcare providers, and lingering stigma that prevent people from seeking help. Given this, telehealth options may be especially impactful[29].

[28] Comagine Health and Oregon Health Authority (OHA). *A Quick Introduction to Medications for Opioid Use Disorder*. https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Documents/MOUD-factsheet.pdf.

[29] Weintraub, E., Greenblatt, A.D., Chang, J., Himelhoch, S. and Welsh, C. (2018), Expanding access to buprenorphine treatment in rural areas with the use of telemedicine. Am J Addict, 27: 612-617. https://doi.org/10.1111/ajad.12805.

BHRNs Supported New Organizations

BHRN funding supported new organizations and substantial expansion for small, grassroots organizations. In our county sample, new organizations included multiple agencies led by **peers, people with lived experience, and representative of the communities they serve.**

"I know that, once again, just speaking from a perspective when it comes to peer services, having a recovery center, a **peer-driven organization is new and innovative for our county. It's never happened before.**"

Peer-led Services Build Trust and Confidence

Peer-based support services are nonclinical forms of assistance provided by people with lived experience and knowledge who help others achieve long-term recovery from SUDs[30]. Peer support plays a key role in substance use treatment and recovery through valuable social connections[31]. Research show peer support enhances treatment retention, improves relationships with treatment professionals, and diminishes return to homelessness. Those in recovery often feel a strong bond with peer mentors, citing trust and a sense of empowerment[32].

[30] Bardwell, G., T. Kerr, J. Boyd and R. McNeil (2018). Characterizing Peer Roles in an Overdose Crisis: Preferences for peer workers in overdose response programs in emergency shelters. Drug and Alcohol Dependence 190: 6-8. https://doi.org/10.1016/j.drugalcdep.2018.05.023.

[31] Bassuk, E. L., J. Hanson, N. Greene, M. Richard and A. Laudet (2016). Peer-Delivered Recovery Support Services for Addictions in the United States: A systematic review. Journal of Substance Abuse Treatment 63: 1-9. https://doi.org/10.1016/j.jsat.2016.01.003.

[32] Tracy, K. and S. P. Wallace (2016). Benefits of Peer Support Groups in the Treatment of Addiction. Subst Abuse Rehabil 7: 143-154. https://doi.org/10.2147/SAR.S81535.

BHRNS ARE LOWERING BARRIERS TO SOME HOUSING PROGRAMS

Participants pointed out that BHRNs encouraged some programs to consider **ways to lower barriers.** Offering housing options for people actively using and relaxing expectations for alcohol and drug-free housing were two examples of lowering barriers to housing. Housing providers noted that they would maintain housing options for people whose goals are recovery and abstinence.

"We've always been low barrier. We've never expected people to come to our housing with clean time. We do have some alcohol and drug free housing, [...] of course, there's a whole process if people were to use drugs. We go through with multiple chances and trying to work with the folks. Eviction would always be a last resort. **Measure 110 has opened up our eyes to the possibility of maybe even more flexibility on that**."

"It's not there yet, but at least with the housing component, **you're localizing individuals**. You're **bringing the services to them in the space they're in**, and so I really am truly hoping. I think the biggest key on that is housing and peers. Those are the two pieces I think are going to be the highest impact when it comes to, hopefully, transforming lives."

"Now the difference here is, with the BHRN grant, **housing has to be inclusive of all populations**, so we will be open to people who are seeking harm reduction but having safe housing, still using, those who are on MAT. And the LGBTQ+ community, veterans—I mean, everything. It'll be all-inclusive: wheelchair accessible, everything."

Finding ways to meet community housing needs, across a spectrum of housing options, was a focus for all BHRN organizations. For some organizations, **BHRN funding supplied vouchers for temporary hotels or motels and gift cards for necessities** as a quicker fix to housing struggles than adding or building additional units. Participants explained how being unhoused challenges clients across a continuum of care.

"[Housing] is a **problem in all ways when it comes to achieving this goal of folks having access to treatment when they're ready**. To harm reduction, too, because our unhoused clients—60 percent of our syringe exchange clients—will say they do not have stable housing. Keeping track of your harm reduction supplies, your medication, all these things you need to be safe, keep your partner safe, those things are totally disrupted by having no safe place in your life at all to do that [...]

Recovery or entering treatment when you are unhoused, that's just really tough. I mean, you're going to go residential, that's fine, but if you're doing any kind of outpatient program, as an

unhoused person, it's rigorous. You have to do things every day. You have to make appointments. **The system is not set up for "come when you can get here" kind of treatment, so it is a huge barrier**."

BHRNS ARE CONSIDERING WAYS TO EXPAND LANGUAGE ACCESS AND CULTURALLY SPECIFIC SERVICES

In interviews, only two participants indicated that providing culturally or linguistically specific services was not particularly relevant to their work or the population they work with. When asked about providing culturally specific services, the majority of participants **identified language access** (e.g., providing materials in Spanish) as a need they were hoping and planning to fill. Participants discussed using BHRN funding to provide interpretation and translation materials.

"One of the things that we're starting off immediately is **providing our materials in both English and Spanish.** There is a little bit of a curve there, because I don't speak Spanish, and so we're finding the appropriate individuals to translate. Spanish is what we're currently using as our displayed alternative to English [...] In the event that we find that there's another need within the community, we'll address that as we move forward."

Related to language access, some BHRN participants discussed the importance of having not just translated materials, but bilingual staff. Some participants felt that having bilingual staff was important to translate materials in other languages and help non-English speakers navigate services and better connect with service recipients. **Participants noted recruiting and hiring bilingual staff as an ongoing challenge.**

"We're trying to find someone who's **bilingual** [...] and **identified as having substance use disorder**. It's a tall order—and wants to be a doula and peer support specialist. But we have trans and non-binary doulas."

"We're hiring a bilingual person who will be able to help folks who are syringe exchange participants or just general. Really, probably will wind up **helping anybody who speaks Spanish and needs to navigate health insurance possibilities**."

"We **don't have any Spanish-speaking or non-English speaking providers**. Our data also show that there were two people in each of the sites who have identified as Hispanic-Latino in overdose at the emergency department. If they're ready to go into treatment, how are they going to be able to do that without a provider?"

Outside of language access, participants discussed the importance of having culturally specific and informed services, with participants in our sample focused on **services tailored to LGBTQIA+, youth, and Native American populations in addition to Spanish speaking populations.** One participant questioned the definition and understanding of culturally specific services across BHRN organizations. They pointed to the differences between serving youth or veterans and creating programing centering communities of color, but advocated for support of both.

"Culturally, I would say our **strongest group that we try to integrate with and support** are **those who identify as LGBTQ+.** Especially in the **rural county that is certainly under-represented.** That's also another thing that I would really like to see our BHRN staff work diligently to get in contact with and form a strong relationship, especially with GSA [Genders and Sexualities Alliance] or some of the different groups within the schools. We know, basically in addition to the way that our county or administration treats that population, that they also suffer disproportionately from mental health issues and substance use disorder."

"We have been able to hire **five Native American representatives on staff**, so we have seen a huge uptick in our population of Native members coming into treatment here from all over the state, not just from [our county]. With that, two of our peer mentors for the BHRN are tribal members. I was excited about bringing them on."

"There are some other **culturally specific services** if we're talking about **young adult harm reduction, or young adult services or family services, or veteran services**. That's why I think it's important to differentiate population specific to culturally specific, because I just don't think population means the same thing."

Many participants noted that **their services would be accessible to anyone.** Organizations specializing in serving youth, veteran, LGBTQIA+, Native American, Black, and Spanish-speaking populations all **emphasized that population-specific needs were central to their program design and staffing.** Participants from those organizations observed that they could provide expertise for BHRNs in designing inclusive services for the populations they serve.

FINDINGS: BHRN IMPLEMENTATION

Key Findings

Participants noted these key facilitators for implementing networked care:

- Peer outreach is a central way to engage people into BHRN services,
- Community relationships and existing partnerships were a strength in some counties.

Participants noted that the referral process, and coordinating between organizations generally, was difficult. Some barriers included:

- State agencies provided inadequate support for coordination efforts,
- A competitive grant making process and tight timeframes for implementation did not allow strong partnership work between organizations.

OUTREACH IS A PRINCIPAL PATHWAY INTO SERVICES

Participants expressed that the most **important pathways into BHRN services would be community outreach, largely through peers.** BHRNs also had some plans to set up websites and advertise services through social media or billboards.

Other possible pathways into BHRN services are Class E Violations, which can be waived by completing a screening with the BHRN in person, or through a 24/7 screening phone line that BHRN organizations are required to offer. Class E violations are infrequent in most of our sample counties, making violations a limited gateway to services.

Participants noted the 24/7 phone line was a difficult staffing need and added that the focus for the phone line would be on addressing client needs directly rather than waiving Class E violations. **Figure 4** highlights the pathways into services participants discussed.

"Our peers will **travel throughout the county**. Our peers are from the community. […] They will be providing support from the very moment they're connected. Our goal is to have peers stay with people until they come back to us and say, "I'm doing really well. I don't need your support anymore."

"We are really looking at the **assessment process of how do we get people in?** There's the hotline part, but you got a hotline call, how do you make sure that people are **assessed quickly?** Once they're assessed, how do we know that the **right referrals are going out?** I think right now we're looking to make sure our focus has been on identifying what the needs are and getting people those services. That's step number one."

Figure 4: Pathways into BHRN Services After Measure 110 Include Outreach, Screening Phone Line, and Class E Violations

COUNTIES RELIED ON EXISTING COMMUNITY PARTNERSHIPS TO BUILD BHRNS

Established organizations emphasized their **prior coordination efforts** as instrumental in facilitating the setup of BHRNs. These pre-existing collaborations provided a foundation for integrating new networks. These already established coordination efforts helped newer and smaller organizations understand and address community needs.

However, the **timeframe and workload expectations associated with setting up BHRNs presented challenges.** Specifically, these expectations became a significant barrier to forging and nurturing partnerships, as organizations grappled with the demands of initiating the new networks.

The support provided by the OHA was necessary to grasp the intricacies of the new BHRN requirements. Some participants expressed a desire for additional support sessions and technical assistance early on. Participants stated that **support for administrative coordination would greatly impact BHRN implementation and service coordination.**

Unclear expectations throughout the grant application, contracting, and BHRN implementation period were **especially difficult for smaller, newer organizations** in part due to their significant growth.

"We didn't meet as a group until we found out that we were all funded. Which makes sense, but a lot of it was, "Okay, we're trying to get the contracts out." What **was really needed was systems change work** and **taking time to build relationships** with different organizations. We haven't had time to do that. It's just **been race, race, run, run with the funding, the policies and procedures, the budget templates, our FAQs, and intakes 24/7.**"

"Technical assistance workshops have been helpful. **We are growing so significantly**, just the number of employees we're going to have, and so having some HR training. OHA [...] sent stuff out in packets. One thing that they started doing **that's been helpful too, they lowered their expectations.** They had us on a tight timeline. They loosened up a bit, so that's been helpful."

COORDINATION CHALLENGES INCLUDE REFERRALS TO HOUSING AND TREATMENT

BHRNs were **still planning** critical aspects of **providing networked care** when we conducted interviews. We asked to hear some of the questions and concerns BHRNs were considering regarding networked care. Participants pointed out that coordinating intake and assessments

across organizations would be difficult. Some BHRNs were using custom forms or software (like Unite Us) to share BHRN client information between organizations.

Additionally, participants noted that **referring to services with wait times like residential facilities would be challenging**, and they hoped to arrange a new system to reduce client wait times. Participants often mentioned peers as the staff that would be responsible for transportation and warm handoffs between organizations within the BHRNs.

"I would say be far more **intentional, around the coordination of services** [...] Having some sort of **very clear expectations laid out for the goals of the BHRN**, not in each individual agency, because the agencies in some ways are competing with each other. So what is the **expectation for the BHRN, overall, and what's the structure around that?** Then, like I said, some sort of **administrative coordination**—I know that seems like a small thing, but it is a small thing that would make a huge difference[...] That could be a middle manager, lower entry-level manager position, somebody who's going to coordinate. That, I think, would be night and day of where we are right now with our BHRN if we had somebody at the helm."

"One of the big challenges is, **how are we going to refer people to treatment? How are we going to know where there's availability within the BHRN? How is that going to be low barrier? How is it going to be consistent?** We're going to have peers all over the place and multiple organizations trying to refer in. How are we going to do that and track that? It's huge. It's a huge area of work, right there. We were talking about that, and one of the treatment providers was like, "Well, can't we just do it the way we're doing it, or just do something like what we're doing basically?" One of the other treatment providers, a leader from the other treatment organization, said, "No, because that's not been working, and people are not getting services. We know that, and that's what this money is about."

One participant noted that they had developed **a BHRN specific referral form**, and that their goal was to **co-locate as many services as possible**. They noted the importance of tracking people between services and making sure there is follow up with BHRN clients.

"We have a **referral form** that we already created. If someone's looking for housing, we will send that referral to the individual to recommend they go to one location. We also will email the organization a referral form, so they'll know that person is coming, and have been referred to them by us. Once they get there, we get a response back from that organization saying, "They showed up. They're now in housing. They're doing well. They're looking for peer support. Make sure your peers are here."

We're also **planning to try to co-locate a lot of the services.** Like at the housing, have a peer person there and a patient navigator there. When they're coming in for housing, at least they have that peer to get them into treatment, so they can have some support. We have already

created a feedback loop on who received the services. If they were declined, if they changed their mind, what happened to that individual, so that there is a **tracking mechanism to stay in place, so we know that people are getting served**."

Finally, some participants worried about **determining BHRN eligibility for programs like housing.** BHRN housing providers noted that they expected demand for BHRN-funded housing to be higher than capacity.

"Our understanding is that individuals for Measure 110, if they receive a violation and it's $100, they can choose to call this 1-800 number in order to not have to pay it, and that's how people get put on the list to enter into our program. The problem is most people know that there's no hook if they don't pay it. Only three percent of anybody that's been given that violation are making calls or using that number.

That's **not a viable option for us on how to utilize these rooms**, so we are banning together to figure out, okay, how does that work? Frankly, do we already have individuals at our facility who are already qualified under that and can we work with them? Those are the pieces that we'll be coming together, identifying, working through, and figuring out. We're not there yet."

RURAL BHRNS HAVE UNIQUE BARRIERS AND FACILITATORS

Rural and frontier counties were more likely to have **fewer organizations involved in their BHRN,** and some participants commented on the **strength of existing organizational partnerships** in rural communities. Rural participants asked that state agencies trust the expertise of the county organizations, especially in the funding process which many organizations (rural and urban) felt was not equitable. One participant observed that even strong community relationships were tested by the funding and budgeting decisions for the BHRNs.

"**Trust the voices of your counties**. There's my mantra: You need to trust the people who have been doing the work. We're stubborn and strong-headed and set in our ways. Yes, there's that, but we've worked hard to build what we've had with decades of a lack of support. We don't have the traditional access to resources that metro areas have."

Rural areas also pointed out that an **outreach-based model is more difficult in communities that are geographically spread out.** Rural participants frequently mentioned transportation as a barrier to outreach and referrals.

"I think a barrier we're going to see is, we're **going to have to have all hands on deck for our agencies with transportation.** Which is always an issue for us because we are open to everybody throughout the county."

"Referrals are difficult because we're **a bit on an island out here**."

Rural providers had a higher likelihood of **community pushback to housing and harm reduction programs.** They cited that rural communities may be very opposed to Measure 110, but education to correct misinformation about services and to show the efficacy of the programs in the area would help address community concerns.

"In this environment that we're in right now in which people are frustrated about the housing situation, the situation with unhoused folks, and the impacts of that on the community, I think **people are fearful about making that worse.**

Even if they support harm reduction, **there's a hesitance that I've noticed, just because it's such a mess and there's no great solution coming.** People don't know what's going to be done about this situation—camps, unhoused folks, garbage, and all the other stuff. It's a tough environment. Some of our counties found out about when the state put out the funding notice for Measure 110, it mentioned safer injection sites [...] We had to do a lot of backpedaling in that county together with the partners to say, "Hey, nobody [in the county BHRN] asked for that."

DISCUSSION AND RECOMMENDATIONS

DISCUSSION

Our interviews with Program and Executive directors involved in Behavioral Health Resource Networks (BHRNs) point to **early successes and challenges** following the influx of Measure 110 funding.

Measure 110 funding has already started to reshape service landscapes for people who use drugs by providing for capital improvements, increasing staffing, and encouraging innovative care philosophies and programs. Participants agreed that housing is a persistent need, even with substantial investment from BHRN funds.

Despite understanding the need to make BHRNs accessible and inclusive to diverse populations, participants expressed that their ability to meet those need has been hampered by workforce shortages and recruitment challenges for bilingual and representative staff.

Challenges include coordinating services and referrals across various organizations involved in BHRNs. Participants voiced mixed reviews about the adequacy of state agency support in this critical area, underscoring a need for new systems of coordination and requesting administrative support. While some participants pointed to the strength of existing community relationships in facilitating implementation, others cited that the competitive nature of the grant application process and the pressure of tight timelines were counterproductive to fostering strong partnerships.

LIMITATIONS

Researchers in this study were unable to reach every BHRN organization in each county, and interviewed participants from one organization at a time. Speaking to organizations together, as a full BHRN, would offer participants more opportunities to collectively think through BHRN service impacts and implementation concerns.

This work intentionally focused on regions outside of the Portland metropolitan area. As Oregon's main population center, a substantial amount of BHRN organizations serve Multnomah County. We recommend additional studies examine BHRN implementation in Portland. Challenges in Portland may be distinct from the counties represented in this report, since BHRNs are likely to encompass more organizations and Portland is home to many culturally and linguistically specific organizations.

We spoke with participants early in the funding cycle. Many organizations were still hiring staff and planning their coordination efforts. As we approach the second funding cycle, BHRNs may be more established in their policies and procedures and may have new funding priorities. The initial two funding quarters involved capital investments that are one-time expenditures.

Cannabis tax revenue projects decreased for the next funding cycle, so organizations will likely encounter new barriers as they adjust their budgets.

CONSIDERATIONS

- **BHRNs are unique in each county, reflecting the flexibility of the model and the distinct characteristics of communities.** Given the flexibility, variability, and novelty of BHRNs, we recommend that state agencies offer substantial support to current BHRNs and in future funding processes. Participants asked for more clear guidelines about BHRN expectations and dedicated, trained staffing to support BHRNs.
  Provide opportunities for organizations to build relationships and collaboration like BHRN learning collaboratives. These can also help organizations work towards systems change.

- **BHRN providers envision peer-provided services as an important pathway into services.** Participants highlighted the importance of peer outreach for engaging individuals and guiding them through BHRN referrals. To support this growing need, allocate additional resources and training to develop the peer workforce.
  Participants also highlighted the need to recruit and retain a culturally and linguistically diverse workforce to help address the current labor shortage and ensure BHRN staff can reflect the communities they serve.

- **Administrative requirements for BHRN implementation and coordination were challenging and would benefit from funding support.** State agencies can share resources on creating referral processes through centralized systems to facilitate better coordination among different organizations. State agencies can consider encouraging and funding centralized administrative positions for the BHRNs in future funding opportunities.

- **BHRNs faced difficulties addressing housing needs, highlighting the ongoing struggle to meet this critical aspect of support for people who use drugs.** In light of this, housing initiatives should be considered and pursued, especially programs tailored to the needs of people who use drugs.

We hope these findings inform decision-making to improve BHRNs, enhance the effectiveness of substance use-related services across the state, and add context for future research interested in the outcomes of decriminalization.

APPENDIX A: DISCUSSION GUIDE

Interview Objectives

The purpose of the interviews is to examine BHRN implementation strategies and contextual factors in 7 counties (majority rural). We will conduct interviews with organizations participating in the counties' BHRN and any key behavioral health entities not included in the BHRN. Core topics include:

- Planned BHRN services
- How services/service approaches (philosophy, collaboration, etc.) are changing
- Anticipated barriers, facilitators, and contextual factors influencing BHRN implementation
- General perceptions and recommendations

Introduction

Thank you so much for talking with me today. Did you have a chance to look through the Information Sheet we sent? If not, I'll walk through it now. [Overview]

Our goal is to reflect on the process of implementing a Behavioral Health Resource Network[s] in [County] and the local context that may affect BHRN formation and service offerings. We believe this information can guide states and counties looking to the BHRN model to expand services.

The interview will last about 60 minutes. **We are recording the interview to help refer back to your answers and analyze the information you provide.** All names and personal identifiers will be removed from this interview after we transcribe the interview. You can stop me at any time if you have questions, if anything is unclear, or if you prefer to skip a question.

Do you have any questions before we begin?

OK, **I'll turn the recorder on now, and we'll get started.**

*Turn on the recorder: State your **name**, today's **date**, and the current **time.***

Example: "Today is August 2nd, it is 11:30 am, and this is Gertrude".

My first question is, do you consent to participate in this study?

Guide

Section 1: General/Background

We'll start by learning more about your organization and your role.

1. Tell me about your position at [organization name].
2. Can you confirm your organization's role in the [xx] County BHRN?

a) *Screening and comprehensive behavioral health assessment,*
b) *Individual intervention planning,*
c) *Low barrier SUDs treatment,*
d) *Peer support and outreach,*
e) *Housing,*
f) *Harm reduction services,*
g) *Supported employment*

Section 2: Service Impacts

In this section, we'll ask about how BHRN funds will affect the services you offer, and impacts you expect BHRN funding to have on your county's service landscape.

3. What do you see as the most significant impact BHRNs will have on the service landscape for people who use drugs (PWUD) in [County]?

a) *What services in your county do you anticipate are most affected by creating a BHRN? How so?*
b) *What, if any, innovative services, or programs are being funded by the BHRN in [County]?*

4. We'd like to hear more about the services **your organization** is offering.

Supportive housing:

- *What types of supportive housing will you offer (explicitly ask about: Housing First, recovery housing, permanent supportive housing]? Is there eligibility requirements for housing services? If you're offering vouchers for housing, please describe. How have you filled previous gaps and what gaps remain?*

Low barrier treatment:

- *What will low-barrier treatment look like within your BHRN? Does the community support low-barrier treatment? How do these services fill previous gaps and what gaps remain?*

Harm reduction:

- *What are the community's thoughts on harm reduction services? What types of harm reduction services will you offer? How have you filled previous gaps and what gaps remain?*

Peer services:

- *How will your organization incorporate peer services? What are your BHRN's new/expanded/needed plans for connecting with people who use drugs? How have you filled previous gaps and what gaps remain?*

Supportive employment:

- *What types of supportive employment will your organization offer? Have you found recovery-friendly employers in your county? Are there gaps or challenges in finding supportive employment?*

Individualized intervention planning:

- *What will individualized intervention planning look like at your organization? How will you address comprehensive individual needs like coexisting conditions, childcare, and other services? How have you filled previous gaps and what gaps remain?*

Comprehensive behavioral health assessments:

- *How have you filled previous gaps, and what gaps remain?*

5. What culturally and linguistically specific services will you offer?

   a) *Are representative stakeholders part of service planning and delivery?*
   b) *How have you filled previous gaps, and what gaps remain?*

6. What barriers exist in your county to providing the entire continuum of BHRN services to all people who may need them?

   a) *What strategies is the BHRN using to address these barriers?*
   b) *[If not discussed:] What impact do you anticipate workforce shortages will have on BHRN implementation in your county?*

Section 3: BHRN Set-up

Now we'll turn to how you envision the BHRN in [County] working going forward.

7. [For counties with more than one organization] Can you walk me through what happens if a client comes to your organization looking for a service you do not provide?

   a) *Can you walk me through how you'll respond if an organization reaches out to you with a client that needs services they don't provide?*
   b) *What are your plans for partnering with other organizations outside the BHRN? With organizations in nearby counties?*

8. What are your BHRN's plans, if any, for administrative coordination across organizations? [If needed: for example, planning meetings/regular convenings to hash out cross-org issues]
9. What changes do you expect from how organizations currently operate/operated pre-BHRN? [Listen for service delivery, workflow, staffing changes]
10. What barriers, if any, has your organization encountered in setting up the BHRN? [Listen for service requirements, timeframes, staffing, and collaboration]
11. What, if anything, has made things easier for your organization in setting up the BHRN?
12. Does your BHRN plan to market/disseminate information on what your BHRN intends to do, and the services provided?

a) *How would you introduce the BHRN and its service offerings to the community?*

b) *How will you reach out to people who use drugs in the community about the BHRN service offerings? [If not volunteered in first section.]*

13. How will the BHRN engage with law enforcement and community corrections?
    a) *How would law enforcement find out about your BHRN services?*
    b) *What has your BHRN done to connect with law enforcement so far?*
    c) *Has your BHRN thought about educational initiatives to educate law enforcement on the services your BHRN center provides (and their role in this system)?*
14. Are there important service providers in your community that aren't a part of the BHRN? (Or sub-organizations we should speak with)?

Section 4: Big Picture

This is our final section! Here, we'd like to know more about your feelings about the new BHRN model.

15. What are you most hopeful about for the BHRN in [County]?
16. What are you worried about for the BHRN in [County]?
17. How do you anticipate the BHRN impacting community cultures related to substance use?
18. What advice would you give other states considering a BHRN model?

19. That's all the questions I have today. I appreciate your willingness to share your thoughts. Is there anything else we should know or haven't covered about setting up a BHRN in [County] that you want to share?

Conclusion: Thank you for talking with me today – we appreciate it. I'm going to turn off the recorder. If you have any concerns, please don't hesitate to reach out at the number or email provided on the information sheet. We expect the report to be ready in (timeframe), and we will share it with all participants.

APPENDIX B: GLOSSARY

Commonly Used Terms and Acronyms		
Behavioral Health Resource Networks	**BHRN**	BHRNs can include one or more entities such as community or government organizations. BHRNs must provide screening services, comprehensive behavioral health needs assessments, individual intervention planning, case management, peer counseling and support, low-barrier substance use disorder treatment, housing services, harm reduction services, and linkages to other services.
Black Indigenous and People of Color	**BIPOC**	An acronym used to refer to communities of color in the United States that also acknowledges not all people of color face equal levels of injustice. BIPOC highlights that Black and Indigenous communities are often most impacted by systemic racial injustices, while also acknowledging solidarity across communities of color.
Measure 110	**M110**	Often used to refer to the decriminalization policy in Oregon, although this report uses "DATRA" instead. Measure 110 refers to the citizen-initiated ballot measure that voters passed in November 2020.
Oregon Health Authority	**OHA**	Oregon Health Authority oversees Oregon's health care programs, including behavioral health, public health and the Oregon Health Plan (Medicaid coverage for low-income Oregonians).
Oversight and Accountability Council	**OAC**	The Oversight and Accountability Council is a community-led governing body in charge of key decisions about defining, funding, and overseeing expanded services for people who use drugs under DATRA.
People who use drugs	**PWUD**	A person-centered way to refer to people who use drugs, inclusive of people who may not have a SUD.

APPENDIX C: COUNTY-LEVEL BHRN OVERVIEWS

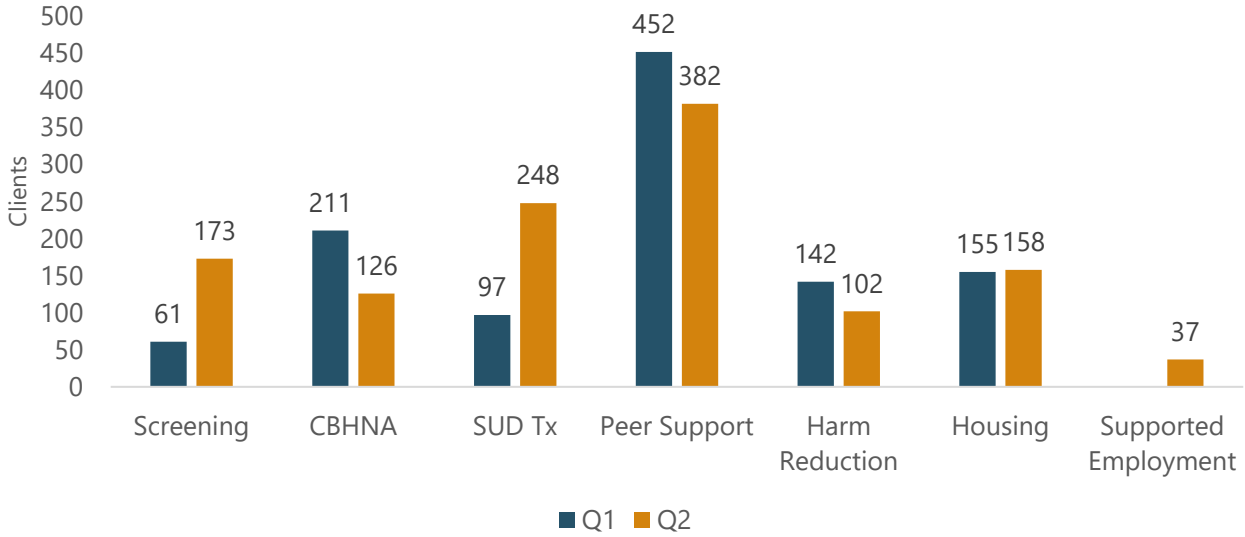
The following county data was compiled from the **OHA BHRN Dashboard** for the study counties.

COOS COUNTY

Expenditures, Client Counts, and Service Encounters

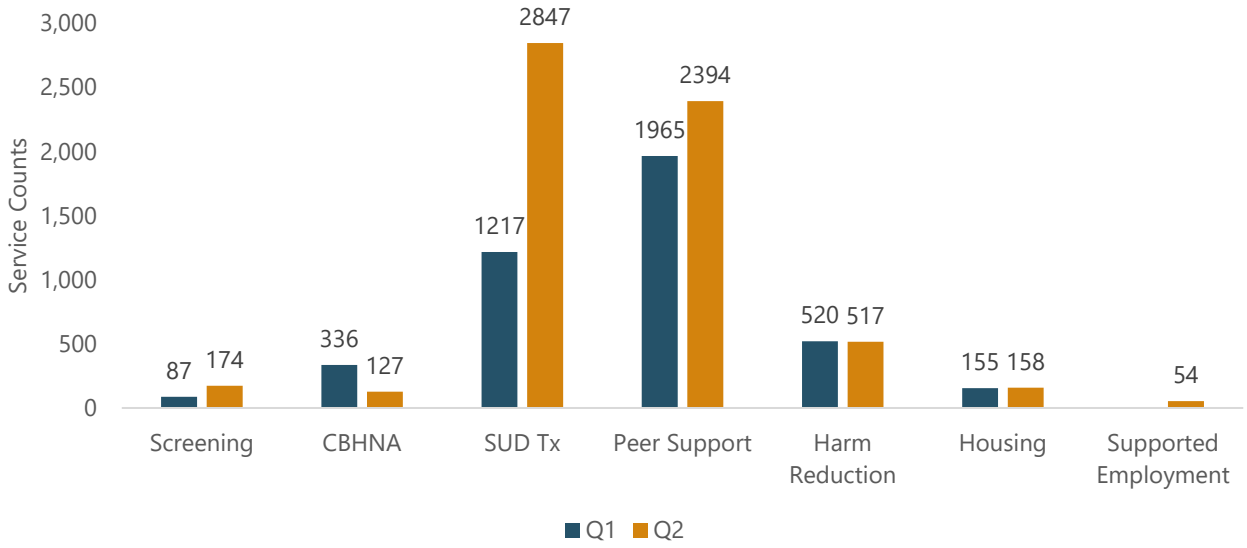
In both Q1 and Q2 Coos County spent the most funds on Housing Services ($667K and $138K respectively).

Between Q1 and Q2, Coos county saw increases in client counts for Supported Employment,



In terms of the number of service encounters with clients, between Q1 and Q2 Coos county saw a decrease in CBHNA, and increases in Screening, SUD Tx, Peer Support Services and Supported Employment encounters.

Figure 6: The Coos BHRN Had High Service Counts for SUD Tx and Peer Support Q1 and Q2



GRANT COUNTY

Expenditures, Client Counts, and Service Encounters

In Q1 Grant County spent the most on SUD Tx ($4k). However, in Q2 most expenditures went to Peer Support Services ($24k) and Housing Services ($30k). For both quarters, Grant County reported 59% of expenditures went to capital, while 41% went to personnel.

Data comparing Q1 and Q2 client counts and service encounters for Grant County were not available. In Q2, Grant reported 48 Supported Employment service encounters.

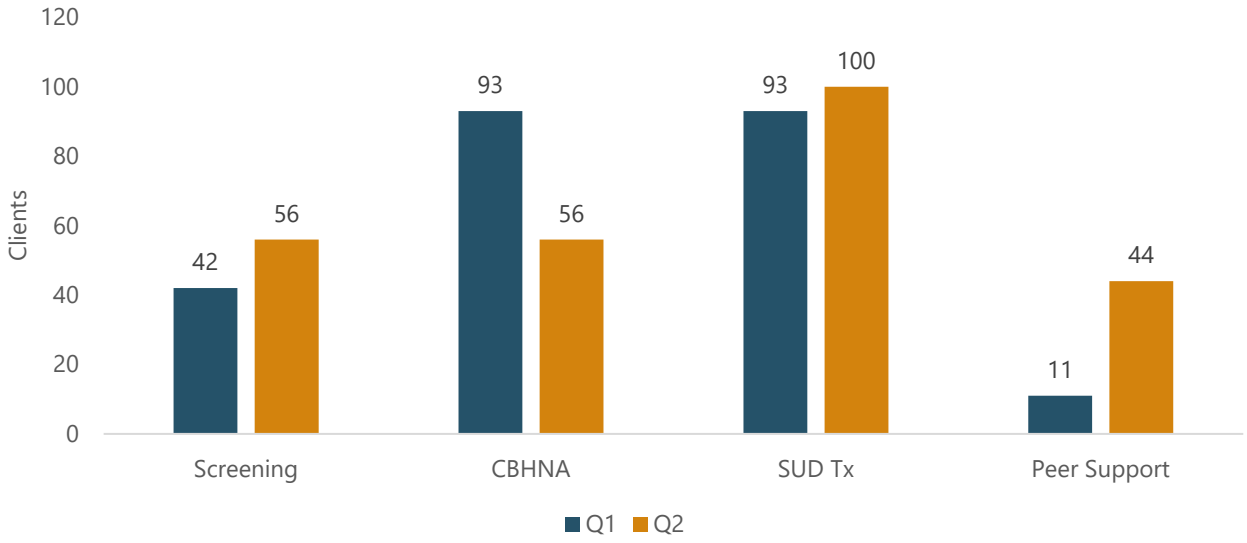
HARNEY COUNTY

Expenditures, Client Counts, and Service Encounters

In Q1 Harney County spent the most on Supported Employment ($52k). Expenditure data for Harney County in Q2 were not available.

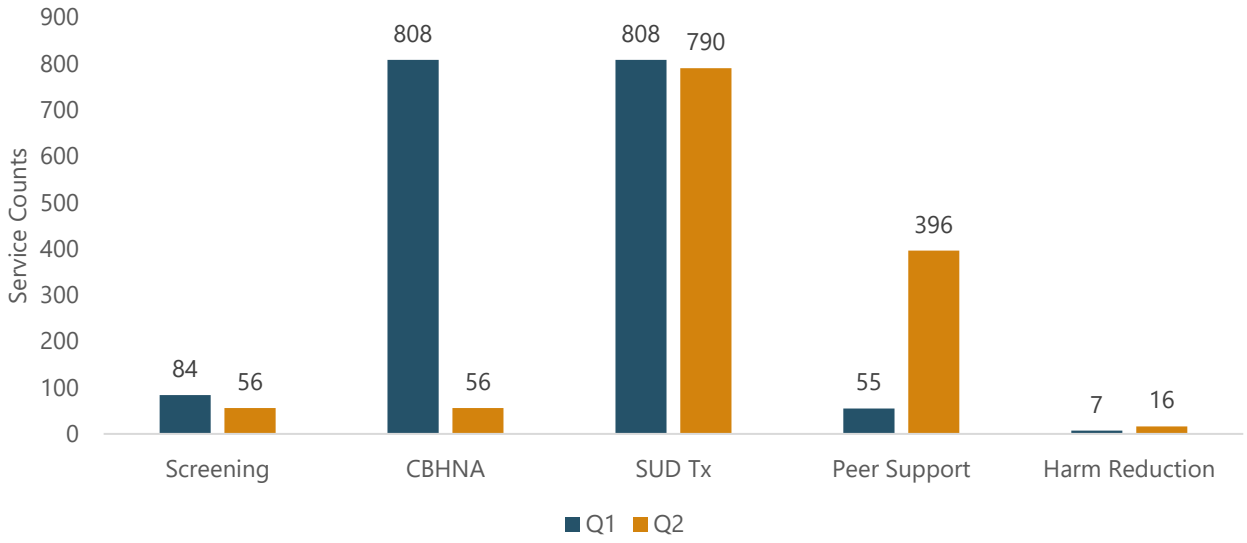
Between Q1 and Q2, available data for Harney County showed increases in client counts for Screening, SUD Tx and Peer Support Services. Harney County reported no Harm Reduction, Housing or Supported Employment clients in Q1 or Q2, and no Housing or Supported Employment encounters in Q1 or Q2.

Figure 7: The Harney BHRN Had High Client Counts for CBHNA and SUD Tx in Q1 and Q2



Between Q1 and Q2, available data for Harney County show saw a decrease in CBHNA, Screening, and SUD Tx, and increases in Harm Reduction and Peer Support Service encounters.

Figure 8: The Harney BHRN Had High Service Counts for SUD Tx in Q1 and Q2



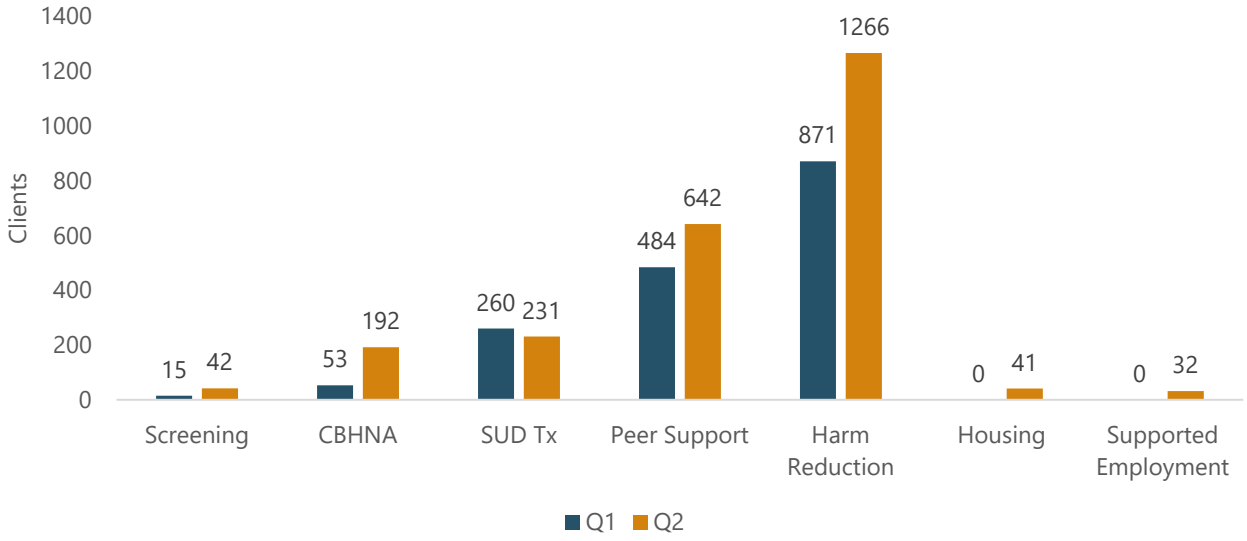
JOSEPHINE COUNTY

Expenditures, Client Counts, and Service Encounters

In Q1 and Q2 Josephine County spent the most on Housing Services ($609k and 1,393K respectively).

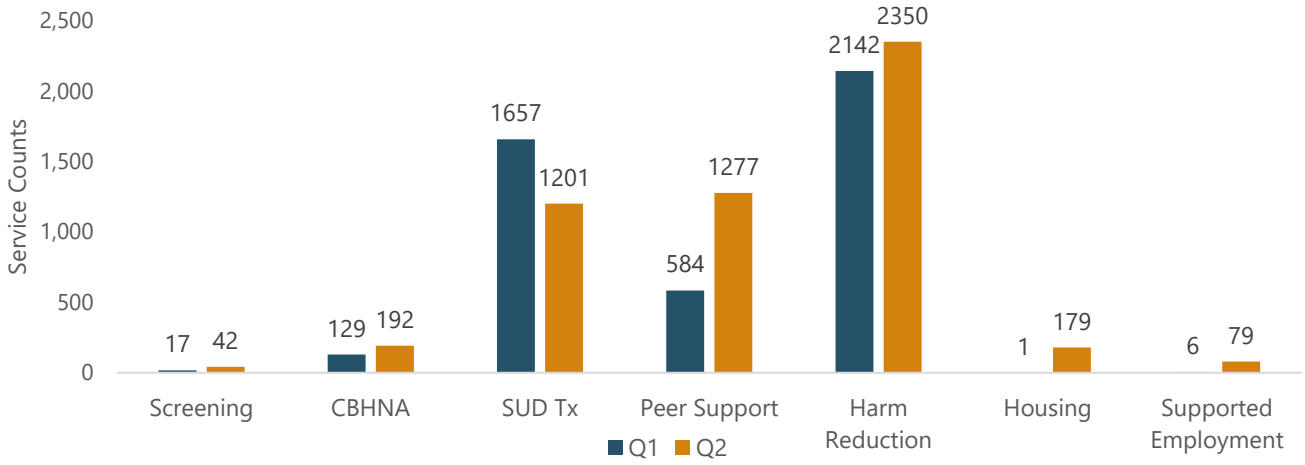
Between Q1 and Q2, Josephine County saw increases in client counts for Screening, CBHNA, Peer Support Services and Harm Reduction.

Figure 9: The Josephine County BHRN Had High Client Counts Harm Reduction in Q1 and Q2



Between Q1 and Q2, Josephine County saw a decrease in SUD Tx encounters, and increases in CBHNA, Peer Support Services, and Harm Reduction encounters.

Figure 10: Josephine County BHRN Had High Service Counts SUD Tx and Harm Reduction for Q1 and Q2



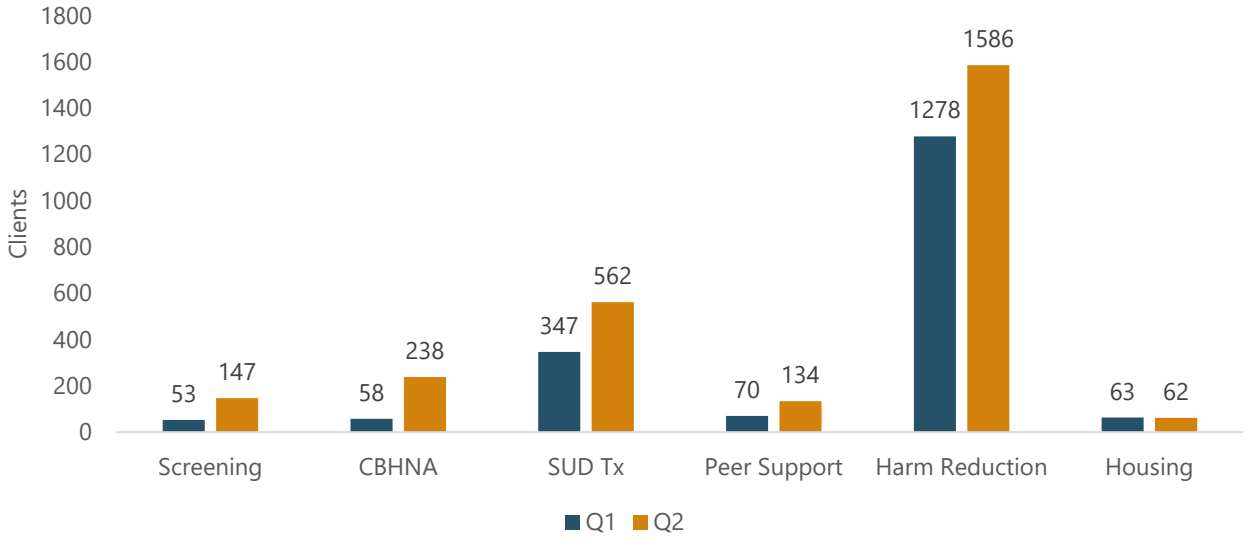
LANE COUNTY

Expenditures, Client Counts, and Service Encounters

In Q1 Lane County spent the most on Housing Services ($103k), SUD Tx ($57k) and Peer Support Services ($56k). In Q2 most expenditures went to Peer Support Services ($408k), Housing Services ($407k) and SUD Tx ($373k).

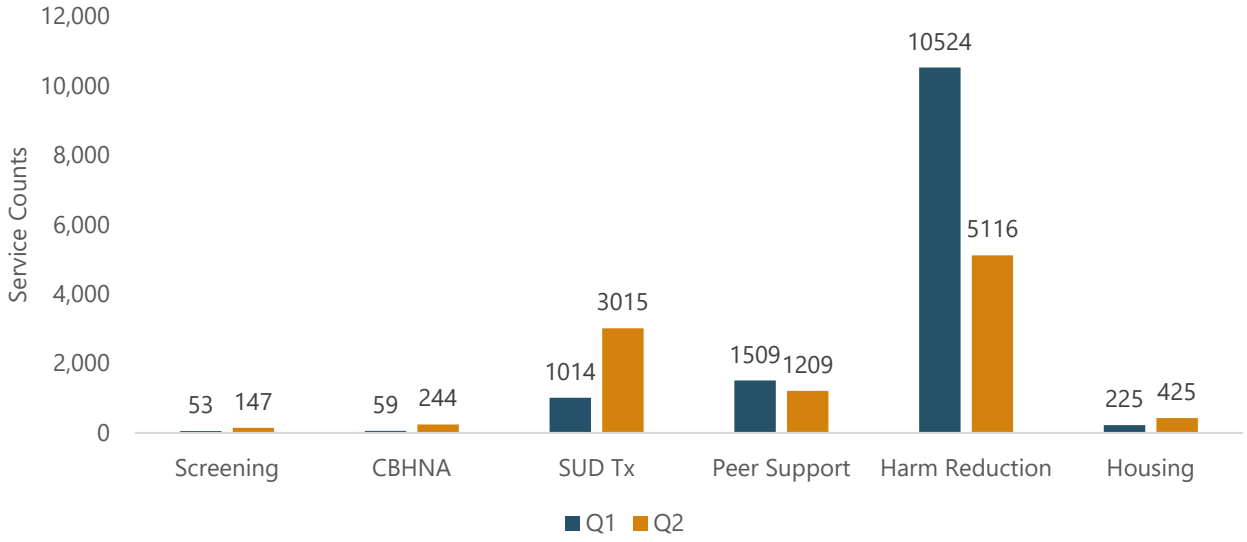
Between Q1 and Q2, Lane County saw increases in client counts for Screening, CBHNA, SUD Tx, Peer Support Services and Harm Reduction. Lane reported no Supported Employment clients in Q1 and Q2.

Figure 11: The Lane BHRNs Had High Client Counts for Harm Reduction in Q1 and Q2



Between Q1 and Q2, Lane County saw a decrease in Peer Support Services and Harm Reduction encounters, and increases in Screening, CBHNA, SUD Tx, and Housing Service encounters. Lane reported no Supported Employment encounters in Q1 and Q2.

Figure 12: The Lane BHRNs Had High Service Counts for Harm Reduction in Q1 and Q2



LINCOLN COUNTY

Expenditures, Client Counts, and Service Encounters

Complete Q1 expenditure data for Lincoln County were not available. In Q2 Lincoln County spent the most on Peer Support Services ($202K) and SUD Tx ($162K).

Apart from Peer Support Services, data for Lincoln County for Q1 was unavailable. However, between Q1 and Q2 Lincoln County did see an increase in both client counts and service encounters for Peer Support Services.

Figure 13: The Lincoln BHRNs Had High Client Counts for Harm Reduction in Q2

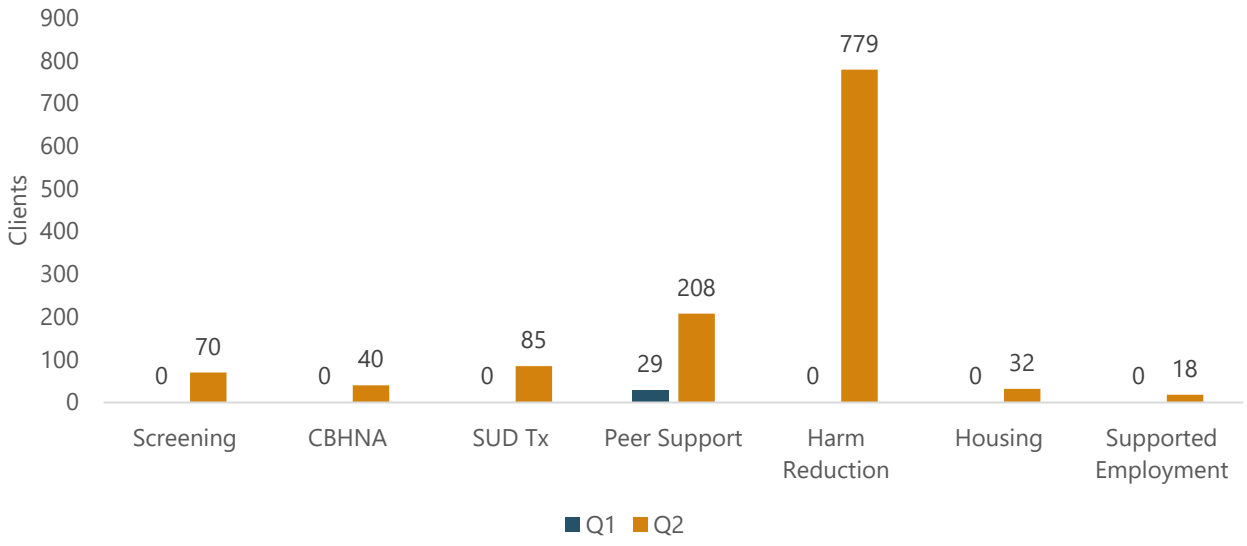
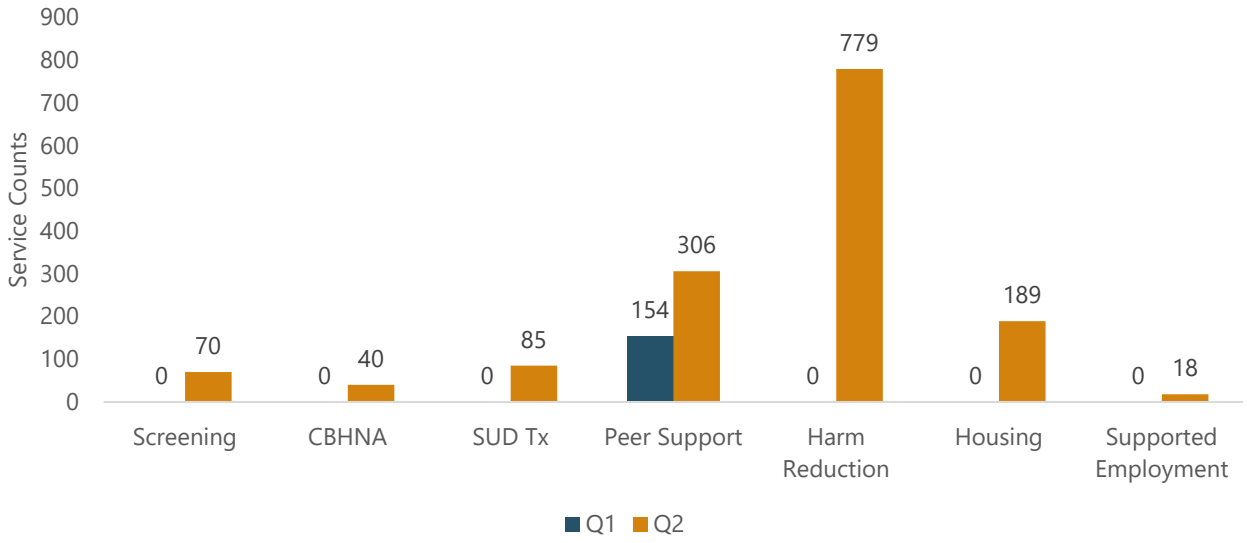


Figure 14: The Lincoln BHRNs Had High Service Counts for Harm Reduction in Q2



UMATILLA COUNTY

Expenditures, Client Counts, and Service Encounters

In Q1, Umatilla County spent the most on Peer Support Services ($145k) and Harm Reduction ($89k). In Q2, Umatilla County spent the most on Housing Services ($257k) and Peer Support Services ($71k).

The majority of Q1 and Q2 data for Umatilla County was not available. However, between Q1 and Q2 Umatilla County saw an increase in client counts and service encounters for Harm Reduction Services and a slight decrease in service encounters for Housing Services.

APPENDIX D: RECOVERY ECOSYSTEMS

RECOVERY ECOSYSTEM INDEX

The Recovery Ecosystem Index allows for an assessment of the strength of the substance use disorder (SUD) recovery ecosystem in communities across the nation to inform efforts to support individuals in recovery. The Recovery Ecosystem Index is calculated for each county in the United States using standardized values of 14 indicators belonging to one of three component classes associated with the recovery ecosystem. The three components represented are SUD Treatment, Continuum of SUD Support, and Infrastructure and Social. Each of these three components is comprised of several subcomponents reflecting aspects of that dimension that are aggregated. For the overall Recovery Ecosystem Index score, 1 represents the strongest, and 5 represents the weakest recovery ecosystem.

According to these data, drug overdose mortality in Oregon increased between 2011-2015 (17.7 deaths per 100k people) and 2016-2020 (19.5 deaths per 100k people). Opioid overdose mortality decreased slightly during this time, 12.5 opioid deaths per 100k people during 2011-2015, and 12.4 deaths per 100k people during 2016-2020. The Oregon state Medicaid plan does not include coverage for behavioral supports for medications for opioid use disorder (MOUD), nor are commercial insurers required to provide coverage for MOUD. State law allows for the operation of locally permitted syringe service programs (SSPs) and possession of syringes by SSP participants.

COUNTIES IN THIS STUDY

Coos County

Coos County received a Recovery Ecosystem score of 3 for SUD Treatment, Continuum of SUD Support, and Infrastructure and Social, suggesting a moderate recovery ecosystem. Compared to both Oregon and the United States, Coos County has fewer Substance Use Treatment Facilities and Buprenorphine per 100,000 residents. Coos County reports no recovery residences, drug-free communities coalition, or drug courts. Most households in Coos County report have at least one vehicle and broadband access. For every 10,000 residents, there are 12.2 social associations, more than in Oregon and the U.S. Compared to Oregon and the U.S., Coos County has a smaller percentage of households that spend 50% or more of their income on housing costs.

Table 3: Coos County Recovery Ecosystem Index

Component	Score (out of 5)	Sub-Component	Coos County	Oregon	United States
SUD	3	Substance Use Treatment Facilities	1.6	5.1	4.3

Treatment		per 100k			
		Buprenorphine Providers per 100k	10.9	21.1	15.2
		Average Distance to Nearest MAT Provider (miles)	36.8	N/A	N/A
		Mental Health Providers per 100k	472.1	614.6	284.4
Continuum of SUD Support	3	Recovery Residences per 100k	0.0	0.9	1.0
		Average Distance to Nearest SSP (miles)	36.8	N/A	N/A
		NA or SMART Meetings per 100	18.7	13.9	8.1
		Is there a Drug-Free Communities Coalition?	No	Yes	Yes
		Is there a Drug Court?	No	Yes	Yes
		State SUD Policy Environment Score (10=highest; 0=lowest)	4.0	4.0	N/A
Infrastructure and Social	3	One or More Vehicles	93.3%	92.8%	91.5%
		Broadband Access	82.0%	88.1%	85.2%
		Social Associations per 10k	12.2	9.6	8.7
		Severe Housing Cost Burden	12.3%	15.2%	13.0%

Grant County

Grant County received a Recovery Ecosystem score of 2 for SUD Treatment, 3 for Continuum of SUD Support, and 3 for Infrastructure and Social, suggesting a moderate recovery ecosystem. Compared to both Oregon and the United States, Coos County has more Substance Use Treatment Facilities, Buprenorphine providers, and Mental Health providers per 100,000 residents. Grant County reports no recovery residences, drug-free communities coalition, or drug courts. Most households in Grant County have at least one vehicle and broadband access. For every 10,000 residents, there are 9.8 social associations, similar to Oregon and the U.S.

Table 4: Grant County Recovery Ecosystem Index

Component	Score (out of 5)	Sub-Component	Grant County	Oregon	United States
SUD Treatment	2	Substance Use Treatment Facilities per 100k	13.9	5.1	4.3
		Buprenorphine Providers per 100k	27.9	21.1	15.2
		Average Distance to Nearest MAT Provider (miles)	68.1	N/A	N/A
		Mental Health Providers per 100k	418.2	614.6	284.4
Continuum of SUD Support	3	Recovery Residences per 100k	0.0	0.9	1.0
		Average Distance to Nearest SSP (miles)	88.9	N/A	N/A
		NA or SMART Meetings per 100	27.9	13.9	8.1
		Is there a Drug-Free Communities Coalition?	No	Yes	Yes
		Is there a Drug Court?	No	Yes	Yes
		State SUD Policy Environment Score (10=highest; 0=lowest)	4.0	4.0	N/A
Infrastructure	3	One or More Vehicles	97.1%	92.8%	91.5%

and Social	Broadband Access	80.2%	88.1%	85.2%
	Social Associations per 10k	9.8	9.6	8.7
	Severe Housing Cost Burden	14.3%	15.2%	13.0%

Harney County

Harney County received a Recovery Ecosystem score of 2 for SUD Treatment, 1 for Continuum of SUD Support, and 3 for Infrastructure and Social, suggesting a strong recovery ecosystem related to SUD treatment and Continuum of SUD Support. Compared to both Oregon and the United States, Harney County has more Substance Use Treatment Facilities and Mental Health providers per 100,000 residents. Harney County reports 13.7 recovery residences per 100,000 residents, no drug-free communities coalition, but the county does have drug courts. Most households in Grant County have at least one vehicle and broadband access. For every 10,000 residents, there are 9.6 social associations, a similar number to Oregon but higher than the U.S. Compared to the U.S. and Oregon, fewer Harney County residents experience severe housing cost burden.

Table 5: Harney County Recovery Ecosystem Index

Component	Score (out of 5)	Sub-Component	Harney County	Oregon	United States
SUD Treatment	2	Substance Use Treatment Facilities per 100k	27.4	5.1	4.3
		Buprenorphine Providers per 100k	13.7	21.1	15.2
		Average Distance to Nearest MAT Provider (miles)	102.9	N/A	N/A
		Mental Health Providers per 100k	670.3	614.6	284.4
Continuum of SUD Support	1	Recovery Residences per 100k	13.7	0.9	1.0
		Average Distance to Nearest SSP (miles)	139.7	N/A	N/A
		NA or SMART Meetings per 100	13.7	13.9	8.1
		Is there a Drug-Free Communities Coalition?	No	Yes	Yes
		Is there a Drug Court?	Yes	Yes	Yes
		State SUD Policy Environment Score (10=highest; 0=lowest)	4.0	4.0	N/A
Infrastructure and Social	3	One or More Vehicles	95.2%	92.8%	91.5%
		Broadband Access	80.7%	88.1%	85.2%
		Social Associations per 10k	9.6	9.6	8.7
		Severe Housing Cost Burden	9.4%	15.2%	13.0%

Josephine County

Josephine County received a Recovery Ecosystem score of 2 for SUD Treatment, 1 for Continuum of SUD Support, and 4 for Infrastructure and Social suggesting a strong recovery ecosystem related to SUD treatment and Continuum of SUD Support but weak Infrastructure

and Social. Compared to Oregon and the United States, Josephine County has more Substance Use Treatment Facilities and Mental Health providers per 100,000 residents but fewer buprenorphine providers. Josephine County reports 1.1 recovery residences per 100,000 residents, no drug-free communities coalition, but the county does have drug courts. Most households in Josephine County have at least one vehicle and broadband access. For every 10,000 residents there are 7.3 social associations, fewer than both Oregon and the U.S. Compared to the U.S. and Oregon, more Josephine County residents experience severe housing cost burden.

Table 6: Josephine County Recovery Ecosystem Index

Component	Score (out of 5)	Sub-Component	Josephine County	Oregon	United States
SUD Treatment	2	Substance Use Treatment Facilities per 100k	5.7	5.1	4.3
		Buprenorphine Providers per 100k	16.1	21.1	15.2
		Average Distance to Nearest MAT Provider (miles)	31.1	N/A	N/A
		Mental Health Providers per 100k	888.7	614.6	284.4
Continuum of SUD Support	1	Recovery Residences per 100k	1.1	0.9	1.0
		Average Distance to Nearest SSP (miles)	17.0	N/A	N/A
		NA or SMART Meetings per 100	27.6	13.9	8.1
		Is there a Drug-Free Communities Coalition?	No	Yes	Yes
		Is there a Drug Court?	Yes	Yes	Yes
		State SUD Policy Environment Score (10=highest; 0=lowest)	4.0	4.0	N/A
Infrastructure and Social	4	One or More Vehicles	94.7%	92.8%	91.5%
		Broadband Access	82.8%	88.1%	85.2%
		Social Associations per 10k	7.3	9.6	8.7
		Severe Housing Cost Burden	18.2%	15.2%	13.0%

Lane County

Lane County received a Recovery Ecosystem score of 1 for SUD Treatment, 2 for Continuum of SUD Support, and 4 for Infrastructure and Social, suggesting a strong recovery ecosystem related to SUD treatment and Continuum of SUD Support but weak Infrastructure and Social. Compared to both Oregon and the United States, Lane County has more Substance Use Treatment Facilities and Mental Health providers per 100,000 residents. Lane County reports 0.8 recovery residences per 100,000 residents, no drug-free communities coalition, but the county does have drug courts. Most households in Lane County have at least one vehicle and broadband access. For every 10,000 residents there are 9.5 social associations. Compared to the U.S. and Oregon, more Lane County residents experience severe housing cost burden.

Table 7: Lane County Recovery Ecosystem Index

Component	Score (out of 5)	Sub-Component	Lane County	Oregon	United States
SUD Treatment	1	Substance Use Treatment Facilities per 100k	5.3	5.1	4.3
		Buprenorphine Providers per 100k	17.5	21.1	15.2
		Average Distance to Nearest MAT Provider (miles)	18.7	N/A	N/A
		Mental Health Providers per 100k	981.6	614.6	284.4
Continuum of SUD Support	2	Recovery Residences per 100k	0.8	0.9	1.0
		Average Distance to Nearest SSP (miles)	20.9	N/A	N/A
		NA or SMART Meetings per 100	14.3	13.9	8.1
		Is there a Drug-Free Communities Coalition?	No	Yes	Yes
		Is there a Drug Court?	Yes	Yes	Yes
		State SUD Policy Environment Score (10=highest; 0=lowest)	4.0	4.0	N/A
Infrastructure and Social	4	One or More Vehicles	92.0%	92.8%	91.5%
		Broadband Access	87.9%	88.1%	85.2%
		Social Associations per 10k	9.5	9.6	8.7
		Severe Housing Cost Burden	17.6%	15.2%	13.0%

Lincoln County

Lincoln County received a Recovery Ecosystem score of 1 for SUD Treatment, 2 for Continuum of SUD Support, and 3 for Infrastructure and Social, suggesting a strong recovery ecosystem related to SUD treatment and Continuum of SUD Support. Compared to both Oregon and the United States, Lincoln County has more Substance Use Treatment Facilities, Buprenorphine, and Mental Health providers per 100,000 residents. Lincoln County reports no recovery residences or drug-free communities coalition, but the county does have drug courts. Most households in Lane County have at least one vehicle and broadband access. For every 10,000 residents, there are 9.1 social associations. Compared to the U.S., more Lincoln County residents experience a severe housing cost burden, however, this amount is slightly lower than the statewide percentage.

Table 8: Lincoln County Recovery Ecosystem Index

Component	Score (out of 5)	Sub-Component	Lincoln County	Oregon	United States
SUD Treatment	1	Substance Use Treatment Facilities per 100k	14.2	5.1	4.3
		Buprenorphine Providers per 100k	30.4	21.1	15.2
		Average Distance to Nearest MAT Provider (miles)	30.7	N/A	N/A
		Mental Health Providers per 100k	482.4	614.6	284.4
Continuum	2	Recovery Residences per 100k	0.0	0.9	1.0

of SUD Support		Average Distance to Nearest SSP (miles)	37.8	N/A	N/A
		NA or SMART Meetings per 100	26.3	13.9	8.1
		Is there a Drug-Free Communities Coalition?	No	Yes	Yes
		Is there a Drug Court?	Yes	Yes	Yes
		State SUD Policy Environment Score (10=highest; 0=lowest)	4.0	4.0	N/A
Infrastructure and Social	3	One or More Vehicles	94.0%	92.8%	91.5%
		Broadband Access	86.8%	88.1%	85.2%
		Social Associations per 10k	9.1	9.6	8.7
		Severe Housing Cost Burden	14.7%	15.2%	13.0%

Umatilla County

Umatilla County received a Recovery Ecosystem score of 2 for SUD Treatment, 1 for Continuum of SUD Support, and 3 for Infrastructure and Social suggesting a strong recovery ecosystem related to SUD treatment and Continuum of SUD Support. Compared to both Oregon and the United States, Umatilla County has more Substance Use Treatment Facilities but fewer Buprenorphine providers per 100,000 residents. Umatilla County reports 1.3 recovery residences per 100,000 residents, and no drug-free communities coalition, but the county does have drug courts. Most households in Lane County have at least one vehicle and broadband access. For every 10,000 residents there are 10 social associations. Compared to the U.S., fewer Umatilla County residents experience severe housing cost burden.

Table 9: Umatilla County Recovery Ecosystem Index

Component	Score (out of 5)	Sub-Component	Umatilla County	Oregon	United States
SUD Treatment	2	Substance Use Treatment Facilities per 100k	11.6	5.1	4.3
		Buprenorphine Providers per 100k	12.9	21.1	15.2
		Average Distance to Nearest MAT Provider (miles)	19.1	N/A	N/A
		Mental Health Providers per 100k	435.9	614.6	284.4
Continuum of SUD Support	1	Recovery Residences per 100k	1.3	0.9	1.0
		Average Distance to Nearest SSP (miles)	21.9	N/A	N/A
		NA or SMART Meetings per 100	29.7	13.9	8.1
		Is there a Drug-Free Communities Coalition?	No	Yes	Yes
		Is there a Drug Court?	Yes	Yes	Yes
		State SUD Policy Environment Score (10=highest; 0=lowest)	4.0	4.0	N/A
Infrastructure and Social	3	One or More Vehicles	94.1%	92.8%	91.5%
		Broadband Access	81.4%	88.1%	85.2%
		Social Associations per 10k	10	9.6	8.7
		Severe Housing Cost Burden	10.2%	15.2%	13.0%

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