Homelessness in Multnomah County - Background and Thoughts
Multnomah County Commissioner Sharon Meieran

Landscape of organizations/entities developing homeless policy and providing services
The following agencies and services are involved in serving and developing policy for the housing/homelessness continuum (this list isn't comprehensive, but describes some key players):

1. ***A Home For Everyone (AHFE)*** - An initiative created in 2014 to bring community together to end homelessness in Multnomah County. AHFE is led by an executive committee (EC) made up of elected officials from Portland, Multnomah County and Gresham, along with representation from Home Forward (formerly the Portland Housing Authority), service providers, the business community, and the faith and philanthropic communities. The EC works with a diverse coordinating board (CB) and several policy-focused work groups. Together, the EC and CB set priorities and make recommendations on policies and spending for Multnomah County's local housing and homelessness continuum of care.
2. ***Joint Office of Homeless Services (JOHS)*** - Established between Multnomah County and Portland in 2016 (and funded by both, in addition to state, federal and other grant funds), JOHS administers contracts for housing and homeless services, conducts one-night homeless street and shelter counts, manages systems of care, and oversees systems reporting and evaluation. JOHS operationalizes many of the priorities established by AHFE.
3. ***Multnomah County Health Department***, including ***Behavioral Health Division*** and ***Public Health Division*** - provides support and services related to mental health, substance use disorder, street behavioral health outreach and crisis response, broader community health, harm reduction (needle exchange, Narcan), public health crisis response, and more. JOHS and the BHD have partnered on a shelter in-reach behavioral health crisis team, development of a Behavioral Health Resource Center, and some transitional housing programs.
4. ***Portland Housing Bureau -*** develops citywide housing policy to increase the supply of affordable housing and promote housing stability, and administers a broad range of federal and local resources. PHB monitors the implementation of the 2016 Portland Housing Bond.
5. ***Homelessness and Urban Camping Impact Reduction Program (HUCIRP)*** (City of Portland) - coordinates cleanup of unsanctioned campsites on land owned by Portland and the Oregon Department of Transportation, coordinates services with other agencies and jurisdictions, and "creates service navigation opportunities for individuals experiencing homelessness while also facilitating the removal of hazardous items and debris from our public spaces." Toward these aims, HUCIRP also manages the City's *One Point of Contact* campsite reporting system.
6. ***Metro Housing Bond and Supportive Housing Services measures***

a. Housing Bond - a $652.8 million affordable housing bond measure passed in 2018 to create permanently affordable housing across greater Portland for seniors, working families, veterans and others.
b. Measure 26-210 - “Provides for the much-needed wraparound services to help reduce homelessness across greater Portland. The program provides services for as many as 5,000 people experiencing prolonged homelessness with complex disabilities, and as many as 10,000 households experiencing short-term homelessness or at risk of homelessness.”
    i. Each County is working to develop its own Local Implementation Plan (LIP), setting forth its system gaps and priorities for investment under the SHS measure. The LIP for Multnomah County was drafted by the Coordinating Board of AHFE, to be approved by AHFE’s Executive Committee, the Multnomah County Board of Commissioners, the Metro Oversight Committee, and finally the Metro Council.
    ii. Once the LIPs for the three regional counties are approved, they will be coordinated and then monitored by a Metro Oversight Committee.

There are two broad categories of people who experience homelessness (see ECO-NW study). In reality, these categories are somewhat artificial, and there are as many reasons for homelessness as there are people experiencing it. But the distinction is helpful for the purpose of conceptualizing the system. The two categories include:

1. People who do not have enough income to meet their housing cost burden, and may be one medical bill/car payment/job loss away from losing their housing. These individuals often need mainly rent assistance and physical housing, but may also need support services such as childcare, utility assistance, or job skills training;
2. People experiencing more “chronic” homelessness, including people experiencing serious mental illness, substance use disorder, or other serious disability, who need not only deeply affordable housing, but intensive supportive services to enable them to sustain that housing.

It is important to note that, if people who fall into the first “category” don’t have their needs met, many may be at risk of becoming chronically homeless.

General strategic approach to “ending homelessness”

Services in Multnomah County and the City of Portland are largely provided through a network of community-based organizations contracted through JOHS. Service priorities are shaped, in part, by guidance from AHFE, with an approach that drives toward three key aims: (1) Prevention of homelessness; (2) emergency shelter and safety on/off the streets; and (3) permanent housing.

In general, the best way to “solve” homelessness is by preventing it from happening in the first place. JOHS employs strategies such as emergency financial assistance to help with utility bills and other basic needs, long term rent assistance, and other mechanisms to prevent people from losing their homes. Shelter and emergency services are geared toward providing a safe place for people to stay while they get connected to services and, ideally, transition into permanent

housing. And permanent housing includes housing that is “deeply affordable” (accessible to households making 0-30% of median family income), “affordable” (accessible to households making 30-60% of median family income), and “supportive” (deeply affordable housing with wraparound services for people with severe underlying disabilities, including mental health and substance use disorder needs).

Allocation among these strategies is where tough budget choices must be made, because any resources expended on one of these strategies is unavailable to allocate to another strategy. For example, resources allocated to shelter will not be available to prevent a family from losing their apartment when they are unable to pay their utility bill.

Services directed to people who are chronically homeless/living unsheltered
Historically, approaches to people living unsheltered have focused on getting people indoors, into “traditional” shelters, and this is the model primarily adopted by JOHS. Traditional shelter has included congregate living spaces in a variety of settings (serving families, adults, women, veterans, couples, people escaping domestic violence, etc.), where the goal has been to transition people into permanent housing as quickly as possible. As permanent housing opportunities have become scarcer, people have been living longer and longer in shelters that were meant to offer safety during a brief stay as people transitioned out of the shelter. In addition, a few “alternative” models of shelter have been put in place, such as tiny home villages and sanctioned government encampments during Covid. However, a broader strategy of alternative approaches to shelter has traditionally not been considered by AHFE or JOHS. **I believe that it is essential that we adopt a more innovative approach and consider a broader continuum of alternative strategies urgently to address unsheltered homelessness as we strive toward longer term meaningful change and permanent housing solutions.**

One way I frame this approach is through a public health lens of **“harm reduction.”** Tragically, our region does not have the capacity to provide housing or even indoor shelter for everyone living on our streets. Therefore, the question we must urgently address is “How can we *minimize* the trauma, suffering, and public health and safety risks associated with unsheltered homelessness while we are working toward longer term solutions, given that people will continue to need to live outside?” This is a different framing of the issue than has traditionally been considered, but I believe that the evolving landscape in our County demands an expansion beyond traditional ways of thinking, and an urgency that to date has not manifested with regard to the local crisis of unsheltered homelessness.

In addition, there is still a siloing of many programs and services that I believe prevents a true coordination and integration of approaches that could meaningfully address unsheltered and chronic homelessness. For example, camp “cleanups” (often referred to as “sweeps”) are under the purview of the City through HUCIRP, while syringe exchange and disposal are implemented through the County via Public Health. Meanwhile, mental health and addiction services fall under a separate County Division of Behavioral Health, though a few scattered programs have been administered by the City. I believe there must be coordination and integration of these

systems (and more) within AHFE if we are to meaningfully address the challenging conditions facing those experiencing chronic homelessness.

Vision for a short term real-time alternative shelter continuum while we strive to end homelessness

I believe that we are facing a humanitarian crisis right now, and that it is unconscionable that people are living outside in conditions that are unhealthy, unsafe, and simply inhumane. Ultimately, we need a continuum of housing that meets people's needs, including the provision of wraparound services, but it will take years, if not decades, to reach this goal.

As we strive for long-term meaningful change, I believe we need a continuum of alternative places people can be if they cannot be housed and they cannot or do not wish to be in traditional shelter. For example, we (local government, in partnership with the faith, philanthropy, healthcare and business communities) could identify small, discreet, publicly owned open spaces in neighborhoods where 10-15 people living unsheltered could set up their tents, bring their belongings, and be assured that they would not be forced to leave in the near term. These "healthy cluster" sites would be accessible to transportation and services, but reasonably distanced from residences and businesses. Basic hygiene and sanitation stations would be provided, along with access to mobile showers and laundry. People would be assisted in getting to the sites, and then they could stay, so long as the sites were reasonably maintained. Other models - such as villages, larger sanctioned governed encampments, hygiene hubs, and parking lots where people could stay in their cars and RVs - could also contribute to a broader network of safer, healthier, more stable options for people experiencing unsheltered homelessness in the near term, while we work toward longer term solutions.

Rays of hope, including Metro Supportive Housing Services Measure

There are a number of things happening in Multnomah County and the region that give me hope that we can get to a place of meaningful change, though this change won't happen overnight. These include the Metro Supportive Housing Services Measure, along with a few additional individual programs and opportunities that can help fill some of the tremendous gaps in our systems of housing/homelessness and behavioral health.

1. ***Metro Supportive Housing Services Measure***

   Metro's Supportive Housing Services Measure was passed to address chronic homelessness in the region, particularly for people with significant disabilities including unique and profound behavioral health needs. 75% is to be allocated to supportive housing services and rent assistance for the chronically homeless population, and 25% is to be allocated to rent assistance and services that serve people at risk of becoming chronically homeless. Throughout the development of Multnomah County's Local Implementation Plan, I have advocated for prioritizing approaches that serve people experiencing chronic homelessness, and including metrics that capture this specific priority. I will continue to advocate for: (1) addressing the significant unmet needs for intensive behavioral health services; (2) prioritizing development and implementation of a strategy to urgently reduce harm and improve health, safety, and dignity for people

living unsheltered while we are working toward longer term permanent housing solutions; and (3) mechanisms for meaningful data collection, along with outcome measures and metrics that specifically demonstrate progress toward the goal of ending chronic homelessness. This ideally would include building out the infrastructure needed to collect data in an effective, centralized and coordinated way (including regional coordination), and providing a forward-facing dashboard that communicates progress to the public in real time.

2. ***Additional opportunities underway in the City, County and State:***
    - Behavioral Health Resource Center. This is currently being developed in Multnomah County, and will essentially serve as a "living room" and more for people with behavioral health needs living in shelters or outside. People will be able to come for respite, a cup of coffee, and being accepted for who they are, and they will have access to services if they want them, including things like group meetings, art therapy and music therapy, showers, laundry machines and bathrooms. The services will be peer-driven and will be culturally responsive. Right now there is nowhere for people experiencing serious behavioral health needs to go, or to be brought by law enforcement or healthcare workers or outreach providers, other than jail or an ER. This will be an alternative that supports people and meets their needs, so they can potentially avoid falling into crisis. It will also provide shelter for people with mental health needs, along with transitional housing for people leaving institutional settings such as the Oregon State Hospital, jail, or inpatient hospital units.

    - Portland Street Response. This is a City of Portland effort, led by Commissioner Hardesty. In our current system, if someone is living unsheltered and experiences a mental health crisis or other serious underlying mental health need, often the only potential response is through law enforcement. This can lead to escalation of the crisis, additional trauma, and is often not effective in addressing the needs of the person experiencing the crisis or the person who called for help. Through Portland Street Response, teams of EMTs, qualified mental health service providers and, ideally, peers will respond to these situations, rather than police officers.
        - Note that there are a number of existing outreach services provided by both the City of Portland and Multnomah County, operating under a number of different departments, agencies and divisions. A mapping of some of these services was accomplished through a "Sequential Intercept Model" and demonstrates a wide range of outreach services, with some prominent gaps in service. Examples of existing services include:
            - Cascadia Behavioral Healthcare Project Respond
                - Crisis outreach services
                - Shelter support team
            - Cascadia Street Outreach Team
            - Cascadia Behavioral Healthcare Urgent Walk-In Clinic

        - Portland Street Medicine
        - Portland Fire & Rescue Community Healthcare Assessment Team

- Behavioral Health Emergency Collaborative Network (BHECN). A facility co-located in a hospital that allows for the triage, evaluation and appropriate referral for people experiencing behavioral health crises. The facility will operate as a "hub," with a number of "spokes" connecting people in an effective and meaningful way with the services they need in real time. This facility will be complementary to the Behavioral Health Resource Center described above, providing a place for people to go, or be brought by family members, law enforcement, emergency medical services, or Portland Street Response, when they are experiencing a behavioral health crisis. It will also address the need for a "sobering center," but be much safer, trauma-informed and broad-based.

- A continuum of alternative shelter concepts, as I described above, under "Vision." These could contribute to a broader network of safer, healthier, more stable options for people experiencing unsheltered homelessness in the near term, while we work toward longer term solutions. Several new and expanding coalitions are working on these ideas, and I am in conversation with my colleagues at Multnomah County and the City of Portland to advance these concepts.

- Frequent User Systems Engagement (FUSE). This model recognizes that some of the people who are most vulnerable and most difficult to house are over-represented in multiple systems, including jails, homeless shelters and ERs. Through this approach, "data is used to identify a specific target population of high-need, high-cost individuals who are shared clients of multiple systems, and whose persistent cycling indicates the failure of traditional approaches. Data is also used to develop a new shared definition of success that takes into account both human and public costs, and where the focus is on avoiding institutions altogether and enable meaningful service provision and engagement, as opposed to simply offloading clients from one system to another."

- Work Group to Decriminalize Mental Illness, chaired by Judge Patrick Wolke and State Senator Floyd Prozanski. Much of Oregon's system of mental health care is governed by state policy, and it will require significant systems and statutory changes at the state level in order to make any headway in improving this dysfunctional system. One issue in particular that has broad implications for behavioral health treatment in general is the issue of "involuntary commitment." Currently, under Oregon statute and as interpreted by Oregon courts, people experiencing serious mental illness cannot receive medication or other treatment unless they affirmatively agree to that treatment, or they are at "imminent risk" of harming themselves or others. This statute has been narrowly interpreted to essentially mean that people cannot be involuntarily treated unless they have a

meaningful plan to immediately harm themselves or others. Unfortunately, as I have seen firsthand as an emergency physician, in some situations people may simply not have the capacity to make decisions regarding their own health or safety, but can still pose serious risks, including putting their own and others' lives at risk. The Workgroup to Decriminalize Mental Illness is considering ways to potentially address these issues. It is a difficult conversation, but one we need to have openly and transparently so we can devise a continuum of least restrictive approaches, with the services, supports and structures in place so people can engage how they want and need.