



**Programmatic and Fiscal Inventory of Primary
Prevention Services in Oregon
In Accordance with House Bill 3321 (2025), Section 1**

Prepared on behalf of:

The Oregon Alcohol and Drug Policy Commission

By

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Executive Summary

House Bill 3321 (2025) directed the Oregon Alcohol and Drug Policy Commission (ADPC) to account for youth-focused primary substance use prevention in Oregon: what programs exist, what the state spends, who does the work, and what should change. The ADPC and the Oregon Health Authority (OHA) selected Third Horizon to carry out the analysis. Primary prevention means the practices, programs, and policies designed to prevent, delay, and reduce youth substance use before a substance use disorder develops. It is not treatment, harm reduction, or recovery support. The assessment covers the 2023–25 biennium with a forward look at 2025–27 and draws on four statewide surveys (65 school districts, 109 provider organizations, 101 members of the prevention workforce, and nine colleges and universities), 21 interviews, a school focus group, and more than 500 agency documents and contracts.

THE CENTRAL FINDING

Less than 3 percent of Oregon's substance use spending reaches community-based primary prevention.

\$31.2M

verified as primary prevention
funding, 2023–25

\$18.2M

stays inside state
government, four-fifths of it
OLCC alcohol retail regulation

\$13.0M

reaches communities as
prevention services

Third Horizon verified \$31.2 million in funding as primary prevention. Of that \$31.2 million, \$18.2 million stays inside state government, four-fifths of it the Oregon Liquor and Cannabis Commission's estimated staff time for alcohol retail regulation, which is genuine prevention work but does not fund services in communities. The remaining \$13.0 million reaches communities. Measured against everything Oregon spends on substance use services of any kind, less than 3 percent supports community-based primary prevention.

This matters because prevention is the highest-return investment in the continuum. Primary prevention returns as much as \$63 for every dollar spent, against \$4 to \$7 for treatment.

Oregon carries a heavier burden than most states: 20.8 percent of residents aged 12 and older met criteria for a substance use disorder in 2023–24, against 16.9 percent nationally. Youth use has fallen across every substance measured since 2022, but adolescent overdose deaths more

than tripled after 2019, faster than in any other state, and about a third of 8th graders and nearly half of 11th graders still see little or no risk in regular cannabis use.

What the funding looks like

Oregon has no dedicated, recurring fund for primary prevention. The money arrives as many small streams, each with its own rules, cycle, and reporting, and is blended before it reaches a service, rather than braided in a way that can be traced, meaning that certain funding sources could not be traced to ground during the analysis. The one dedicated source is the 20 percent primary prevention set-aside in the federal Substance Use Prevention, Treatment, and Recovery Services block grant, about \$4.3 million a year. Oregon meets that floor exactly; nine other states go above it, Rhode Island at nearly 40 percent. The \$13.7 million opioid settlement commitment to prevention is the largest dedicated infusion on record, and under current allocations it must be spent by mid-2027 with no renewal committed. Tobacco prevention grants to local public health authorities totaled \$19.7 million in a single award year, roughly twice what the entire county alcohol and drug prevention system receives in a biennium, but state law restricts those funds to tobacco. Though tobacco prevention and control work were not included in this report given this limitation, the delta reflects a gap in investment in non-tobacco related financing. Communities are filling the gap themselves: of \$33.8 million that responding organizations reported, \$15.9 million, or 47 percent, came from local, federal, health plan, and philanthropic sources that no state financial report captures.

What the system looks like on the ground



The assessment documented 265 primary prevention programs. Only 41 use a recognized or branded curriculum; the rest is locally defined work, including 37 innovative or grassroots practices that communities built themselves. Every county has at least one program, but no region has a complete system: Clackamas County alone documents more programs than all nine frontier counties combined. Delivery is overwhelmingly universal. Counties coded 85 percent of their reported activities as universal, 12 percent as selected, and 3 percent as indicated, which means the young people at highest risk have the least access to services matched to that risk. Schools have carried a prevention planning mandate since 1989, yet only 19 of 65 responding districts have a completed plan, and the Department of Education's identifiable prevention budget for the biennium is one coordinator position and a one-time campaign. The workforce is small and thinly spread: 48 people hold an active Certified Prevention Specialist credential

statewide, 14 counties have none, and five specialists cover all of Eastern Oregon. Finally, the data needed to target investment is limited. Only 12 percent of students answered the 30-day alcohol question on the 2025 Student Health Survey, against 99.5 percent for the survey's first question, so county-level comparisons cannot be made reliably.

Findings and recommendations at a glance

What the assessment found	What the report recommends
Less than 3 percent of Oregon's substance use spending reaches community-based primary prevention, and there is no dedicated, recurring source for it.	Set a goal of raising community-based primary prevention to at least 20 percent of substance use funding over time, without reducing treatment, recovery, or harm reduction. Create a dedicated prevention fund from distilled spirits proceeds, commit a fixed share of flexible funds to prevention, and use more of the federal SPTRS block grant than the 20 percent minimum.
Oregon has no single definition of primary prevention in use across the system, and providers apply the term inconsistently.	Codify the HB 3321 definition in statute, together with the six CSAP prevention strategies and the universal, selected, and indicated framework, and require funded agencies, schools, and organizations to use it. HB 3321 sunsets on January 2, 2027.
Prevention reaches every county, but no region has a complete system. Programs, staff, and money are siloed and inconsistently organized.	Consolidate prevention coordination into a single regional primary prevention system in each region, with unified staffing, workplans, contracts, and reporting.
Prevention is overwhelmingly universal. Youth already showing higher risk have the least access to services matched to that risk.	Expand selected and indicated prevention statewide, give public awareness campaigns a youth focus, and stand up a well-financed central resource for training, technical assistance, and data.
Schools carry a prevention mandate that dates to 1989 with almost no money behind it, and most districts pay for it out of general funds.	Direct funding to school districts for prevention planning, delivery, and reporting, including use of Medicaid to Schools.
The specialized prevention workforce is thin, and made up of professionals with a diverse variety of credentials, including but not limited to the Certified Prevention Specialist (CPS).	Continue growing the Certified Prevention Specialist workforce and build a core competency framework that maps the other credentials already delivering prevention to a common standard.

What the assessment found	What the report recommends
Prevention dollars cannot be traced from source to service, and youth substance use data access is not reliable enough for local planning.	Give the ADPC both advance and after-the-fact review of substance use spending plans, adopt a traceable braiding method for contracts and reporting, and fix youth substance use data sharing infrastructure to make usable data more accessible.

Oregon’s primary prevention field is committed and inventive, and it is working without a definition, a dedicated funding base, a regional structure, a sized workforce, or usable local data. The recommendations above are designed to be taken together: a codified definition makes funding traceable, traceable funding makes a regional structure accountable, and a regional structure gives the workforce somewhere to grow. Acting on them would let Oregon reduce the burden of substance use while supporting young people toward healthy lives.

Introduction

In 2025, the Oregon Legislature passed [House Bill 3321 \(HB 3321\)](#), directing the Oregon Alcohol and Drug Policy Commission (ADPC) to conduct a strategic financial and programmatic review of youth focused primary substance use prevention in Oregon. Following a competitive procurement led by the ADPC and the Oregon Health Authority (OHA), Third Horizon, a national health care and health analytics advisory firm, was selected to carry out the analysis as directed in the statute.

This report provides a financial and programmatic accounting of primary prevention as HB 3321 defines it, while elevating and resolving, to the extent possible, accounting and programmatic inventory for services that may fit prevention definitions that fall outside of the specific definition utilized in HB3321. The report documents the funding that supports primary substance use prevention across local, regional, state, and federal sources, the approaches communities are implementing, and the status and needs of the prevention workforce. It closes with recommendations for regulators, policymakers, and funders to address gaps services, supports and financing of primary prevention.

Defining Primary Prevention

In the simplest terms, primary substance use prevention (which will be referred to as “primary prevention” throughout the report) is defined as *practices, programs, and policies designed to prevent, delay, and reduce the incidence and prevalence of youth substance use*. While most primary prevention activities are geared towards children and adolescents, there are proven programs and practices that can prevent substance use across the lifespan.

However, primary prevention services are not directed at individuals who have a clinically diagnosed substance use disorder – for those individuals, harm reduction, treatment and

recovery supports are critical parts of the continuum of care. While the term “prevention” can appear across social services, such as “overdose prevention” or “prevention of child abuse” – both examples connected to substance use consequences in communities- these are not the same as youth focused primary substance use prevention, which is the focus of this report.

Within this basic primary prevention context, researchers, public health leaders and state and federal agencies have developed several definitions and frameworks that further encapsulate what constitutes primary substance use prevention efforts. At the root of these are two frameworks that are particularly relevant in understanding the delivery of primary substance use prevention services in Oregon as presented in this report.

[The Center for Substance Abuse Prevention \(CSAP\)](#) defines the six strategies through which prevention is delivered. Effective programs developed to prevent youth substance use involve the use of one or more of these strategies:

- **Information Dissemination:** providing information through one-way communications efforts, such as informational brochures, media campaigns, or public presentations
- **Education:** delivering coaching, curricula, and programs to an audience that builds life skills, decision-making, and refusal techniques to reduce the likelihood of use.
- **Alternatives:** expanding the availability of pro-social, community-building, and recreational activities that do not involve substances.
- **Community-Based Processes:** building collaborative coalitions and groups that bring together youth and adults across the community to address root causes and improve the resiliency of individuals, families, and communities
- **Environmental Strategies:** Changes to written or unwritten community standards, regulations, and policies that reduce access to and appeal of substance use
- **Problem Identification and Referral:** supporting structures, programs, and services that can identify early signs of risk for substance use or early problem use and connecting those in need to specialized interventions to prevent the onset of a clinical SUD.

The National Academy of Medicine (formerly the Institute of Medicine) further categorizes specific activities and programs based on the population they are intended to serve:

- **Universal strategies** are those that seek to influence the general population in a community. The most common examples would be broad policies, age-restricting legal substances to adults, universal screening for substance use during well-child visits for adolescents, or mass media/marketing campaigns to encourage being substance-free.
- **Selected strategies** are those that focus on a subset of the population that is known to be at higher risk of engaging in substance use or developing a clinical disorder. Examples here can include culturally responsive programs focused on a population with disproportionately higher rates of substance use disorder than the general public, or children in families with a parent or other family member with a substance use disorder.

- **Indicated strategies** are those that focus on individuals who are experiencing negative consequences because of their substance use but do not meet the clinical criteria for a SUD diagnosis. These programs could include juvenile diversion programs for youth who encounter the justice system due to drug possession charges, or support and reintegration strategies for youth who violate a school's substance use-related codes of conduct.

How Primary Substance Use Prevention Works

Taken together, primary prevention programs, policies, and strategies work to address risk and protective factors that can increase or decrease risk for the onset of substance use as well as other risk behaviors and health challenges.

Risk factors are conditions, characteristics, or experiences that increase the probability that a person will engage in risky behavior, such as substance use. Protective factors are conditions that decrease the probability, or that buffer a person against risk they are already exposed to. The framework comes from developmental epidemiology, most directly from Hawkins, Catalano, and Miller's [1992 synthesis](#), and it treats substance use the way public health treats other health outcomes: as the result of accumulated exposure rather than a single cause. Factors are organized across five domains: individual, family, peer, school, and community/society. Their influence shifts with the developmental stage. Table 1 provides an overview of the risk and protective factors.

Table 1. Risk and Protective Factors

Domain	RISK FACTORS Increase the probability of substance use	PROTECTIVE FACTORS Reduce probability or buffer against risk
Individual	• Early first use of alcohol or other drugs • Impulsivity and sensation-seeking • Untreated mental health conditions • Favorable personal attitudes toward use • Conduct problems in childhood • Genetic predisposition and family history	• Social and emotional competence • Self-regulation and coping skills • Sense of purpose and future orientation • Personal disapproval of substance use • Accurate perception of peer norms
Family	• Parental substance use • Permissive parental attitudes toward use • Inconsistent or harsh family management • High family conflict and low parent-child attachment • Adverse childhood experiences (ACEs), including abuse, neglect, household instability, and parental incarceration	• Stable bond with at least one caring adult • Clear, consistently enforced family rules • Parental monitoring and supervision • Open parent-child communication • Clear family disapproval of use

Programmatic and Fiscal Inventory of Primary Prevention Services in Oregon

Peer	• Friends who use substances • Perceived peer approval of use • Peer rejection or social isolation • Association with older, using peers	• Friends who do not use substances • Prosocial peer group membership • Positive peer leadership roles • Peer norms that discourage use
School	• Academic failure beginning in late elementary grades • Low commitment to school • Chronic absenteeism • Exclusionary discipline	• School connectedness and belonging • Meaningful opportunities to participate • Recognition for that participation • Supportive relationships with teachers
Community and society	• Easy retail and social availability of substances • Low perceived risk of harm • Permissive local norms and marketing exposure • Poverty, housing instability, and community disinvestment • Community disorganization and low neighborhood attachment • Racism, discrimination, and historical trauma	• Opportunities for prosocial involvement • Access to health care and behavioral health services • Safe recreation and youth spaces • Cultural connection and cultural identity • Effective policy: pricing, age restrictions, retail density limits, and enforcement

Framework: Hawkins, Catalano and Miller (1992) social development model ¹; SAMHSA and NIDA prevention guidance. Aligned to the Institute of Medicine prevention continuum and the CSAP strategies applied in the HB 3321 assessment. Factor lists are illustrative of the established prevention science literature and are not Oregon-specific findings.

Given the diversity of risk and protective factors that can impact risk for substance use and its associated individual and societal consequences, there is no “single” primary prevention program or strategy that can fully prevent the onset of use or eliminate risk. Like other chronic, relapsing conditions such as heart disease, type II diabetes, or cancer, prevention of substance use disorder requires a comprehensive public health approach, bringing together a suite of interventions at the individual, community, and institutional levels, to foster prevention-oriented environments and services that support individuals and families across the lifespan.

Efforts to increase protective factors and reduce risk factors can include interventions that carry benefits beyond the prevention of substance use. Stable housing, access to after-school programming, arts or athletic activities, and early childhood supports all can contribute to addressing risk and protective factors, fostering substance-free environments while reducing toxic stress and other challenges that can negatively impact the health and wellbeing of youth.

However, while vital components of a collective strategy, these examples are not implemented with the primary goal of preventing substance use. Rather, their impact on substance use is one

of several benefits such interventions have. This can make conceptualizing what constitutes a primary substance use prevention program, policy, or practice hard to identify, making it challenging for communities, policymakers, and organizations to ascertain the extent to which there are sufficiently focused primary substance use prevention efforts underway in their communities. This confusion can be furthered in a fiscal context, where there are very few funding sources at the local, state, or national level that are specifically designed to invest in primary substance use prevention – making it difficult to assess the extent to which primary prevention efforts are adequately funded.

To meet the requirements of HB3321, this analysis will focus on programs, policies, strategies, and financing where the prevention of youth substance use is the primary stated goal. This approach is not to suggest that other preventative efforts and financing do not play a role. On the contrary, safe and affordable housing, early childhood care and support, access to appropriate educational pathways, after-school programming, and other public health approaches are vital to fostering youth resiliency and reducing substance use. However, to assess the extent to which Oregon’s communities are resourced to deliver primary youth substance use prevention efforts as defined by HB3321, a focus on services, supports, and financing that is specifically focused on primary substance use prevention is warranted.

Legislative and Policy Context

With this background in mind, the analysis presented here is grounded in the legislative mandate calling for this study, alongside endorsed frameworks adopted by the Oregon Alcohol and Drug Policy Commission.

The Mandate: House Bill 3321 (2025)

[HB 3321](#) directs the ADPC, among other things, to conduct a financial and programmatic analysis of Oregon’s primary substance use prevention system and to report its conclusions to the Legislature. The law sets three tasks: a complete inventory and assessment of the primary prevention programs operating statewide; a financial accounting of what Oregon spends on primary prevention and where those funds originate; and a set of findings and recommendations for the Legislative Assembly’s health committees.²

HB 3321 includes the definition of primary prevention referenced earlier: “practices, programs, and policies designed to prevent, delay, and reduce the incidence and prevalence of youth substance use.” Further, the legislation includes the classification framework created by the National Academy of Medicine as previously referenced (Universal, Selected, and Indicated strategies).

The Alcohol and Drug Policy Commission (ADPC)

The [ADPC](#) is an independent state agency charged with improving access to evidence-based and culturally responsive substance use prevention, treatment, and recovery services across Oregon. It works in partnership with OHA and other state agencies. The Commission operates through committees aligned to the continuum of care: Prevention, Health and Safety Interventions,

Treatment, and Recovery. It co-leads the Oregon Youth Addiction Alliance (OYAA) with the Oregon System of Care Advisory Council (SOCAC) to align youth-focused supports. Its Prevention Committee served as the standing advisory body for this assessment and shaped the scope, the operational definition of primary prevention, and the analytic approach.

In 2025, the Commission adopted its 2026–2030 Comprehensive Plan, [*Opening Doors: Achieving Access, Belonging, and Connection Across Oregon*](#). The plan sets three goals: reducing the prevalence of substance use and substance use disorder, reducing deaths related to substance use, and reducing disparities related to substance use.³

Specific to primary prevention, the comprehensive plan calls for trauma-informed, community-embedded, and culturally responsive strategies across five domains:

- Strengthen regulatory and fiscal strategies to bolster primary prevention services.
- Establish a “Prevention Center of Excellence” to expand the implementation of best practices and support the growth of the primary prevention workforce.
- Expand access to primary prevention activities in K-12 schools.
- Expand access to primary prevention programs and strategies on college campuses.
- Expand community-based prevention efforts focused on children, youth, transition-aged youth/young adults, and families.

HB3321 directive for the analysis in this report furthers the prevention goals of the ADPC, and the ADPC Prevention Committee and leadership have participated heavily in advising on this report.

Oregon’s Substance Use Landscape

Substance use in Oregon relative to the nation

Oregon’s rate of substance use disorder (SUD) sits well above the national average. In the [*2023–2024 National Survey on Drug Use and Health \(NSDUH\)*](#), roughly 20.8% of Oregonians aged 12 and older met criteria for a past-year SUD, compared with 16.9% nationally. That figure represents more than one in five residents.⁴ Oregon exceeds the national figure on nearly every substance measured: past-year cannabis use (31.3% versus 22.0%), past-month illicit drug use (24.6% versus 16.8%), and alcohol use disorder (11.7% versus 9.9%).

Oregon has long ranked near the top nationally for substance use prevalence and near the bottom for treatment access. Recent changes in federal survey methods have made precise state rankings less reliable, but surveillance continues to indicate a persistent treatment gap. In 2024, roughly four of every five Oregonians who needed SUD treatment did not receive it (81.1%), essentially matching the national figure of 80.7%. This report uses SAMHSA’s 2023–2024 state estimates, released in December 2025. Because the 2024 NSDUH questionnaire redesign creates a break in comparability with earlier years, these figures should not be compared directly with Oregon estimates from 2022–2023 or earlier.

Table 2. Oregon versus national substance use, ages 12+ (NSDUH, 2023–2024)

Measure (past year unless noted)	Oregon	United States
Any substance use disorder	20.8%	16.9%
Cannabis use	31.3%	22.0%
Illicit drug use (past month)	24.6%	16.8%
Alcohol use disorder	11.7%	9.9%
Needed treatment but did not receive it	81.1%	80.7%

Note: SAMHSA NSDUH model-based state prevalence tables, 2023–2024; national figures are the “Total U.S.” row of the same tables. Treatment-gap figures are 2024 annual estimates; all others are 2023–2024 annual averages.

Substance use among youth

Self-reported youth substance use is falling. Table 3 shows that between the 2022 and 2024 [Oregon Student Health Surveys \(SHS\)](#), the statewide survey of 6th, 8th, and 11th graders that replaced Oregon Healthy Teens in 2020, past-30-day use declined across every substance measured and across all grade levels, extending a longer trend down from the pre-pandemic peak, when 11th-grade cannabis use sat near 20% in 2019.^{5 6} The same survey points to protective strengths the prevention system can build on: 85% of students report a safe place or person to turn to, and 77% report a caring adult at school.⁵

Table 3. Oregon youth past-30-day use, Student Health Survey (statewide)

Substance (past 30-day)	Grade	2022	2024	Change
Alcohol	8th	5.9%	4.8%	▼
Alcohol	11th	16.6%	13.2%	▼
Cannabis	8th	3.1%	2.3%	▼
Cannabis	11th	12.0%	9.6%	▼
Nicotine vaping	8th	4.7%	4.1%	▼
Nicotine vaping	11th	10.8%	8.9%	▼
Rx opioid misuse	8th	0.9%	0.5%	▼
Rx opioid misuse	11th	0.9%	0.5%	▼

Note: The 2020 SHS was collected during pandemic school disruption and is not a reliable comparison year; 2025 SHS results were not yet published as of July 2026. The 2024 survey moved online, so year-over-year comparisons are directional.

Two youth risk factors run counter to that progress. Perceived risk remains low: about 32% of 8th graders and 45% of 11th graders see little or no risk in regular cannabis use, even as product potency has climbed from historic levels near 4–7% tetrahydrocannabinol (THC) to 25–35% or higher, so the risk each user carries rises as use falls.⁷ And fentanyl has made the drug supply far more lethal, with Oregon’s adolescent overdose deaths more than tripling after 2019, faster than in any other state.⁸ Among Oregon youth and young adults, fentanyl drove 83% of 2024 overdose deaths, down from 2023, while methamphetamine-involved deaths rose to 47%; a bystander was present in most fatal youth overdoses.⁹

Among 12–17-year-olds, stimulant use rates sit below 0.3% and near national levels, so the stimulant gap opens after adolescence rather than during it.

Substance use among young adults

HB 3321 names transition-aged youth and young adults as a distinct population for prevention investment, alongside children, youth, and families, and separately directs attention to prevention on college campuses.

Young adults aged 18–25 carry Oregon’s heaviest use burden. Among adolescents aged 12–17, roughly 10.2% met SUD criteria, above the national 8.1%. Alcohol remains the substance Oregon youth use most, though cannabis, legal for adults in Oregon, is a significant and growing concern.⁴ About 32.0% reported a past-year SUD, and 43.3% used cannabis, both well above the national rates of 26.5% and 35.8%. Stimulant use is less common than alcohol or cannabis but concentrates in the young-adult years: 5.7% of Oregonians aged 18–25 reported past-year cocaine use, against 2.7% nationally, and 0.5% reported methamphetamine use, against 0.4%.⁴

Upstream drivers

Substance use tracks closely with the conditions in which people grow up and live. Oregon reports the highest prevalence of adverse childhood experiences (ACEs) of any state, with 22.7% of adults reporting four or more, and the relationship between ACEs and later substance use follows a steep dose-response curve in which each additional adverse experience meaningfully raises the odds of a future disorder.¹⁰ Housing instability compounds that risk: Oregon’s 2024 point-in-time count found 22,875 people experiencing homelessness, up nearly 14% year over year, the eighth-largest homeless population in the nation, and among the highest per capita.¹¹ Housing loss and substance use reinforce each other in both directions. These pressures concentrate among Oregonians in poverty, about 12% of residents. The families exposed to trauma, instability, and economic stress are the families most likely to enter the systems downstream.

Relative to risk and protective factors, Oregon has measurable protective strength in place. In the Oregon Student Health Survey, 85% of students reported a safe place or person to turn to and

77% reported a caring adult at school. This provides a strong foundation upon which Oregon communities can build upon through primary prevention efforts.

The downstream toll

Unaddressed risk surfaces later as measurable harm across Oregon’s mortality, health, justice, child welfare, and education systems, and the cost falls heavily on the public. Table 4 sets out the mortality, acute-care, and public-cost side of that toll. The human cost appears early in the systems that serve children and young people. Substance use disorder is pervasive among justice-involved youth: Oregon Youth Authority (OYA) risk-needs assessment data show a history of regular drug or alcohol use for 74% of male and 80% of female youth under OYA supervision, and a diagnosed mental health disorder for 63% of male and 83% of female youth.¹² Among adults, 63% of the roughly 12,300 people in Oregon Department of Corrections custody in 2025 had a substance use issue. Oregon also recriminalized some drug possession in September 2024, after which statewide drug arrests rose about 20% the following year. In education, Oregon reached a record four-year graduation rate of 83% in 2024–25, with dropout down to 2.9%, but the state still trails the national average of roughly 86%, and chronic absenteeism of 33.5% remains among the highest in the country, the clearest early-warning signal for the disengagement that precedes both dropout and use.^{13,14} In child welfare, caregiver drug use was a factor in 48.6% of foster-care removals in federal fiscal year 2024, and parental substance use was the single most common stress factor, present in about 40% of founded abuse cases.¹⁵

Table 4. Mortality, acute care, and public cost of substance use in Oregon

Domain	Indicator	Figure
Mortality	Drug overdose deaths	1,544 (2024), down from 1,833 (2023)
Mortality	Alcohol-attributable deaths	more than 2,500 per year (about six per day)
Health system	Overdose-related emergency department (ED) visits	11,125 in 2023 (a record high); down 13.2% in 2024
Economic	Cost of excessive alcohol use (2019)	\$4.8 billion (lost productivity 46%; justice and motor vehicle 27%; health care 15%)
Justice	Cost per adult in custody	~\$42,664 per year

Sources: OHA 2025 Oregon Opioid Overdose Report 18; Centers for Disease Control and Prevention / National Center for Health Statistics (CDC/NCHS) overdose mortality 18; Trust for America’s Health 16; OHA/ECONorthwest Alcohol Harms interim report 17; and Oregon Department of Corrections (cost per adult in custody).

Drug overdose deaths rose from roughly 1,383 in 2022 to 1,833 in 2023, a near-33% jump, and Oregon’s death rate increased about 31% over the same period, the second-fastest rise in the nation behind only Alaska.^{18,19} Fentanyl was involved in roughly 71% of 2023 deaths⁸. Deaths then

fell about 16% in 2024, the first decline since 2016, though the rate remains well above the national average, with fentanyl and methamphetamine involved in more than 90% of deaths.²⁰

Provisional data show the decline continued into 2025, when Oregon overdose deaths fell a further 20.8% for the year ending September 2025²¹; fentanyl was present in 68.7% of the state's 2025 overdose deaths, methamphetamine in 65.6%, and both together in 44%²².

Methamphetamine now rivals fentanyl as a driver of harm, appearing in a larger share of 2025 drug seizures than fentanyl, and stimulant-and-opioid combinations account for just over half of the state's overdose deaths²³.

American Indian and Alaska Native communities are identified as a population of focus in Oregon's overdose-prevention work, and the data reviewed document pronounced disparities. State agency reporting states that overdose "disparities continue to worsen for Oregon's American Indian/Alaska Native and Black communities," places American Indian and Alaska Native residents among those experiencing the highest overdose death rates, and identifies Tribal communities as disproportionately affected by both the overdose crisis and the broader harms associated with drug-policy enforcement. American Indian and Alaska Native Oregonians died from overdose at 110 per 100,000 in 2023, against 43 per 100,000 statewide, roughly two and a half times the rate²⁴.

The case for primary prevention

Primary prevention is a high-return investment. Cost-benefit work compiled for the ADPC, drawing on the Washington State Institute for Public Policy, shows that well-implemented prevention returns far more than it costs. The National Institute on Drug Abuse estimates that treatment returns \$4 to \$7 per dollar in reduced crime and justice costs, and up to about \$12 once health and productivity gains are counted.^{25 26} However, compared to the return on investment for treatment, investment in primary prevention demonstrated far larger economic return, as Table 5 sets out.

Table 5. Return on investment for prevention and treatment (benefit per \$1 invested)

Program / approach	Return per \$1 invested
Good Behavior Game <i>school-based</i>	~\$63
Communities That Care <i>community prevention</i>	~\$12.88
Nurse–Family Partnership <i>early childhood</i>	~\$2.88
SUD treatment <i>justice-cost savings</i>	\$4 to \$7

Program / approach	Return per \$1 invested
SUD treatment <i>incl. health & productivity</i>	up to ~\$12
Comprehensive tobacco prevention	>\$5

The ADPC’s 2023–25 substance use disorder financial assessment found that of roughly \$1.5 billion in SUD spending across eleven state agencies, \$39.1 million, or 2.6%, went to primary prevention, while treatment accounted for 73% of the total.²⁷ Annual alcohol and drug prevention funding distributed across the 36 counties and nine Tribes was reported as roughly \$10.1 million, and Oregon’s own programs show what sustained investment returns: the state’s Juvenile Crime Prevention program recorded recidivism of 39% against 75% predicted among high-risk youth, with school dropout down 62% and effects sustained at 36 months. The Financial Analysis that follows examines these figures in detail while conducting further vetting of prevention financing in alignment with HB3321 requirements.

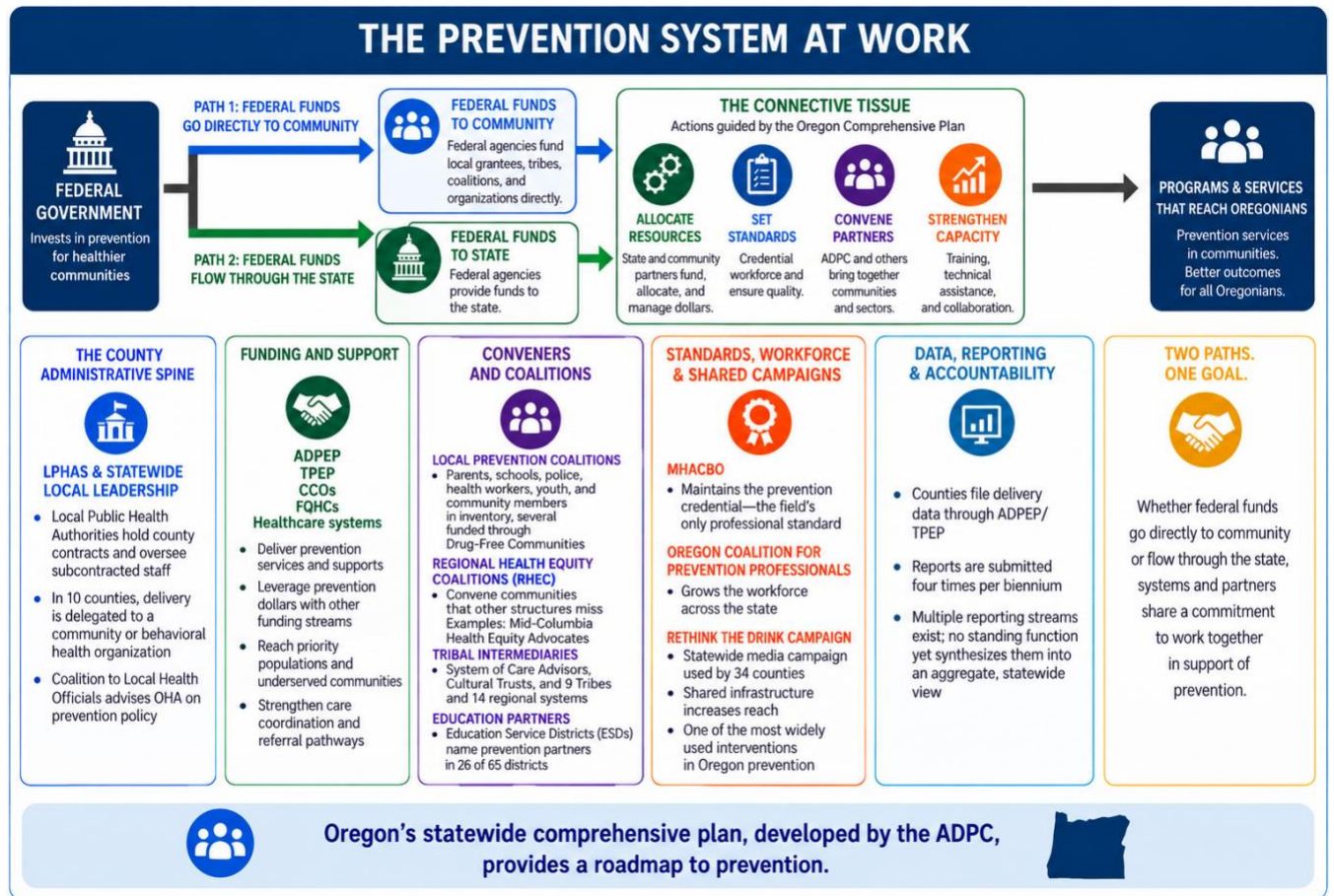
Prevention Infrastructure in Oregon

Oregon’s primary prevention system starts with federal and state policies and financing that drive service delivery. This report follows that flow: from federal and state regulations and funding down to the programs delivered in schools and communities across Oregon.

While community-based organizations do receive direct funding from federal and state agencies to deliver primary prevention services, Oregon also leverages a layer of organizations and arrangements that move funding, establish expectations, convene partners, certify or strengthen the workforce, and collect information. These intermediaries may not appear as individual “programs,” but they form much of the infrastructure through which prevention is organized and delivered.

Figure 1 illustrates how prevention works in Oregon. It starts with federal and state funding that moves through the organizations that plan, coordinate, and support prevention work in local communities.

Figure 1: Prevention System Map



As the figure represents, there are several Infrastructure elements that serve as a potential bridge between community programming, cross-sector engagement and planning, financing, contracting and reporting. These intermediaries represent vehicles that receive and disperse prevention funding, supporting program and strategy delivery at the local level alongside community partners.

Alcohol and Drug Prevention and Education Programs. Exist in every county in Oregon, with the goal of preventing alcohol, tobacco, and other drug use and associated effects across the lifespan. They coordinate and implement primary prevention programs and receive funding that can support community-based efforts. ADPEP programs can be operated by county government, sometimes through County Public Health departments or County Behavioral Health, or, in some instances, via contracts with community-based organizations to serve this function.

Tobacco Prevention and Education Programs. Provide similar efforts that are tobacco-focused, leveraging Tobacco Prevention and Control Funding. They may share operating infrastructure with ADPEPs, but more often exist as separate entities within County/Local Public Health Agencies (LPHAs). While the methodology of this study limits review of the full suite of TPEP programs, it represents an existing piece of the infrastructure with degrees of relevance that

warrant inclusion in understanding the broad systems that finance, support, and deliver primary substance use prevention programs in Oregon.

Beyond these elements of infrastructure, primary prevention services are delivered and supported in several community settings, including schools, community-based organizations, and state and local government. To meet the objectives of HB3321, Third Horizon set about the analysis included in this report to ensure capture of the current fiscal and programmatic landscape at all levels of Oregon's communities.

Methodology

How the Assessment Was Conducted

Third Horizon designed this assessment based on the directives of HB3321. While this section of the report provides an overview of the analysis process, methods, and limitations, a more robust technical methods overview is provided in the report appendix.

What the assessment covered

Third Horizon focused this assessment on investments, systems, programs and activities where the prevention of substance use, as defined by the statute, is a stated, explicit goal, and directly aligned with the definitions and qualities outlined in HB3321. To capture the methods of impact programs and financial investments deployed to achieve the goal of preventing substance use, Third Horizon also used alignment with the six CSAP Strategies to validate program inclusion. Where an investment, system or activity was not entirely aligned with the statutory definition, it was reviewed against generally understood best practices in substance use prevention. Work that has a secondary benefit of preventing substance use without that as its primary goal, services for people already experiencing a clinical substance use disorder, and programming serving a broad public health or wellbeing purpose not tied to substance use were labeled prevention-adjacent rather than primary prevention. They are listed in Appendix B, so the full prevention landscape is visible, but they are not counted in the program analysis. Examples include harm reduction and related safety efforts, naloxone distribution and overdose response, treatment, and recovery support services.

There are two specific investment and program types that are represented in the report, with some limitations.

Tobacco Prevention: Oregon has one of the most robust tobacco prevention and control programs in the United States, inclusive of significant funding appropriated in the Oregon state budget that meets investment levels recommended by the Centers for Disease Control (CDC). These state funds are leveraged against additional tobacco-specific funding from the CDC. Given the history of tobacco prevention and control programs in the United States, such financing and interventions are often siloed from other primary substance use prevention efforts. Specifically, Oregon law restricts these funds to tobacco-use-reduction purposes by dedicating them to that purpose ([ORS 431A.153, 431A.155](#)), and federal grant terms and OHA grant agreements

reviewed by Third Horizon reinforce it. As a result, tobacco prevention and control funding and oversight are structurally separate from primary prevention efforts related to substances other than tobacco. Additionally, the degree of operational separation varies by county. In some counties, tobacco and substance use prevention are delivered by the same staff and planned together. In others, they operate as distinct programs, and may even exist in separate organizations. Lastly, the ADPC has no statutory role in the strategic development, sustainability, or delivery of tobacco prevention and control programs. Given these dynamics, Third Horizon includes tobacco prevention and control programs and financing only if it is reported as part of an integrated primary prevention infrastructure or program that is inclusive of both tobacco and other substances.

Problem Gambling Prevention: One percent of all Oregon Lottery net proceeds support problem gaming/gambling addiction prevention and treatment through a Problem Gambling Treatment Fund (Oregon Revised Statute (ORS) [461.549](#), [ORS 413.522](#)), which is administered by the Oregon Health Authority (OHA). Several providers who deliver substance use prevention programs in the state report receiving resources from the fund to deliver gambling prevention programming. However, like tobacco, funding purpose and other administrative rules limit the use of these funds to address substance use, and the ADPC has no statutory authority overseeing such efforts. Therefore, Third Horizon limits inclusion of gambling prevention resources or efforts to providers who reported such services existing as part of a comprehensive substance use prevention strategy and did not analyze the totality of Oregon’s fiscal or programmatic approach to problem gambling prevention in this report.

Taking these frameworks into account, the assessment examined four parts of Oregon’s prevention system:

Programs	Funding	Workforce	Innovative practices
What is offered, who provides it, who it serves, where it operates, and whether the provider described it as evidence based.	How prevention dollars move through federal, state, regional, county, and local systems, and whether the spending supports primary prevention.	Who carries out prevention work, where workers are located, what credentials they hold, and what training and support they need.	Promising, community-led, culturally grounded, and cross-sector approaches inside and outside formally funded systems.

Information used

The assessment combined several types of information. Using more than one source ensured Third Horizon could see where findings agreed, where they differed, and where information was missing. For the purposes of this analysis, Third Horizon focused on the period of 2023-2026, mindful that 2020-2023 state financing, in general terms, was significantly impacted by the COVID pandemic and related relief financing.



Surveys

Four online surveys were conducted from March through June 2026. They gathered information from schools, prevention providers, community agencies, colleges and universities, and the workforce. The surveys received 65 school district responses, 109 provider and community agency responses from about 102 organizations, 101 workforce responses, and nine college and university responses. Third Horizon reconciled the presence of skipped responses by showing the number of people or organizations that answered that question. Questions that allowed more than one answer may add to more than 100 percent.

Interviews and focus group

Third Horizon held 21 virtual interviews with state agency staff, prevention leaders, funders, providers, community organizations, and presented for three local coalitions (See Appendix E for a full list). The team also held one 60-minute virtual focus group with school districts, an education service district, and a local public health authority. These conversations explored how prevention is planned, funded, delivered, and tracked within the school system.

Public and agency records

Third Horizon reviewed local, state and federal public data on funding availability and distribution, population, geography, and substance use burden. State agencies assisted in this analysis by providing agency and administrative records, including contracts, funding records, agency budgets, grant materials, plans, reports, and workforce certification data. To ensure efficiency and consistency in fiscal reporting, Third Horizon utilized the ADPC Cross-Continuum financial report assembled by the ADPC and state agencies during the discovery phase of the project, in addition to the supplemental materials provided to Third Horizon directly. In total, over 500 documents provided by state agency partners were included in the analysis. Lastly, Third Horizon reviewed state-specific and federal regulations governing prevention financing, programs, and policy.

How the information was analyzed

The assessment combined records from surveys, interviews, the focus group, agency documents, public data, and administrative data. When the same program or funding element appeared in

more than one source, the records were reanalyzed to remove duplication and accurately account for local, county, state, and federal funding appropriations.

Financing and programming were reviewed using the same basic questions:

- Does it fit the definition of primary prevention in HB 3321?
- Who does it serve?
- What type of prevention strategy does the investment or program focus on?
- What is the efficacy of the financed program?

The assessment recorded the organization, population served, location, funding source, and reported evidence status when that information was available. Evidence labels such as “evidence-based,” “promising,” or “innovative” were utilized to invite providers and other informants to share the extent to which primary prevention programs, policies, and strategies have behind them evidence of effectiveness in achieving primary prevention goals. Though Third Horizon did not independently evaluate the efficacy of programs presented, researchers with deep experience in substance use prevention reviewed provider responses to validate efficacy claims against known, nationally recognized programs and best practice standards.

For the financial analysis, Third Horizon conducted a top-down review of federal and state funding sources, state agency administrative processes, requests for proposals (RFPs), contractor proposals, and reports, as well as publicly available datasets of available state and federal funding implicated in the delivery of primary prevention services in Oregon. Of particular use was the required cross-continuum financial reporting of the ADPC, which undertook the state agency financial reporting process in parallel with this inquiry. Rather than making duplicative requests for financial data from state agencies, Third Horizon leveraged the ADPC reporting process as a vehicle to tie specific funding sources to contracts across state agencies in Oregon.

While the ADPC cross continuum financial report provided a clear line to primary prevention programs and contracts, there were a number reported by the Oregon Health Authority (OHA) – which provides the vast majority of substance use related funding to communities – as “cross continuum”, inferring that the contract in question was for delivery of activities that span primary prevention, harm reduction/health and safety, treatment and/or recovery supports. To attempt an accurate capture of prevention financing and programming in identified “cross continuum” contracts, each of the 100 OHA line items identified as cross-continuum, surveillance, or workforce was checked against its underlying contract, budget, or federal report before classification. Dollars were counted as primary prevention only where the documents support it, and blended or multi-purpose contracts were counted at reviewed shares. In other words, if contract evidence suggested an equal impact across the continuum of care of prevention, harm reduction, treatment and recovery, then one-fourth of the contract total was counted towards primary prevention.

For program inventory analysis, each program reported through all data sources (surveys and agency data) was identified to fall under the primary prevention definition as mandated by HB 3321, or prevention adjacent for those falling under the cross-continuum range (i.e., treatment, harm reduction, recovery, overdose prevention as being adjacent to prevention). Programs

identified as being prevention adjacent were removed from the analysis, though an inventory of those reported programs is included in the report appendix (Appendix B).

Every program in the inventory was analyzed to match against a catalog of branded prevention curricula and named prevention strategies. Programs that did not identify a specific named approach or curricula were grouped, where possible, into recurring families of similar approaches, such as parenting supports, information and awareness activities, or positive alternatives. This method has an important limitation. Providers frequently described what they do without naming a formal curriculum. Accordingly, counts of named evidence-based approaches should be treated as minimum counts, not as proof that no additional organizations use those approaches. County delivery records confirm that some named programs are more widely used than survey responses alone indicate.

State agency records contribute 80 counted records, of which 36 are the county Alcohol and Drug Prevention and Education Programs, one for every grantee. Funding lines that reflected financing, administration, staffing, or duplicate budget periods are excluded and logged separately.

School districts mainly reported types of prevention activity rather than named programs, so those activities are reported as coverage rather than counted individually. Only 13 named district programs are included. Ten districts reported prevention work without naming a program, so the school count is a minimum. Campuses named individual programs, so all 36 campus records are counted: 21 as primary prevention and 15 were excluded from the analysis since they were not identified as primary prevention.

Innovative, grassroots, and locally developed practices were identified from the surveys and interviews described above and from existing state and Tribal records. Each practice was sorted into one or more of the six CSAP Strategies, and the assessment recorded the reporting source, the systems the practice operates through, the population it serves, and how it is funded. Individual respondents are not named, while organizations and named practices are retained so that each observation can be traced to its source. Appendix A lists every practice with its reporting organization and source, and the technical appendix (Appendix G) describes the sorting process.

Finally, Third Horizon cross-referenced fiscal, programmatic, and outcomes data where possible to understand the extent to which financing, programming, and geographic/population focus sit relative to the consequences of substance use in Oregon communities, to assess the extent to which financing, program delivery, and workforce capacity are matched with local need.

How findings were validated

The analysis compared results across multiple sources rather than relying on a single dataset. Findings were considered more reliable when sources agreed. Differences between sources were reviewed and reported. Key figures were recalculated, and selected records were checked against original responses. Detailed counting rules, exclusion, and inclusion criteria can be found in the detailed technical methods section (Appendix G).

As a platform-enabled advisory firm, Third Horizon used machine learning to cross-reference, review, and analyze all financial and programmatic data across sources received. This output was then stress tested and validated through human-led descriptive analysis to compare programs, populations served, strategies, organizations, funding, workforce, and geography. Interview, focus group, and open-ended survey responses were re-reviewed for repeated themes, strengths, challenges, and gaps. All review and validation were conducted by Third Horizon staff with significant subject matter expertise in behavioral health policy, financing, and primary substance use prevention science.

Limitations

As with any analysis of this nature, there are several limitations that are worth considering in the review of the findings.

- Given that there is no single database available of primary prevention programs and organizations known to deliver such services in Oregon, Third Horizon relied upon extensive partnerships with state agencies, statewide organizations, and prevention leaders who serve on the ADPC Prevention Committee to recruit and promote the survey across schools, community-based organizations, governmental units, and members of the prevention workforce. Because outreach was conducted without a starting certainty of the number of possible respondents, a “response rate” based on a defined audience was not possible for most surveys. For three of the four, Third Horizon did not have information on how many people received them and cannot report a response rate. Only the school survey has a denominator: 65 of Oregon's 197 districts answered, covering 27 of the 36 counties. Taking part was voluntary, and the organizations most likely to answer a survey about prevention are the ones already doing it and staffed to describe it. Every count in this report is therefore a minimum rather than a full picture. It also means differences between counties partly reflect who answered: Jackson County shows four programs for 221,338 residents, while Clackamas shows sixty for 424,396, which is not a real fifteen-fold gap. The only part of the inventory that is complete for all 36 counties is the county ADPEP programs, which come from contracts rather than survey replies. Nor can this assessment say whether people can get to these programs, since there is no source or reporting that counts how many people a program serves in a usable way. Similarly, community colleges were not included in survey dissemination for the intercollegiate survey
- Participation in surveys, interviews, and the focus group was voluntary. The results may reflect organizations and workers that are more active or better resourced in prevention, missing services and programs from organizations, schools, and members of the workforce who did not respond.
- Program information, financing, and efficacy claims from providers of primary prevention services were largely self-reported. While Third Horizon engaged in significant analysis to validate provider claims, it is feasible that inputs from external sources included errors and omissions that were unable to be captured during validation.

- Financial and programmatic information that served as the basis for this analysis is a point-in-time snapshot of conditions in the community. This is particularly important relative to federal investment and strategy, given significant volatility in federal funding, regulations, and contracting standards, which may create material changes in both the financing and delivery of services in Oregon communities after the publication of this report.
- Provider, agency, and public records use different definitions, schedules, and reporting methods. This is particularly complex in the context of financial analysis and budgeting, where state, federal, and individual organization fiscal years, grant periods, and program delivery timelines are not the same. This dynamic can impact reconciling financial reporting from state agencies versus budgetary information shared from providers on the ground.
- Tribal substance use prevention efforts are significant among tribal communities in Oregon. While Third Horizon included tribal experts and state-financing of tribal programs in this review, Third Horizon did not request financial information from Tribal communities directly, out of respect for their independent oversight of tribal financials. The assessment does not attribute figures to any individual Tribe. Tribal approaches and programs were uncovered through tribal expert input and voluntary responses to the provider survey by tribal-focused organizations and entities but may represent an undercount of tribal service delivery and investment.
- Program Counts may overstate local coverage, given that the existence of a program in a specific region or community is not an indication that the program itself can fully reach the intended audience, and most data provided to Third Horizon did not include specific counts of people serviced against regional need/demand for the services
- Frontier regions with low populations face data collection challenges, where data ethics guidelines require suppression of some population level data given small numbers.
- The provider survey did not include response choices for racial, ethnic, or cultural communities other than tribal communities, or for adults over age 65. While respondents did include culturally responsive programs in open questions asking them to identify programs they operate, programs serving these groups are likely undercounted.
- The surveys went through partner networks rather than to a fixed list.

Program Inventory and Assessment

As noted earlier, inventorying primary prevention programs in alignment with HB3321 required Third Horizon to pinpoint programming that most directly complies with the definition of primary prevention included in the statute. For programs that were identified as not directly aligning with HB3321, Third Horizon uses the term “prevention-adjacent” and includes them in this report only when those practices meet other established criteria demonstrating direct benefit in preventing use by the population.

The statewide prevention landscape

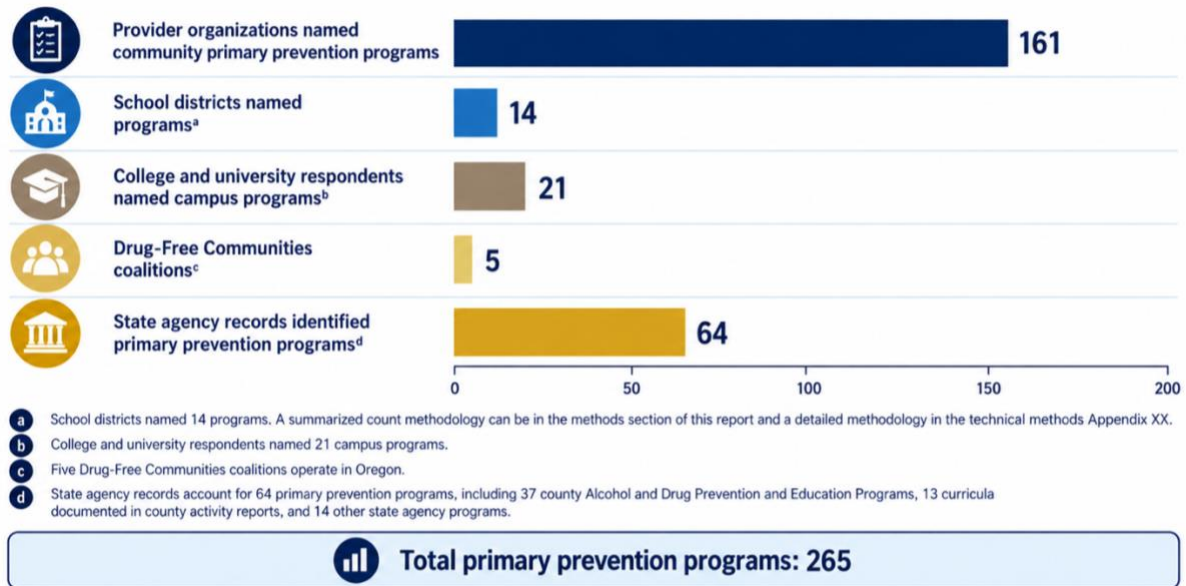
HB 3321 defines primary prevention as work intended to prevent, delay, or reduce youth substance use before problems begin. To do so, the assessment bucketed programs within primary prevention and also identified prevention-adjacent programs. These programs are counted separately to keep the primary prevention total focused on what the HB 3321 assessment requires, while still showing the broader system Oregon funds. For this report, Third Horizon only reports on primary prevention programming.

How much prevention activity was documented

A program is a named or otherwise identifiable set of activities whose primary goal is to prevent substance use. Programs may use universal, selective, or indicated approaches and may be delivered by schools, community-based organizations, government agencies, or other organizations. For this assessment, each program is counted as one record, regardless of how many activities, components, or delivery sites it includes, when the administering organization operates, funds, and reports those activities as a single program. An organization is not a program, and neither is a funding line. A state budget entry that sends money to counties is financing; the county activity it pays for is the program. Of the 265 programs compiled in the inventory (refer to Appendix A), 41 are named or otherwise recognized and researched programs and branded curriculum (such as LifeSkills, SBIRT, Project ALERT).

Figure 2 illustrates that through surveys, provider organizations named 161 programs, school districts named 14, college campuses named 21, five Drug-Free Communities coalitions operate in Oregon, and state agency records account for 64, of which 37 are the Alcohol and Drug Prevention and Education Programs, one in each of the 36 counties with an exception of Multnomah county currently having 2.

Figure 2. Documented prevention programs by data source (Provider, school, and intercollegiate surveys; state agency records (2023–25).



Note: Each source is counted separately and uses its own unit (programs, districts, campuses).

Program Inventory Inclusion and Exclusion Criteria:

Programs counted as ‘primary prevention’ were based on the following inclusion criteria:

- It is truly a program and not a funding stream
- It targets youth substance use
- It works before a substance use disorder is established — universal, selective or indicated
- It was named by a survey respondent, a state agency, a federal grant record, or a county ADPEP report

Programs excluded and bucketed into ‘prevention adjacent’ (See Appendix B) were based on the following criteria:

- Tobacco, nicotine or vaping only, or smoking cessation — unless it is fused with alcohol and drug prevention in one named program
- Suicide prevention, mental health promotion, or social-emotional learning
- Treatment, clinical services, or recovery support
- Harm reduction and naloxone distribution
- Programs that were identified but are not specific to substance use
- Problem gambling on its own funding — kept if delivered inside a substance use program
- A duplicate — the same curriculum at several sites, or a county ADPEP counted more than once

Agency Engagement and Regional Infrastructure

State agency records identify ten agencies and public bodies that may administer or fund prevention work, including the Oregon Health Authority (OHA), the Department of Human Services (DHS), the Oregon Department of Education (ODE), the Department of Early Learning and Care (DELC), the Oregon Youth Authority (OYA), the Oregon Liquor and Cannabis Commission (OLCC), Youth Development Oregon (YDO), the System of Care Advisory Council, the Oregon Military Department, the Oregon-Idaho High Intensity Drug Trafficking Area (HIDTA) and the National Guard. Prevention administration is therefore spread across the state government; however, **the largest funder of community-based primary prevention programming is the Oregon Health Authority.**

Alcohol Drug Prevention Education Program

Central to OHA's investment in primary prevention is The Alcohol and Drug Prevention Education Program (ADPEP). ADPEP is the only primary prevention structure that touches every Oregon county, through contracts administered by OHA and its Public Health Division. The profile below is informed by documents sourced from ADPEP 23-25 contracts, workplans, reports and practice guides provided by OHA, as well as direct provider input collected by Third Horizon during this analysis.

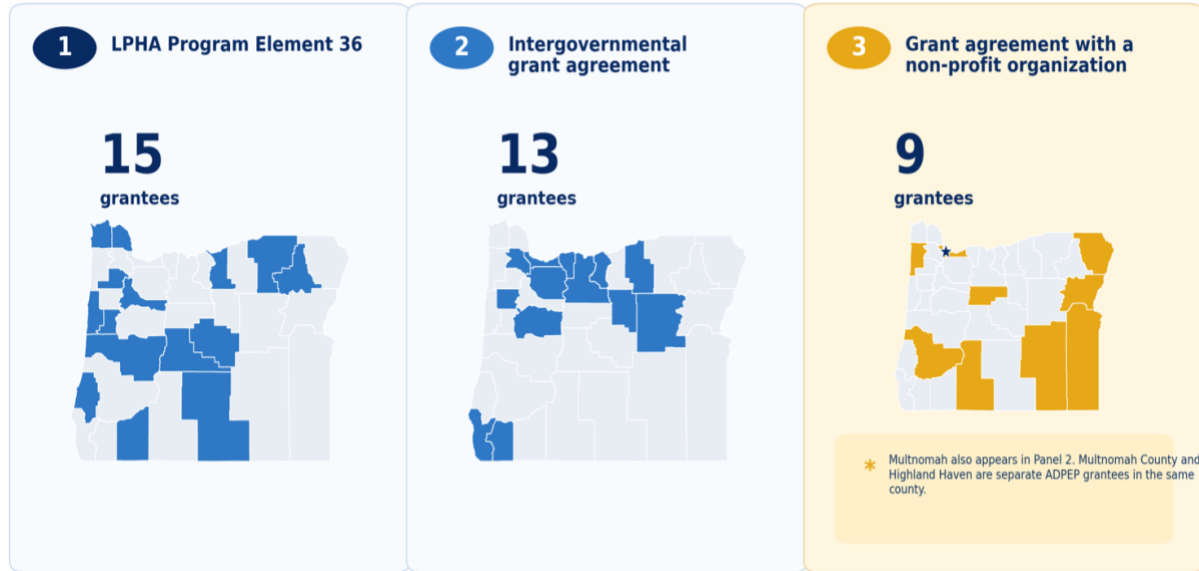
Purpose of ADPEP

The purpose of each ADPEP is "to prevent alcohol, tobacco and other drug use and associated effects, across the lifespan." The work covers community and state interventions, surveillance and evaluation, communications, and screening. Counties must use the funds across all six federal (CSAP) prevention strategies. The program spans the full range of prevention levels, from universal to indicated.

Who delivers it

ADPEP reaches its grantees across all 36 counties through three contracting mechanisms, as noted in Figure 3

Figure 3. ADPEP Contracting Mechanisms in Oregon



Source: OHA FINAL Proposal-Modernization Formula Funding Distribution for Primary Prevention Allocation

Fifteen ADPEP contracts are received through a local public health authority under Program Element 36. Thirteen ADPEP contracts are facilitate through an intergovernmental grant agreement, and nine through a grant agreement with a non-profit organization. Where a non-profit or behavioral health organization holds the contract, it delivers the county's prevention program directly. Examples include New Directions NW (Baker), ADAPT (Douglas), Symmetry Care (Harney), Best Care (Jefferson), Klamath Basin Behavioral Health (Klamath), Lifeways (Malheur), Community Counseling Services (Morrow), Tillamook Family Services (Tillamook), Building Healthy Families (Wallowa), and YouthThink (Wasco). One grantee, Highland Haven, is not organized around a county: it is a culturally specific provider serving Black, African American and African communities in Multnomah County – meaning that Multnomah County has two ADPEPs.

ADPEP Workplans and Activities

What the ADPEP's focus on. ADPEPs describe their activities using the six prevention strategies set by the federal Center for Substance Abuse Prevention (CSAP). Three of the six carry most of the work. These are **community-based processes** (building and running coalitions), **information dissemination**, and **education**. Over the 23-25 reporting period, community-based processes grew into the largest single strategy. One-way information sharing declined. ADPEPs also report how their resources divide across the strategies, noting that expenses related to required staff time allocate significant budget attention to educational activities.

Who the work reaches. Based on the National Academy of Medicine framework. More than **eight in ten reported activities are universal**, reaching everyone in a group or place. Several ADPEP's reported engagement with Oregon's statewide Rethink the Drink campaign as a part of their

universal approach. **About one in seven is selective**, reaching youth who are known to be at higher risk. About one in forty is indicated, reaching young people who are misusing substances but do not meet the clinical criteria for disorder. This balance held steady across all four reporting periods. **Selective work is unevenly spread**, and a handful of ADPEPs reported none of it. Indicated work is likely rarer than the forms show. Several ADPEPs coded plainly universal activities, such as a public awareness campaign and training for professionals who work with youth, as indicated. The workplan asks ADPEPs to mark the level for each objective. This reporting block was inconsistently used, as some ADPEP respondents left it blank, while others chose only one category, even if their workplan descriptions clearly identified work across categories.

Work that changes rules and settings. Environmental and policy work is about one in eleven activities, and it is concentrated in a small number of ADPEPs. It is also dropped far more often than any other kind, at roughly four times the rate of education or public awareness. In most cases, staff turnover was a driving factor in a reduction in implementation of strategies, alongside changes in the regulatory or local policy climate that made such activities harder to implement.

Concerns ADPEPs raised. Nearly every ADPEP named staffing and workforce issues as a primary challenge in their work, and such statements rose in every reporting period under review. Vacant coordinator posts stopped whole programs, in one case for most of a year. Turnover cost institutional memory. Several ADPEPs reported they could not account for their predecessor's work, and one noted its report likely did not reflect everything performed. Many ADPEPs run on part of one position, often split with the tobacco program. Reliance on a single individual also impacted programming and work during times where the employee was out of office, on maternity leave, etc.

Funding concerns were few for most of the period, then rose sharply at the end of reporting. ADPEPs said the award is too small for the work asked of them. One said plainly that it will not pay for one full-time position. Another said its funding had not risen in seven years. A third said the federal block grant amount had been flat for more than a decade. In the final months, ADPEPs reported federal funding uncertainty, county budget cuts, and promised local money withdrawn, amplifying risk to sustainability and viability of efforts. One reported a subcontractor closing its prevention program, and prevention professionals leaving the field. Opioid settlement funds were also reported to have arrived late, and ADPEPs describe them as one-time money that is hard to use well.

School access was the largest barrier outside staffing, and nearly every ADPEP named it. They describe districts that do not respond, school staff who change each year, and school leaders who do not see the need. Data access followed, with long waits for routine data, no epidemiologist to call on, and survey results several years old with limitations to their use.

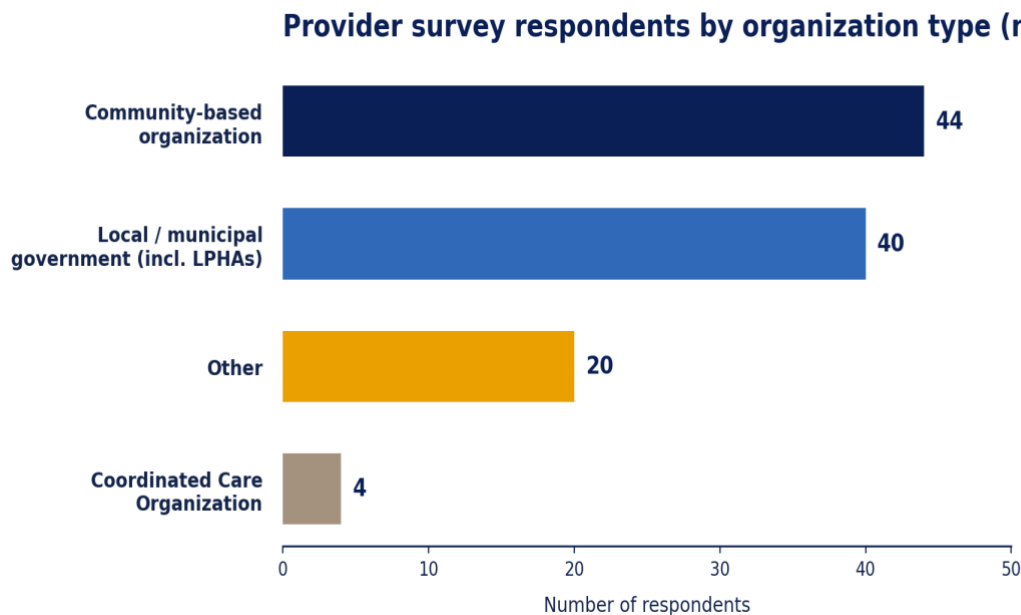
Programs Delivered Beyond ADPEP

Beyond ADPEP, prevention is administered by a wide range of organizations:

- Local public health authorities and the county or municipal government
- Community-based organizations and prevention coalitions
- Coordinated Care Organizations
- School districts and education service districts
- Colleges and universities
- Tribal and Native-serving organizations
- Community mental health and behavioral health providers
- Juvenile departments and other specialty organizations
- State agencies, such as the primary prevention practices delivered by OLCC

While state agency input came from direct key informant interviews and data sharing from said agencies, the remaining provider types referenced above were invited to complete a survey to gather data around primary prevention programs and financing. From the survey respondents, community-based organizations (44) and local or municipal government (40) were the two largest categories, together accounting for more than three-quarters of responses, followed by 20 organizations in other categories and 4 Coordinated Care Organizations.

Figure 4. Provider survey respondents by organizations (Provider survey, n=108 of those who responded)



Note: Because nine ADPEP grantees hold their contract through a grant agreement with a non-profit organization, that county's core prevention work appears in the community-organization row rather than the government row. Structurally, county government sits behind more of Oregon's prevention than the chart suggests.

Prevention Programs Implemented in Oregon

This section describes the kinds of prevention Oregon invests in, including recognized curricula identified in the inventory, the named strategies and frameworks in use, and the locally developed, innovative, and grassroots practices that respondents described in their own words.

Data received suggests that many programs reported in different communities represent the same underlying curriculum. Conversely, many locally named programs may use similar strategies without identifying a formal branded curriculum. The assessment, therefore, examined program names and descriptions to distinguish individual program records from the underlying approaches they represent.

The inventory shows a prevention landscape characterized by a relatively small number of identifiable named/branded curricula and strategies alongside a much larger amount of locally defined prevention activity. The inventory identified 41 distinct branded curricula.

The [Rethink the Drink](#) campaign is OHA's statewide initiative and is the most widely reported single intervention in the records reviewed, named by 27 counties in their ADPEP reports. It is a universal approach that fits under the CSAP Information Dissemination strategy.

Counties were separately asked whether they implemented at least one evidence-based program during the reporting period, and to list the program they counted. Of the 137 county reports that answered, 56 percent said yes. The program counties listed included established substance use prevention curricula such as LifeSkills Training, Strengthening Families, Triple P, One Circle, Positive Action, and Safety First. Counties also listed suicide prevention and mental health programs (for example, Mental Health First Aid) among them, which fall outside the scope of this inventory and are therefore not counted as programs here, though they are documented as ADPEP-funded delivery.

Named Programs

The following represent the more formally established or researched prevention programs identified in the inventory. Because respondents often described their work without naming a curriculum, all named programs here are minimums.

Programs Identified in the Provider Survey

[LifeSkills](#): An evidence-based program for preventing tobacco, alcohol, and drug use. It is a classroom program for middle and high school students. Students practice refusal skills, handling social pressure, and managing stress. It is one of the most-studied prevention programs in the country, with strong evidence that it reduces tobacco, alcohol, and drug use.

[Healthy Families Oregon](#). Oregon's statewide home visiting program for families with new babies. Trained visitors support parents from pregnancy through the early years. It is evidence-based for strengthening parenting and preventing child abuse and neglect. Those are

risk factors for substance use later in life, so this report counts it as upstream prevention rather than substance use prevention.

Positive Community Norms. A communications framework built on the fact that most teens do not use, but young people believe their peers use far more than they do. Campaigns using this approach (often branded "Most of Us") use accurate local data to correct that mistaken belief. The approach is promising for reducing youth drinking and smoking.

SBIRT. Screening, Brief Intervention, and Referral to Treatment: a quick screening and a short, judgment-free conversation in a clinic or school, with referral when needed. It is a proven practice for identifying risky use early and connecting people to care. This practice can be considered primary prevention if it is offered universally, during well child, primary care and/or school health visits.

The Blues Program. It is a six-session small-group program for teens showing early signs of low mood, to help prevent depression. It is evidence-based for preventing depression, a reminder that mental health promotion and substance use prevention travel together.

Nurturing Parenting. It is evidence-based parenting-skills program that strengthens nurturing, communication, and discipline skills in families, an upstream, family-side model

Additional named programs and curricula come from the school and intercollegiate surveys, which were reviewed for named programs alongside the provider data.

Programs Identified in the School Survey

SBIRT and LifeSkills were also named programs identified by schools. Below is a list of additional programs being conducted according to responses to the school survey.

Teen Intervene. This is the most widely reported program in the school survey, appears at five sites in a state with 36 counties and 197 school districts. It is a brief, structured early-intervention program for adolescents showing early substance use, the indicated end of prevention, and one of the few indicated programs named anywhere in the inventory. Additionally, it is evidence-based as a gambling prevention strategy.

Other named programs identified by two districts each are:

Wayfinder. a life-skills and purpose curriculum. It is promising for building students' sense of purpose and social-emotional skills, based on one published evaluation. It has not been tested for substance use outcomes.

Stanford REACH Lab materials. widely used for vaping and nicotine prevention. Evaluations show gains in student knowledge and attitudes; evidence for changes in vaping behavior is still emerging.

Project ALERT: An evidence-based substance use prevention curriculum for middle school students, typically delivered in seventh and eighth grades. The program uses interactive lessons, skill-building, and repeated practice to help students resist peer pressure, strengthen healthy decision-making, prevent initiation of alcohol and drug use, and reduce progression to regular use among students who have already experimented.

Named programs identified once each include:

PAX Good Behavior Game, an elementary classroom approach with an unusually long research record. It is evidence-based for reducing disruptive behavior, and follow-up studies tracked participants into their twenties and found lower rates of drug and alcohol use and misuse and dependence among the boys who were most aggressive in first grade.

Guiding Good Choices, a parenting program for families of early adolescents. It is evidence-based for slowing the growth of alcohol and polysubstance use, with effects still visible at age 21.

Athletes Training and Learning to Avoid Steroids (ATLAS) and Athletes Targeting Healthy Exercise and Nutrition Alternatives (ATHENA), sport-team-based prevention programs for high school athletes originally developed in Oregon at OHSU. They are promising for reducing intent to use steroids and improving refusal skills.

Programs Identified in the Intercollegiate Survey

Two further named programs come from the campus survey, both of which are established programs of effective collegiate prevention:

AlcoholEdu: An online alcohol prevention course, typically assigned to incoming college students. It is evidence-based for reducing drinking in the first months after students take it, but studies have not found effects lasting beyond six months.

Brief Alcohol Screening and Intervention for College Students (BASICS): Two short, non-judgmental motivational interviewing sessions with personalized feedback, aimed at students already drinking heavily. It is evidence-based for reducing heavy drinking and alcohol-related harms, with effects holding at two- and four-year follow-up.

Programs Named in State Agency Records

Primary Prevention often involved policies, regulations, and direct governmental action that influence the environment such that the likelihood of youth substance use is reduced. This includes activities that are often delivered by state and local government. A prime example in Oregon is the work of OLCC. Oregon has ownership of the sale of distilled spirits in the state,

often referred to as a “control state” model. As the controlling entity, OLCC sets retail pricing for distilled spirits, and has jurisdiction over retail operators. OLCC mission focuses on temperance, alongside preventing sale to minors and visibly intoxicated people. OLCC also conducts work to regulate the sale of alcohol and cannabis in the Oregon Market. Such activity is a form of primary prevention, as many of its core functions contribute to reducing underage access and enforcing safe and responsible retail practices. Below is a brief overview of programs implemented directly by both OLCC and the High Intensity Drug Trafficking Area (HIDTA), which also has direct activities that constitute primary prevention work.

OLCC:

Minor decoy and compliance checks. Retail compliance operations using paid minor decoys. This an environmental strategy with a strong evidence base for reducing youth access.

Responsible-service education. ID-checking classes and the First Call program for newly licensed businesses.

HIDTA:

Tobacco, Marijuana, and E-Cigarette (TMEC) instructor training. Children Learning through Education and Research (CLEAR) alliance's substance use curriculum for use in Drivers' Education programs, with 179 trained instructors across 32 of Oregon's 36 counties

It is important to underscore that the Oregon Health Authority (OHA) also directly contributes to primary prevention, beyond the just administration of grant funds. OHA contracts with entities that provide data collection and analysis, as well as marketing and communication firms that develop statewide messaging campaigns such as Rethink the Drink. While these efforts are statewide and would not constitute primary prevention programs as defined in this report, OHA's public and behavioral health leadership works on critical elements of the prevention delivery system through their oversight, planning and resource building work.

Named strategies and frameworks

Beyond packaged curricula, the inventory names various commonly used prevention strategies and frameworks:

Prevention coalitions. Local prevention coalitions bring together parents, schools, public health agencies, law enforcement, youth, service providers, and other community partners to assess local needs and coordinate prevention strategies. The assessment classifies this as primary prevention. This includes:

- [Drug Free Communities Support Program Coalitions](#), which receive direct funding from the federal government and may or may not receive state or local funds as well.
- [Communities That Care](#), which is a community prevention system that uses local youth data to identify risk and protective factors and select evidence-based prevention strategies.

[Strategic Prevention Framework](#). The Strategic Prevention Framework is a federal planning process based on assessment, capacity building, planning, implementation, and evaluation. It is a process for selecting and organizing prevention strategies rather than a stand-alone prevention program.

Youth-led models. Youth advisory groups and youth-designed prevention campaigns place young people in active roles developing or communicating prevention strategies.

Where prevention is delivered

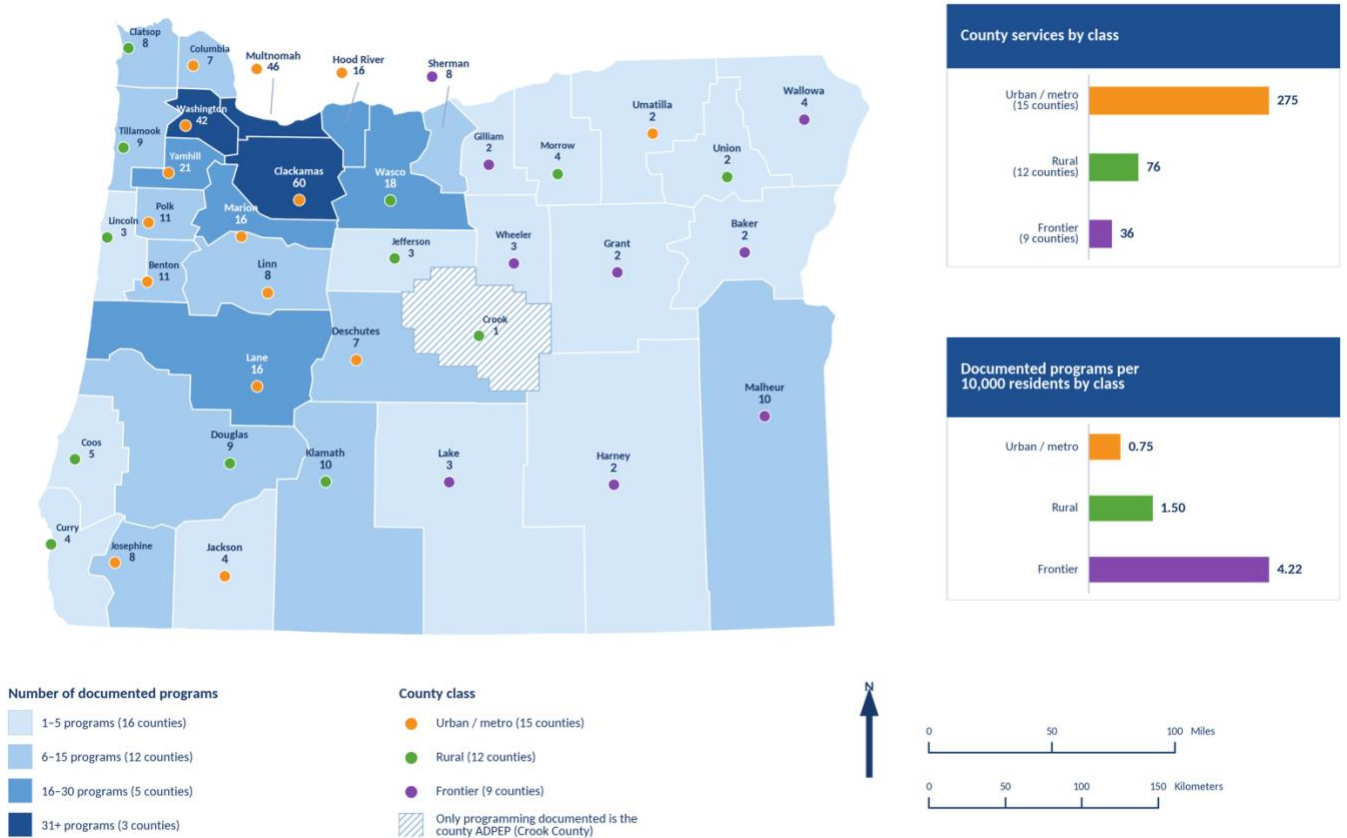
Geographic distribution

Prevention programs operate across Oregon's urban, rural, and frontier communities, but the geographic pattern looks different depending on whether it is measured by total programs or relative to population.

Figure 5 shows the geographic analysis where fifteen counties are classified as urban or metropolitan, twelve as rural, and nine as frontier. The nine frontier counties are Baker, Gilliam, Grant, Harney, Lake, Malheur, Sherman, Wallowa, and Wheeler. Morrow County falls just above the frontier threshold used in the analysis. The classification follows the Oregon Office of Rural Health, which defines a frontier county as one with fewer than six residents per square mile.

The side panels show the same data grouped by type of geography, both as raw counts and per 10,000 residents.

Figure 5. Geographic distribution of primary prevention programs



Note: the map shows documented distinct primary prevention programs with a recorded county service area, drawn from the provider, school, and intercollegiate surveys, state agency records, and the federal Drug-Free Communities grantee listing. Programs are counted once in each county served, so county labels and the side panels count county services rather than programs. The map shows primary prevention programs only, consistent with the scope HB 3321 sets for this inventory. It covers 244 of the 265 primary prevention programs; 17 operate statewide, and 4 have no service area recorded. Every county in Oregon has at least one documented primary prevention program. In Crook County, the only prevention programming documented is the county Alcohol and Drug Prevention and Education Program. These counts are a floor: they record what was reported, not everything that exists. Only the ADPEP layer is complete for all 36 counties.

Most prevention activity is focused on more population-heavy areas. Urban and metropolitan counties hold about seven in ten of the county-level records counted here. Clackamas County by itself has more documented programs than all nine frontier counties combined, which have 36.

Per person, the picture flips, and it is easy to misread. For every 10,000 residents, frontier counties have 4.2 documented programs, rural counties 1.5, and urban counties 0.8. However, this does not mean frontier Oregon is better served. Frontier counties have very few people – and given geographic distance, programs may have more difficulty reaching even the smaller population. Wheeler County has 1,436 residents, so one program there produces a high rate – but it is still one program and should not suggest that Wheeler County has adequate primary prevention programs to meet the needs of youth and families in the region. The nine frontier

counties hold about 85,000 people between them, and half their programs sit in just two of them, Malheur and Sherman.

Two other things point in the same direction. First, a program that works in several counties is counted in each one. Eighty programs do, so one regional program can raise the rate in several small counties at once. Second, every county has an Alcohol and Drug Prevention and Education Program (ADPEP). In the smallest counties, the ADPEP may be the only program counted in the region.

The way programs are counted is not what creates this pattern. Count each program once overall, rather than once in every county it serves, and the rates are 0.5 per 10,000 residents in urban counties, 1.0 in rural, and 2.9 in frontier — the same order, with a slightly wider gap.

Program Audience by Prevention Level

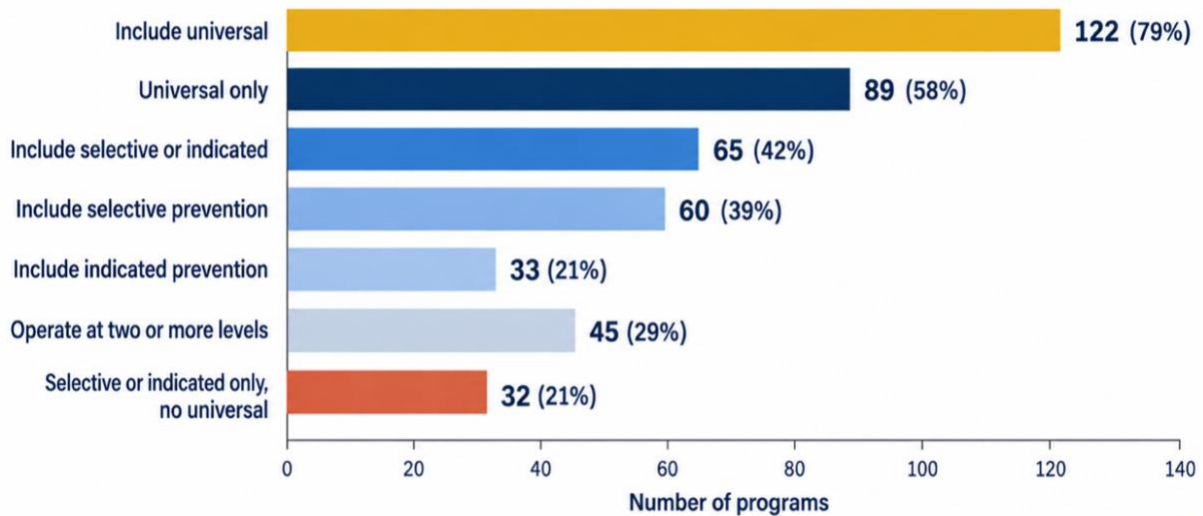
Community programs by prevention level

Providers named 161 primary prevention programs. Not every program carries every classification: across all sources, 154 report a prevention level and 124 report a CSAP strategy, with 106 reporting both. Each analysis below uses the programs that answered the relevant question, so the denominators differ. Two counts are also reported for work above the universal level, because they answer different questions: 65 programs include selective or indicated work of any kind, and 45 operate at two or more levels. A further 32 programs work only at the selective or indicated level, with no universal component.

Among the 154 primary prevention programs that reported a prevention level:

- 89, or 58 percent, operate only at the universal level.
- 60, or 36 percent, span two or more prevention levels.
- 31 span all three levels.
- 60 include selective prevention.
- 33 include indicated prevention.
- Three are indicated-only programs.

Figure 6. Community programs by prevention level (provider survey; excludes programs that did not report a level, n=154)



The program design data, therefore, show more selective and indicated activity than a simple universal-versus-everything-else split would suggest. Many programs combine universal prevention with selective or indicated components, which is ideal in a comprehensive prevention delivery system. At the same time, delivery remains weighted toward universal activity.

Counties tagged activities in their ADPEP progress reports with a prevention level. Of those, **85% were universal** (combining the form's 'universal direct' and 'universal indirect' options), **12% selective**, and **3% indicated**.

The provider survey and county administrative data, therefore, point in the same direction: selective and indicated prevention exists in program design, but the day-to-day volume of prevention delivery is predominantly universal.

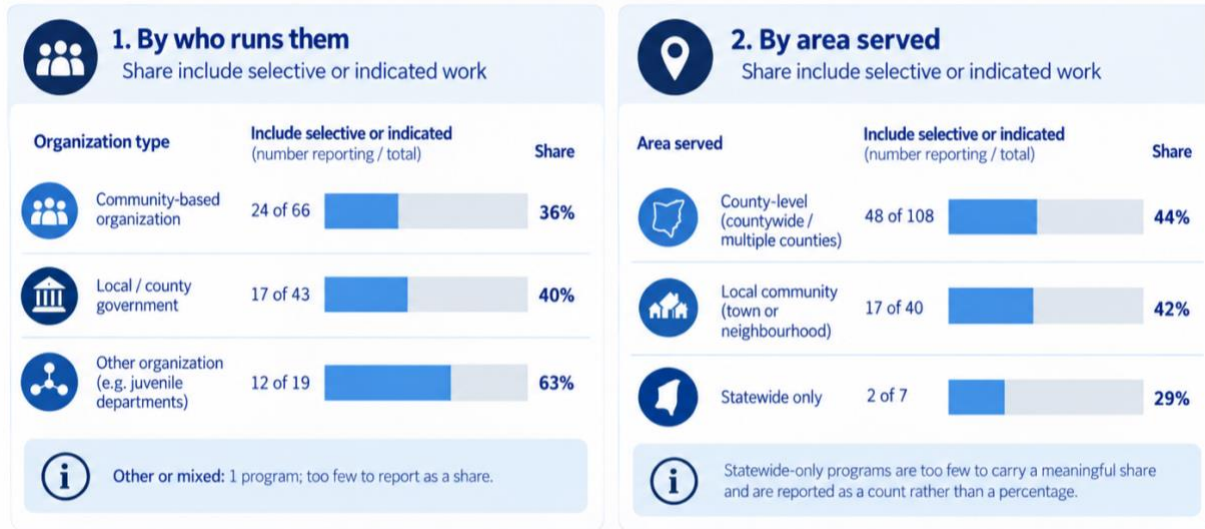
Variation by organization and geography

Selective and indicated prevention appear across organization types. Forty percent of local-government programs include selective or indicated work, compared with 36 percent of community nonprofit programs and 63 percent of programs administered by specialty organizations such as juvenile departments.

Selective and indicated prevention also vary by service area:

- 44 percent of county-level programs include selective or indicated work.
- 42 percent of programs serving a town or neighborhood include selective or indicated work.
- Too few programs report a statewide service area only, seven in the provider survey, to calculate a meaningful share for that category.

Figure 7. Share of programs that include selective or indicated work, by who runs them and by area served. (Provider Survey, *n* varies across the charts displayed in figure)



Note: Programs may report more than one level and more than one service area, so categories are not mutually exclusive.

The survey reaches only the organizations that chose to answer; however, the agency data corroborate this finding as well. Across the activities that counties tagged in their mandatory ADPEP progress reports, **85% were universal, 12% selective, and 3% indicated**. The two measures are not directly comparable. Counties assign each activity to a single tier, while providers could report more than one level for a program. Both show the same concentration at the universal level. Indicated work is genuinely rare. Only fifteen ADPEP grantees coded a single Indicated activity across the whole biennium, and Umatilla alone accounts for 21 of the 74 activities. Five ADPEP grantees reported neither a Selective nor an Indicated activity in any period.

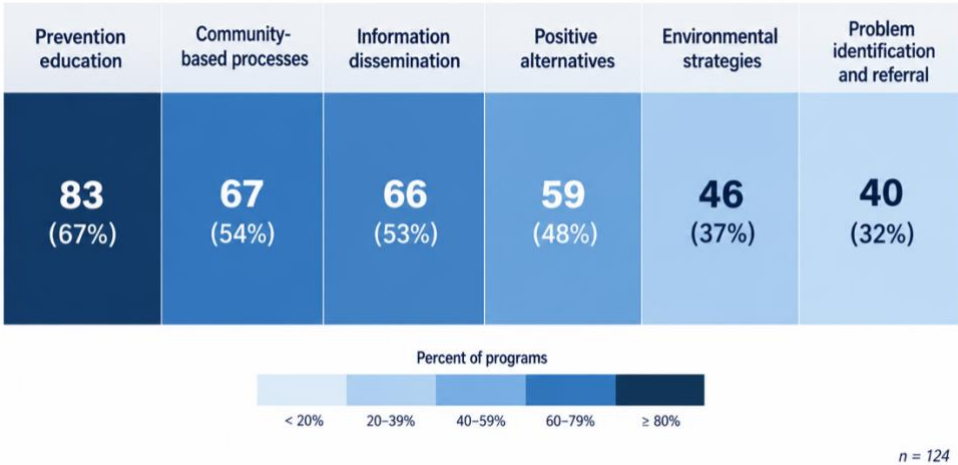
The differential in availability of universal versus selected and indicated strategies means that the youth most likely to develop a substance use problem currently receive the least targeted help, exposing a critical gap in Oregon's prevention infrastructure.

Prevention strategies: detailed CSAP coding

The assessment also coded programs using the six strategy categories established by the federal Center for Substance Abuse Prevention:

Figure 8 provides an overview of reported primary prevention programs, broken down by CSAP strategy, and includes programs that may deliver multiple strategies through a single program.

Figure 8. Community programs by CSAP strategy (provider survey, *n*=124).



This also matches the county ADPEP progress reports, where education also takes the largest share of counties’ time and money. The one strategy that lags in both plans and delivery is environmental and policy work: counties planned it as 14% of their ADPEP objectives but delivered only 6% of resources to it. Problem identification and referral lags further still, as it is the least-reported strategy in the survey as well.

School-based prevention

This section reports school prevention as coverage, how many districts deliver each kind of activity, and where, rather than as a program count. Given that many activities are embedded in the functionality of a school, most described their work by category rather than by program name. The named programs and districts reported are counted in the statewide inventory and listed in the appendix.

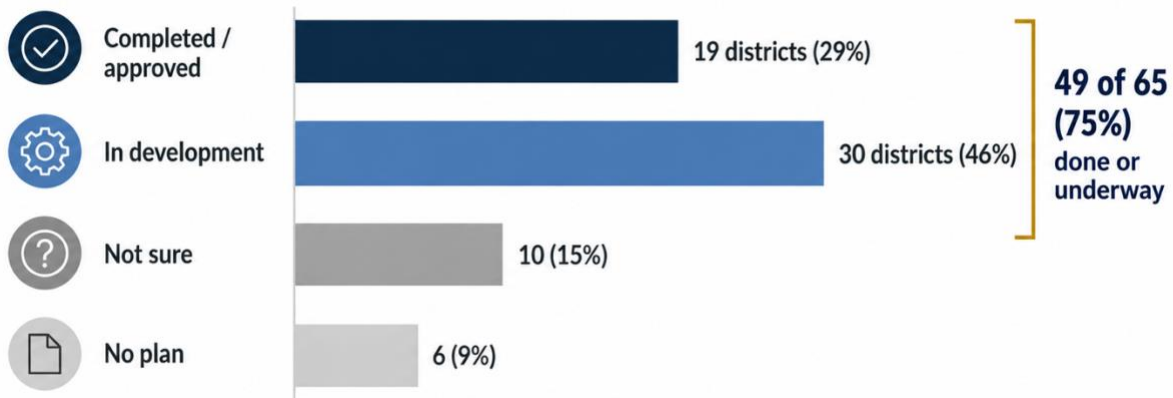
Division 22 planning

Division 22 of Oregon's school rules ([Oregon Administrative Rule 581-022-2045](#)) requires every school district to develop and maintain a comprehensive substance use prevention and intervention plan.

That requirement dates to 1989 and has not substantially changed since. What is new is a set of lessons and a set of supports. Senate Bill 238 (2023) required opioid prevention lessons in every district from the 2024–25 school year and assigned the Oregon Department of Education to oversee compliance with the rule. The department published its planning template and example plan in August 2025, and now has a designated position supporting school-based prevention. When this survey went out in spring 2026, districts had been working with those tools for less than a school year. Read that way, the results describe something other than slow uptake of a new rule. A planning requirement more than three decades old is being widely engaged now, and what changed immediately beforehand was not the rule but the support behind it.

However, data suggests that compliance with Division 22 as a transparent and clear indication of a school district's primary prevention plan remains low. Of the 65 districts that responded, 19 (29%) report a completed plan, 30 are developing one, six report no plan, and 10 are not sure (Figure 9). In all, 49 of the 65 responding districts (75%) have finished a plan or are actively building one.

Figure 9. School districts by Division 22 plan status (School District Survey; n=65)



What districts report having in place

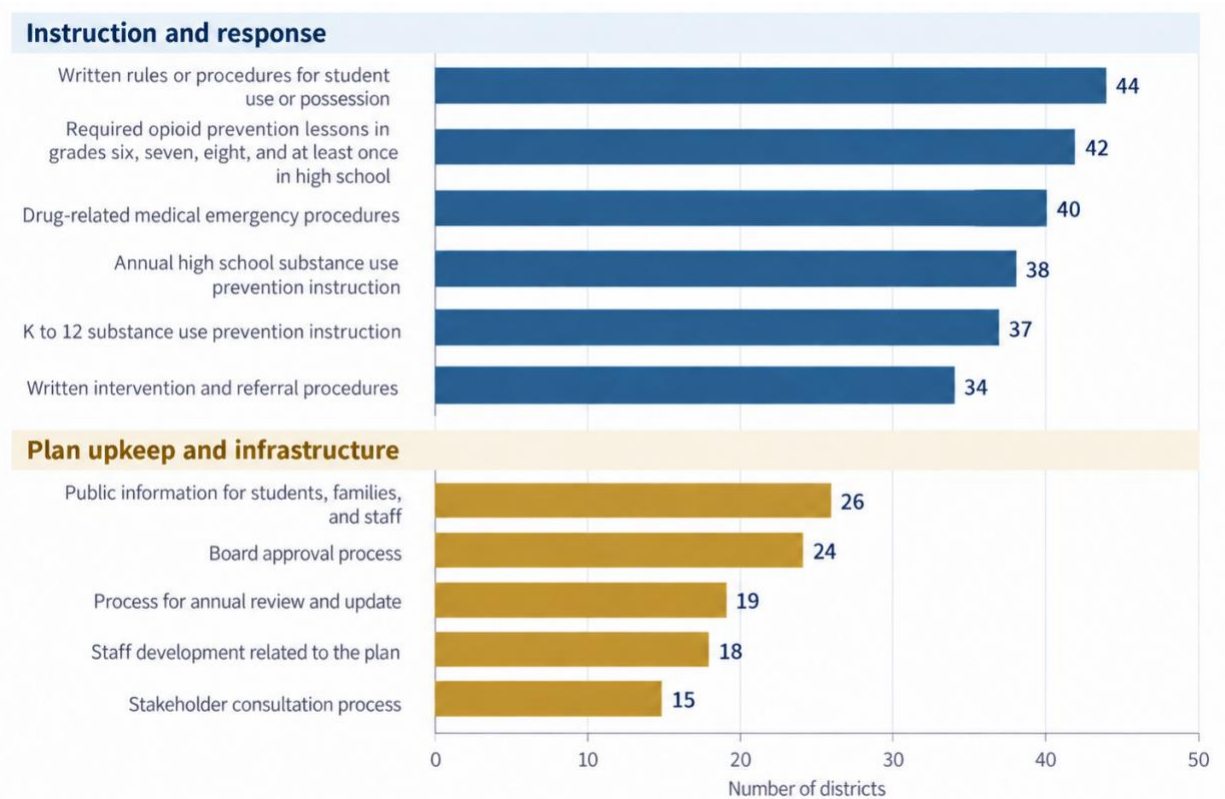
[Division 22](#) requires every district to hold a comprehensive substance use prevention and intervention plan. The rule sets out what the plan must contain (for example, classroom instruction, a public information program, and policies covering rules, consequences, intervention and referral, and annual review) and requires school board approval after consultation with parents, teachers, students, administrators, community agencies and health and alcohol and drug professionals, plus staff development for all staff. The school district survey broke these requirements into eleven items so districts could answer for each separately and added the opioid prevention lessons required under Senate Bill 238. Districts answered for current practice, whether or not it is written into a formal plan. Fifty-three districts answered.

Between 34 and 44 of the 53 districts answering have written rules on student use, drug-related emergency procedures, the required opioid lessons, and classroom prevention instruction. Between 15 and 26 have the components that sustain a plan: public information for families, a board approval process, an annual review, staff development, and stakeholder consultation. Only 18 districts report annual staff development, which Division 22 requires. 15 report a stakeholder consultation process.

The gap matters more than the plan count. A district can hold a completed plan and still lack the training, review, and consultation that would turn it into practice. The two components that districts report most often – written rules on student use and possession, and drug-related medical emergency procedures – are about consequences and response rather than promoting substance free choices or similar prevention messaging. The components closest to primary

prevention sit lower: K to 12 instruction at 37 districts, public information for families at 26 districts, and staff development at 18 districts.

Figure 10. Division 22 plan components districts report having in place (School District Survey, n=53 districts).



Note: Components are grouped by how often districts report them, not by the structure of the rule. Counts are of districts answering yes; the remainder answered no or were unsure.

Where responding districts are

Where a district is matters. Of the 65 districts that responded, 49 are in urban or metropolitan counties, eight are in rural counties, and seven are in frontier counties. Completed plans follow that pattern: 17 of the 49 urban districts report one, two of the eight rural districts do, and none of the seven frontier districts. Four frontier districts are developing a plan, one has none, and two do not know their status. The statewide figure, 19 completed and 30 in development, therefore rests mainly on urban districts. These counts are too small to express as rates, but the direction is clear, and it matches what districts said about their limits: staff capacity and funding were the two barriers named most often. Smaller and more remote districts carry the same requirement with far less to meet it.

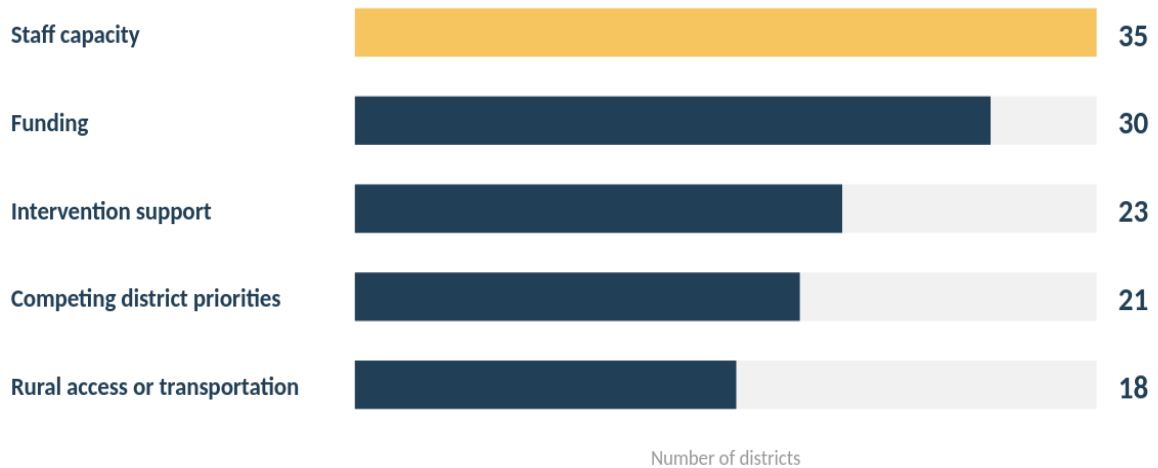
Coverage matters as much as comparison. 64 of the 65 responding districts named the county or counties they serve, and 22 of Oregon's 36 counties are represented: 12 of 15 urban or

metropolitan counties, 6 of 12 rural, and 4 of 9 frontier. Fourteen counties had no district respond at all. That is where the school survey reached, not where school prevention exists.

Barriers to planning and implementation

Most responding districts are engaged with the Division 22 requirement. That engagement is recent, even though the requirement is not, which points to the support rather than the rule as what changed. The survey also points to practical limits.

Figure 11. Barriers to strengthen substance use prevention (School District Survey, n= 49)

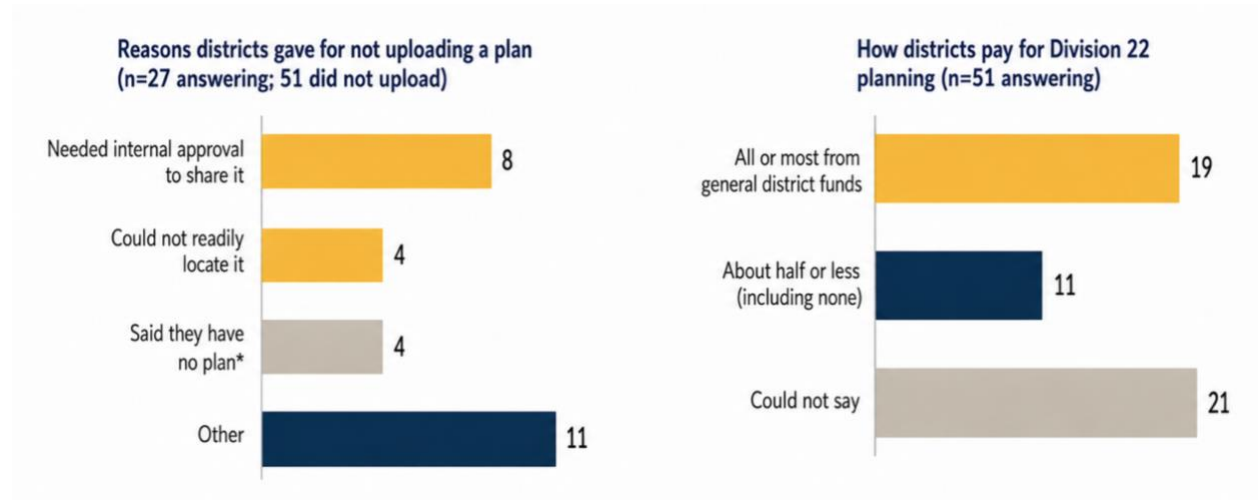


Note: Counts reflect the number of districts selecting each limitation; districts could select up to three responses

From survey responses, two other things stand out about the Division 22 planning requirement on its own:

- **First, plans that exist are hard to produce on request.** Nineteen districts report a completed written plan. When asked to upload it, only 14 did. Among all districts that did not upload a plan, the most common reasons cited included needing internal approval before sharing, needing ready access to the plan, or having nothing in writing yet, since their plan was in development. Third Horizon would not suggest from this analysis that lack of materials shared is indicative of non-compliance with the regulation. However, it signals that a plan a district can approve, retrieve, and share with the public is a higher bar than a plan a district reports having, and most districts are still somewhere on that path.
- **Second, the work is mostly self-funded.** 51 districts answered the funding question. Twenty said all or most of their Division 22 prevention work comes from general district funds, regular district resources, rather than dedicated prevention funding. Ten said about half or less comes from general funds, including three that use none. Twenty-one could not say. Put differently, of the 30 districts that could estimate, two-thirds are absorbing this work into their general budgets.

Figure 12. Why plans went unshared, and who pays (School district survey, *n* varied across the two charts)



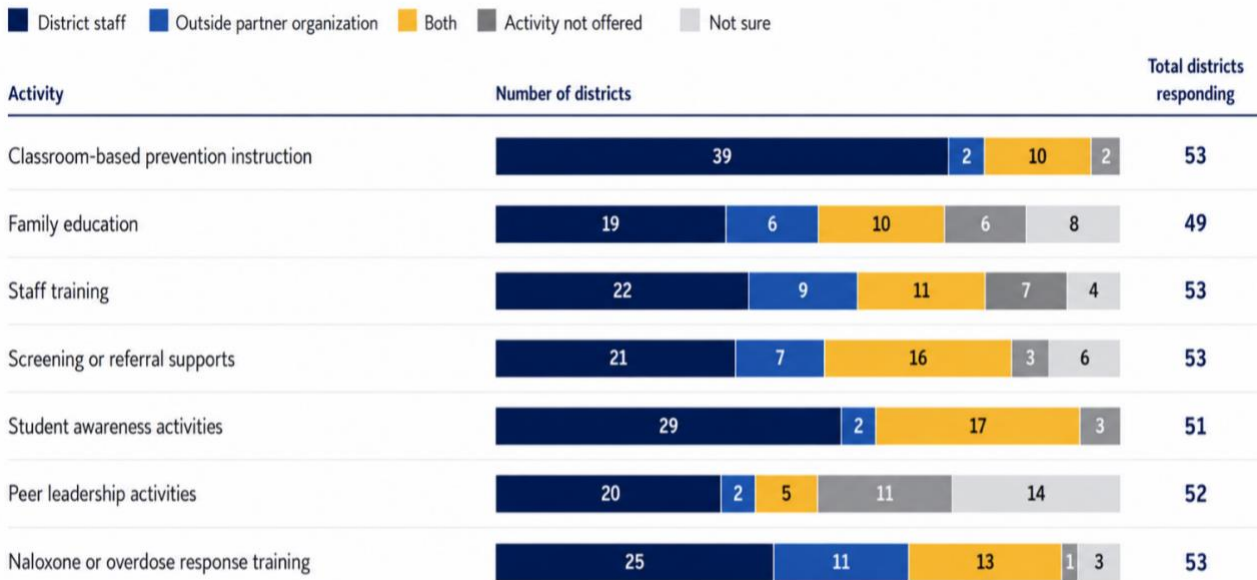
Who delivers school prevention

District staff deliver much of the school-based prevention directly. Among districts reporting who primarily delivers specific activities, district employees were the dominant provider for classroom prevention instruction and student awareness activities. However, stakeholder feedback and focus group findings suggest that staff responsible for delivering prevention may not always have sufficient training in prevention practices, pointing to a potential gap between who delivers prevention and the support available to deliver it effectively.

Outside organizations play larger roles in activities requiring specialized expertise, particularly around staff training and screening and referral supports, the latter of which was the activity most frequently reported as jointly delivered by districts and outside partners.

Youth-led peer leadership was among the least established activities in the survey, with multiple districts reporting that the activity was not offered or that they were unsure who delivered it.

Figure 13. Who primarily delivers each prevention activity, as reported by schools (School district survey, n is listed as totals in the figure)



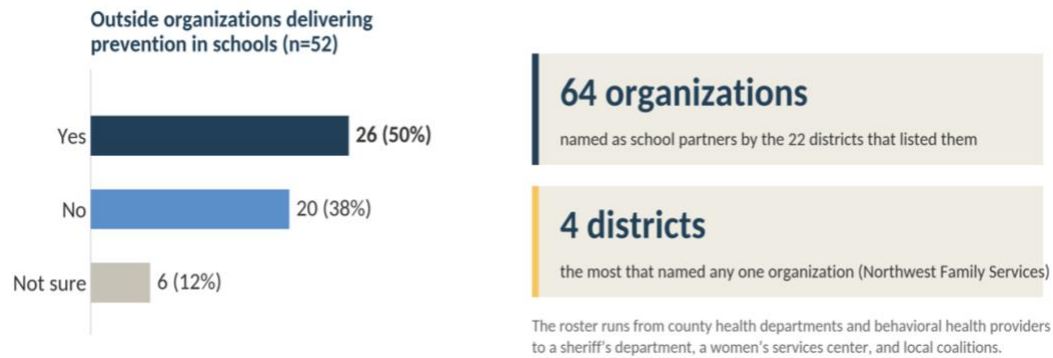
School-community partnerships

School prevention depends on a broad local partner network, and prevention providers often will look to offer services and support to school district efforts. Among 50 districts reporting partnership relationships, the most identified partner types included:

- Community-based prevention providers.
- Local public health authorities.
- Education Service Districts.
- Behavioral health treatment providers.
- Law enforcement.

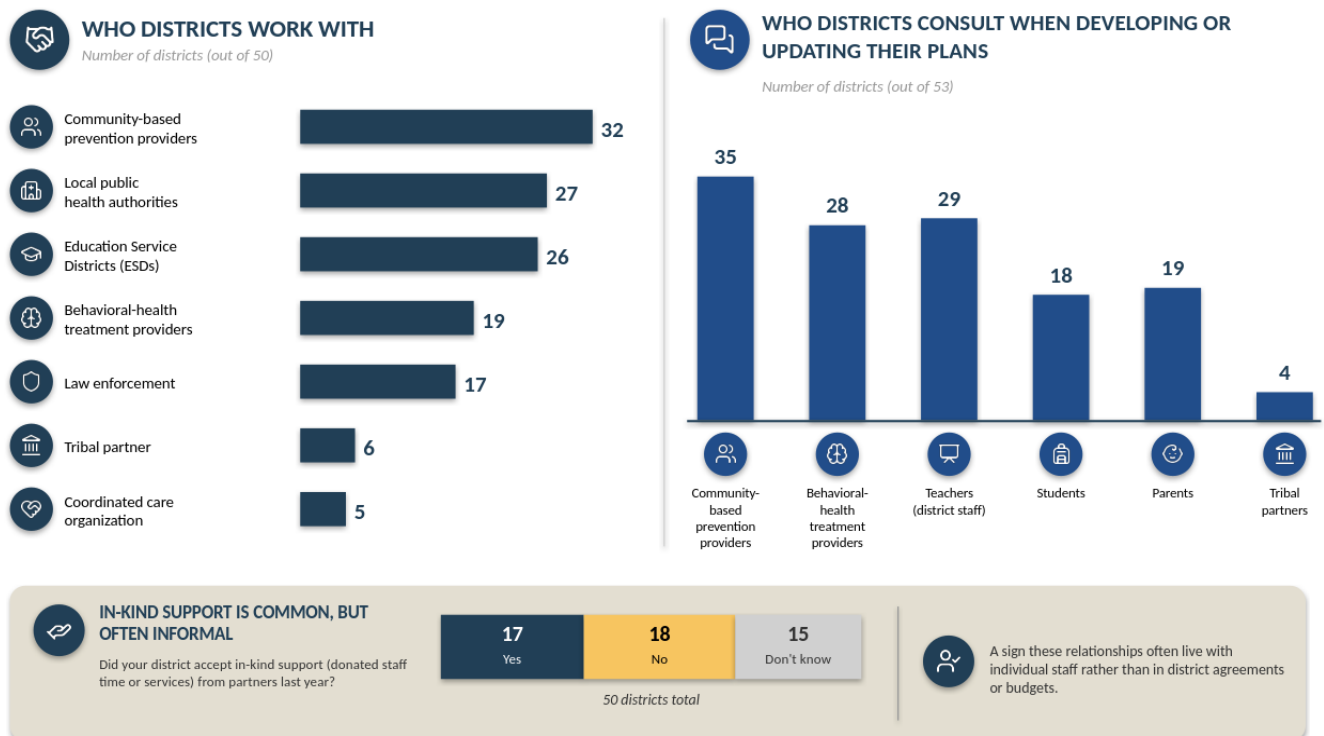
Districts also consult community prevention providers, behavioral health providers, teachers, district staff, students, parents, and tribal partners when developing or updating prevention plans, although participation varies substantially by partner type.

Figure 14. Who helps schools deliver prevention programming (School district survey, n=52)



The survey identified considerable uncertainty regarding in-kind support from partner organizations. That pattern may indicate that some school-community partnerships are maintained through individual relationships rather than through formal agreements or dedicated funding.

Figure 15. illustrates how fifty districts described their local partnerships and networking landscape (School district survey, n varies across the graphic)



When districts use outside prevention providers, no single statewide organization serves as the common delivery partner. Districts assemble partnerships based largely on locally available

organizations. School prevention, therefore, reflects the broader county-by-county prevention infrastructure around each district.

Intercollegiate prevention

Nine college and university respondents reported campus prevention activity. The colleges and universities that participated are part of an active intercollegiate workgroup focused on these issues and may have demonstrably different focus and capacity to engage in primary prevention efforts on campus given their focus. Therefore, the findings are descriptive and should not be generalized to all Oregon colleges and universities.

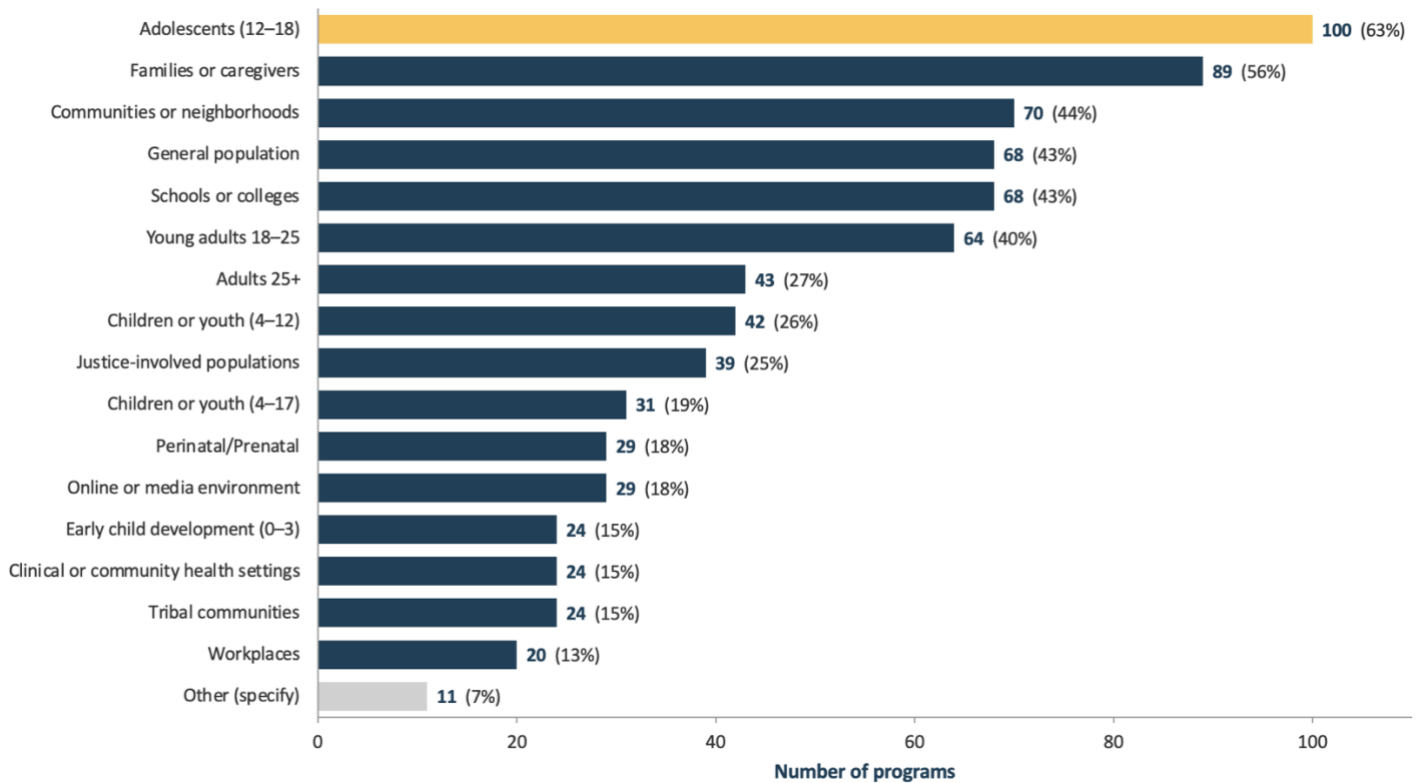
Among the nine, campus prevention is real, layered, and self-funded:

- **Activity is broader than a single program:** The nine campuses named 37 distinct prevention programs and activities, and only 21 were identified as primary prevention. All nine report prevention planning, direct prevention education, and peer-to-peer programming; in addition to their prevention efforts, six also provide recovery supports, and six provide harm reduction services. Campuses also described three locally developed innovative practices: trained peer health educators who deliver prevention messaging and social norms work, substance-free social programming including alcohol-free events and late-night alternatives, and peer and national social-norms campaigns that correct misperceptions of student use.
- **Recognizable programs appear:** Campuses named BASICS (an evidence-based brief alcohol screening and intervention), collegiate recovery groups, bystander intervention training, and Rethink the Drink, the statewide campaign, reaches campuses as well as counties.
- **Staffing is thin but trained:** Dedicated prevention staffing ranges from 0.2 to about 3.5 FTE, with most campuses at or below one position. Even so, seven of the eight campuses answering said lead prevention staff received formal prevention training within the past year.
- **Funding is institutional, not state:** Where campuses identified funding for specific programs, they named university funds, student-fee dollars, and residence-hall budgets rather than state prevention streams. Campus prevention largely operates outside the state's prevention funding architecture as described in earlier sections.
- **Challenges echo the rest of the system:** Limited funding (seven of nine), staff turnover (five), and difficulty measuring effectiveness (four) lead the list. Asked which students need more attention, campuses converged on those hardest to reach through campus programming: commuter and non-traditional students, student athletes, fraternity/sorority life, and underrepresented students. In addition, as of September 2026, the Intercollegiate Council's organizational home was under review and may change. This is a potentially impactful change that is not contemplated in this study, given the recent nature of the development, but should be monitored by the ADPC and the legislature as it could impact, positively or negatively, both existing and new work in primary prevention at the college level.

Community and agency-based prevention: populations reached

Unless otherwise noted, the level, strategy, and population analyses in this report describe the 265 primary prevention programs. The survey provider data identify 161 distinct primary prevention programs with self-reported information on levels, strategies, populations, and funding.

Figure 16. Populations reached by community programs (Provider Survey, n=159)



Note: Programs can identify more than one population, so these counts are not mutually exclusive. Populations are self-reported using survey's categories. The survey offered no category for racial, ethnic, or cultural communities other than Tribal communities, so culturally specific programming is under-recorded.

Additional Population Findings from Agency Records

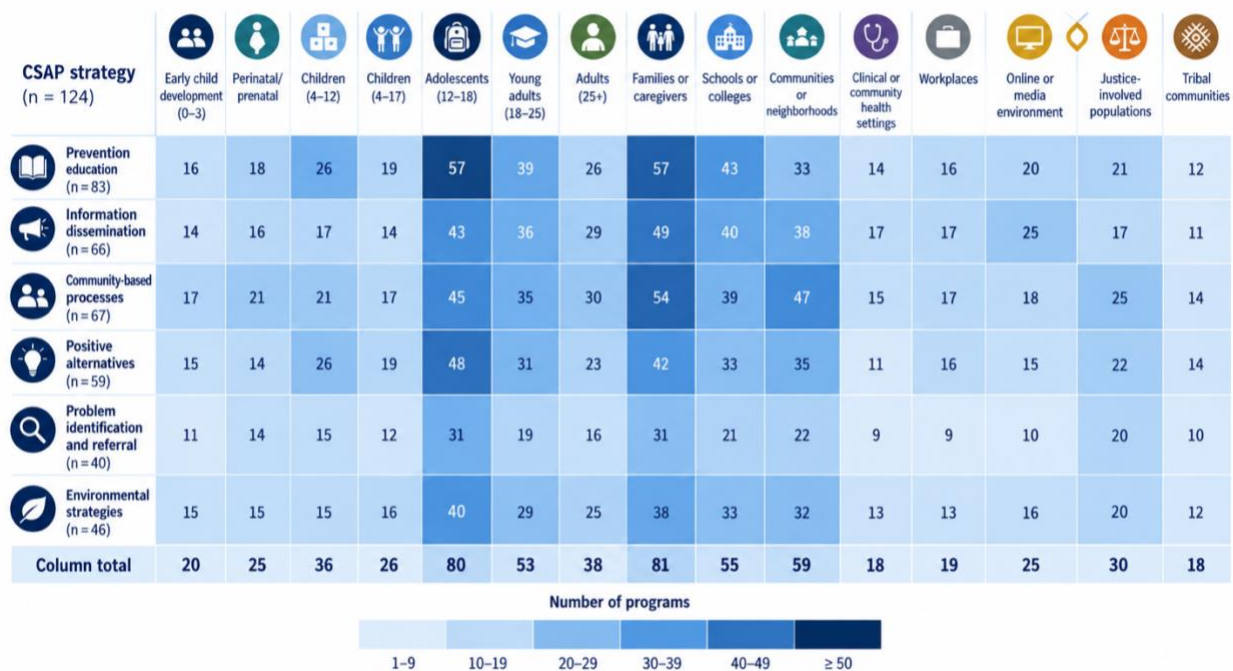
- **Most state-funded prevention is written for all ages.** Of the 42 entries that include primary prevention (16 squarely, 26 in part), 26 of those are coded to serve youth, young adults, and adults together. ADPEP's contract directs counties to work "across the lifespan." The concentration on youth described above is a feature of community programming; the state's funding language is broader.
- **ADPEP work plans spread education across age groups.** Of the education objectives counties planned, 23 target youth, 15 target parents, and 22 target the broader community.

- **One population appears more fully in agency records than in the survey.** The state's main early-childhood investments, Preschool Promise, Baby Promise, Oregon Prenatal to Kindergarten, and the childcare subsidy, appear in agency records rather than in the provider survey. They are counted as prevention-adjacent and so fall outside the 265 primary prevention programs.
- **Tribal prevention is documented in both sources.** Thirty primary prevention programs name tribal communities among the populations they serve, and tribal System of Care systems exist for all nine federally recognized Tribes, though the records received do not show which funding supports them.

Strategy by population served

The assessment cross-tabulated CSAP strategies against the population's programs reported serving. In the survey, information dissemination is the leading strategy for most populations, from perinatal to adults, though county activity reports suggest the survey overstates this.

Figure 17. CSAP strategy by population served. Cell values are program counts (Provider survey, n=124)



Among 124 primary prevention programs that reported both a CSAP strategy and at least one population. Programs may reach several populations, so counts sum to more than the number of programs.

Prevention education and community-based processes reach the widest range of populations. Prevention education is reported by 83 programs and community-based processes by 67, the two highest strategy totals. Across the 16 population groups shown, prevention education counts range from 12 to 57 programs, while community-based processes range from 14 to 54,

with relatively high counts across adolescents, families or caregivers, communities or neighborhoods, schools or colleges, and young adults. These strategies show comparatively high counts across most population groups, reinforcing their central role in the provider-reported prevention landscape.

Prevention strategies concentrate among specific populations in several notable ways:

- **Adolescents and families or caregivers are the most consistently served populations across strategies.** Prevention education reaches 57 programs serving adolescents and 57 serving families or caregivers. Community-based processes reach 45 programs serving adolescents and 54 serving families or caregivers.
- **Communities or neighborhoods also receive relatively broad coverage**, particularly through community-based processes (47 programs), prevention education (40), and information dissemination (38).
- **Perinatal, early childhood, Tribal, workplace, and clinical or community health populations/settings are reached by fewer programs.** Tribal counts range from 10 to 14 programs across strategies, while early childhood counts range from 11 to 17.

Culturally Specific and Tribal Prevention

HB 3321 asks this assessment to examine whether prevention services are responsive to the cultures and communities they serve. This section answers that question in two parts. The first describes culturally responsive prevention delivered through Oregon's general prevention system. The second describes Tribal prevention, which Oregon supports through a government-to-government relationship and dedicated investment, and which operates as a self-directed system rather than as a component of the state system.

Information for both parts was assembled from the provider, school, intercollegiate surveys, funding records, and program documents. Cultural responsiveness was not a required reporting field in any of these sources, and many programs were identified from written descriptions rather than from a direct question. The counts in this section are therefore minimum counts, not statewide totals.

Culturally responsive prevention

Cultural connection and cultural identity are recognized protective factors against substance use and racism; discrimination and historical trauma are recognized risk factors. Prevention that is designed with a community, delivered in its language, and grounded in its practices, therefore acts on the same risk and protective factors set out in the Background section of this report. Cultural responsiveness is not only a question of access; it is a question of whether a program acts on the conditions that produce risk in a given community.

For this assessment, prevention is treated as culturally responsive when a respondent described it as designed for, adapted for, or delivered in the language of a specific cultural community. This

describes what respondents reported. It is not a standard that the assessment applied, and no single definition of culturally responsive prevention was in use across the sources reviewed.

While survey limitations prevented a clear sense of culturally responsive program implementation and outcomes, through the ADPEP workplans and reports, Third Horizon did observe specific questions and focus on culturally responsive efforts. All ADPEP plans reviewed by Third Horizon have a workplan and reporting section on health disparities and health equity, including workplan templates asking for equity notes at each goal.

Most ADPEP workplans name a target population group they mean to reach. Three groups tie for first, in nine plans each. These are Latinx and Spanish-speaking residents, rural residents, and people living in poverty. LGBTQ+ residents and communities of color follow, being called out in five plans each. Tribes and Native American residents are named in three. Half the plans name language access as a main element to their work, with most of these promising Spanish-language materials as part of their information dissemination work. Three ADPEPs name having bilingual staff.

ADPEP Reports name culturally specific work as well. Clackamas County leads *Empoderando Familias*, a tri-county program for Spanish-speaking Latinx families. Its Spanish-language community conversations drew more than 90 people. In Washington County, a partner program held parenting classes in each family's own language. These included Spanish, Arabic, Russian, and Ukrainian. The same partner backed two culturally specific groups through a county process. Tillamook County used one-time grant money to hire a part-time bilingual specialist and held a parents' night in Spanish in the last quarter of the 23-25 reporting period. Multnomah County reports holding a summit to learn what culturally specific programs its area already has. Jefferson County planned Native American outreach and had a booth at the Pi-Ume-Sha Treaty Days health fair. Baker County's coordinator reported leading the equity group of the local coalition. Across all reports, ten ADPEPs named Tribes as a partner. Eight named their Regional Health Equity Coalition (RHEC).

One ADPEP, itself, is a culturally specific organization. Highland Haven holds Multnomah County's second ADPEP contract and serves Black, African American, and African immigrant and refugee communities. Its first workplan goal is to increase the perception of harm associated with alcohol, cannabis, and other drugs within the Black community. It delivers programming through Black Student Union groups in the David Douglas School District, a youth policy academy that brings policymakers of color together with students, health literacy sessions with Black physicians, and community listening sessions on fentanyl and polysubstance use co-hosted with the county REACH/ACHIEVE coalition and the African Coalition of Oregon.

Table 6 below provides an overview of culturally responsive prevention approaches, citing examples from the provider survey and/or ADPEP reports that indicate the approaches use in Oregon.

Table 6. How culturally responsive prevention is delivered in Oregon

Approach	What it means	Examples as reported
Language access	An existing program is delivered in a community's language, with translated materials. The program design does not change.	- Clackamas County Children, Family and Community Connections delivers Spanish-language prevention education events. - Multnomah County Behavioral Health delivers Spanish-language parent and family education with community organizations across Multnomah, Clackamas and Washington counties. - A regional fentanyl awareness campaign led by Clackamas County Public Health provides a website in English and Spanish, audio advertising in Spanish, Chinese and Vietnamese, and social media toolkits in six languages.
Cultural adaptation	An established program is revised in content, examples and delivery for a specific community.	- La Nueva Drug Talk, delivered by Song for Charlie and The New Drug Talk Oregon, is a culturally responsive Spanish-language version of a fentanyl and counterfeit pill education program for Latino families. - Values to Action delivers an acceptance and commitment program adapted for African refugee women who have experienced trauma.
Community-designed	The community designs and delivers the program, and cultural practice is the prevention activity itself.	- Empoderando Familias, a family-centered prevention program for Latino and immigrant families, delivered by Clackamas County Children, Family and Community Connections and extended into Washington County as a tri-county effort. - The Slavic Community Center of Northwest delivers workshops, mentorship and prosocial activities for Slavic and Eastern European youth and families, with commercial tobacco prevention campaigns in Ukrainian, Russian and Romanian. - The Native American Youth and Family Center delivers prevention through Native cultural practice. - Highland Haven holds Multnomah County's second ADPEP contract and delivers prevention designed for and by Black,

Approach	What it means	Examples as reported
		African American, and African immigrant and refugee communities, including youth policy work through Black Student Union groups and health education through faith-based partners.

Note: HB 3321 provider survey program descriptions. The three approaches are a Third Horizon reading of those descriptions and were not a survey field. Examples only.

In the provider survey, four organizations described work designed for, adapted for, or delivered in the language of a specific cultural community other than a Tribal community. Empoderando Familias, a Spanish-language family prevention program, accounts for two of them: Clackamas County Children, Family and Community Connections and Multnomah County Behavioral Health both reported delivering it, and Washington County Public Health described a tri-county effort to expand it using one-time Opioid Settlement funds. The Slavic Community Center of NW supports Slavic and Eastern European youth through workshops and mentorship, and Values to Action delivers Acceptance and Commitment Therapy in the African refugee community. Two further programs provide materials or training in Spanish alongside English rather than being designed for a specific community.

Schools reported the same activity at a comparable level and report considerable uncertainty about it. Of the 53 districts that answered the item, 18 reported culturally specific programming during the 2024–25 school year, 18 reported none, and 17 were unsure. Ten reported “Tribal-informed programming,” as they surveyed it, 21 reported none, and 22 were unsure.

Two factors drive that uncertainty. The survey did not define culturally specific or Tribal-informed programming, so districts applied their own definitions. The two counts are therefore less reliable than the other activity questions in the survey. The uncertainty is also uneven. Across the fourteen activity items, respondents answering “not sure” range from 8% to 45%. Survey wording alone does not explain a spread that wide. Districts answered confidently about middle school classroom instruction (8% unsure), high school overdose prevention instruction (8%), and naloxone training (11%). The same districts were far less certain about peer leadership (45%), Tribal-informed programming (42%), family education (34%), culturally specific programming (32%), and after-school programming (32%). Districts can account for the activities they deliver on a district schedule. They cannot account for the activities delivered building by building, often by outside partners.

Both factors point in the same direction. Districts that cannot classify their own culturally specific and Tribal-informed programming are not planning, funding, or evaluating it at the district level. Limited reporting back to state agencies and the general nature of the Division 22 requirement

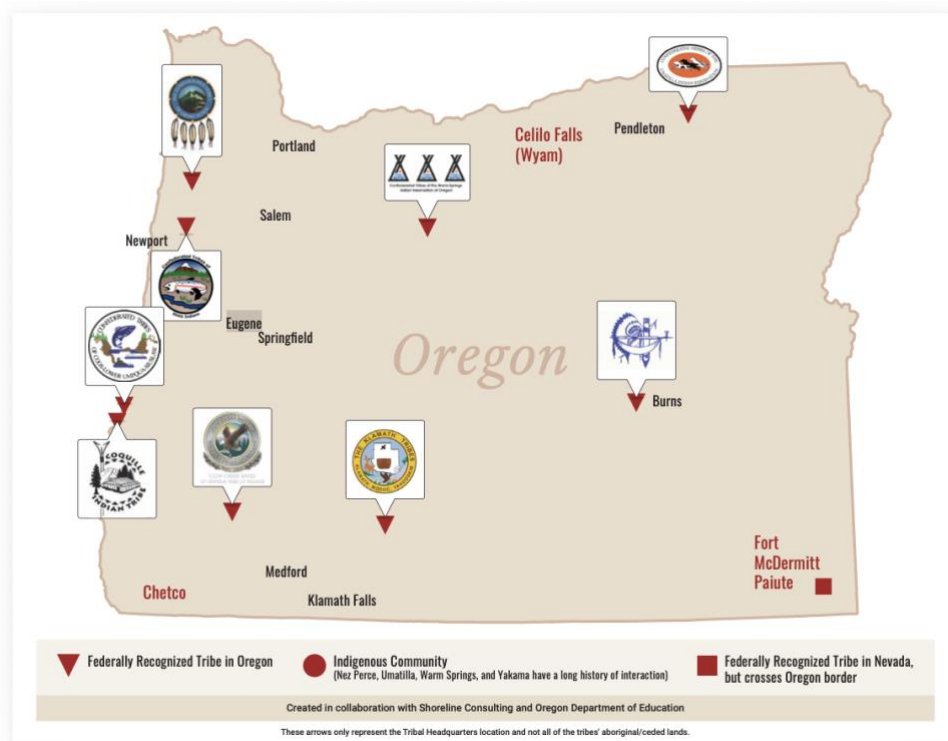
leave state agencies without a line of sight, particularly where services are delivered by the schools themselves or by a community-based organization that is not using state funding.

Collegiate survey respondents identify the populations they believe need more attention rather than the programming they deliver. Eight of the nine responding institutions named student populations that need more targeted prevention efforts. Four named students of color, or students from underrepresented or marginalized groups, and three named LGBTQIA+ students. Commuter and non-traditional students, student athletes, and students in recovery were also named.

Tribal Prevention

Oregon is home to nine federally recognized Tribes, each a sovereign nation with its own government, health system and prevention priorities: the Burns Paiute Tribe; the Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians; the Confederated Tribes of the Grand Ronde Community of Oregon; the Confederated Tribes of Siletz Indians; the Confederated Tribes of the Umatilla Indian Reservation; the Confederated Tribes of Warm Springs; the Coquille Indian Tribe; the Cow Creek Band of Umpqua Tribe of Indians; and the Klamath Tribes. Each Tribe governs its prevention work independently, and the agency documents reviewed for this assessment describe the Tribes as a group rather than individually, so no single description applies to all nine.

Figure 17. Tribal Communities of Oregon



Source: Oregon Department of Education, [Map of Oregon Tribes](#) ²⁸

Tribal prevention aligns with the frameworks used throughout this report, with one addition. Oregon Health Authority prevention staff describe Tribal prevention plans as evidence-based and oriented toward environmental and systems-level change. The plans align with the six CSAP strategies and with the National Academy of Medicine categories of universal, selective, and indicated prevention. The addition is a defined set of 22 tribal-based practices. In this report, Tribal-Based Practices refers only to the OHA-defined set of culturally grounded prevention practices that each Tribe implements with flexibility and autonomy, according to its own priorities. OHA staff note that examples of tribal-based practices include powwows, talking circles, sweat lodge and other ceremonies, and land-based and equine approaches.

Table 7. The 22 Tribal-Based Practices recognized in Oregon

Tribal-Based Practice	Tribal-Based Practice
Adventure Based	Native American Community Mobilization
Basketball Against Alcohol and Drugs (BAAD)	Native American Storytelling
Baby Doll Cradle	Positive Indian Parenting
Canoe Journey/Curriculum	Pow-Wow
Ceremonies & Rituals	Promoting Peace with family-tribal based meditation
Cradle Boards	Round Dance
Cultural Camp	Sweat Lodge
Domestic Violence Group Treatment for Men	Talking Circle
Family Unity	Tribal Crafts
Healthy Relationships Curriculum	Tribal Family Activities
Horse Program	Tribal Youth Conference

Note: Tribal Based Practices in Oregon, presented at the Oregon-Idaho HIDTA Summit. Practice names are reproduced as defined. Each Tribe implements these practices with flexibility and autonomy, according to its own priorities.

OHA staff credit several of these practices with meaningful outcomes, including reduced recidivism and reduced substance use, and note that they work through mechanisms well recognized in prevention science: building trust, creating social accountability, developing skills, and reinforcing clear community standards. Because these approaches address risk and protective factors that are shared across behavioral health conditions, some have potential application in the wider community. Oregon Health Authority partners see value in raising the profile of tribal-based practices within Oregon's broader prevention system. They also caution

that doing so responsibly requires attention to community readiness, relationship-building, and the risk of cultural appropriation. The activity documented most consistently across sources is the annual Tribal Opioid Summit. Supported by the Centers for Disease Control and Prevention and the Substance Abuse and Mental Health Services Administration since 2018, the Summit is co-led by the Northwest Portland Area Indian Health Board with the nine Tribes and is developed by a panel that includes a representative from each Tribe. It disseminates Tribal practices in wellness and prevention across Tribal communities. At the state level, the Alcohol and Drug Policy Commission's 2026–2030 comprehensive plan commits to supporting Oregon's Tribal Health Strategic Plan, where applicable to substance use prevention, health and safety intervention, treatment, and recovery.

Survey responses confirm that Tribal and Native-serving prevention is taking place across Oregon, but it does not document the prevention work of the nine federally recognized tribes. Though Third Horizon gained insight into Tribal approaches through key informant interviews with state and community leaders who are members of tribal communities, none of the Tribal entities responded to the surveys and the information contained in this reporting, therefore, it includes programs reported by community-based organizations and local governments providing Native-culture-grounded programming delivered by non-Tribal organizations. In the provider survey, 28 program entries report reaching Tribal communities among the populations they serve. Thirteen entries were reported under a separate response option labeled "Tribal-based" when respondents were asked to categorize the type of program. None came from a Tribe or tribal government: four from the Native American Youth and Family Center, an urban Indian organization, and nine from two community-based providers, three local government departments, and a consulting practice. The Native American Youth and Family Center reported five prevention-related entries, of which two fall within the definition of primary prevention used in this report: community building, and self-care activities delivered through Native cultural practice, including sweat lodge, hiking, beading, Native crafts, and making lotion from native plants and herbs. Its referral, harm reduction and recovery entries — the last including hand drum making, basket weaving and traditional medicines — are accounted for outside the primary prevention inventory.

Two Native-serving organizations account for much of the documented service delivery. The Native American Rehabilitation Association of the Northwest, Oregon's Urban Indian Health Program, has received prevention funding for more than three decades and serves a Portland-area urban Native population of approximately 60,000, many of whom are not enrolled in an Oregon Tribe; its funding priorities are determined by the vote of the nine Tribes. The Native American Youth and Family Center is the state's largest Native-serving tobacco-prevention grantee.

Two further examples show how Tribal and county systems work together. The Klamath County Juvenile Department maintains memoranda of understanding with the Klamath Tribal Court covering case referrals, joint case management, and a shared Tribal probation officer, and provides a small grant fund to the Tribal Court through the Juvenile Crime Prevention process to support young people on probation. In the Columbia Gorge, the Four Rivers Early Learning Hub is

working with the Native American liaison at the Columbia Gorge Education Service District to establish a Native Family Leadership Council.

The Oregon Department of Education's Office of Indian Education administers an American Indian and Alaska Native Student Success Plan and the required Tribal History and Shared History curriculum.

School district engagement with Tribes is limited. Three districts reported consulting a Tribal partner when developing their current prevention plan, and five reported working with a Tribal partner on prevention delivery. Given that nine Tribes and several Tribal and Native-serving organizations operate prevention programs in the state, this indicates that Tribal prevention expertise is not routinely drawn on in school district planning.

In October 2024, the Centers for Medicare and Medicaid Services (CMS) approved Oregon, together with Arizona, California, and New Mexico, as the first states authorized to cover traditional health care practices under Medicaid and the Children's Health Insurance Program (CHIP). Under [Oregon's section 1115 demonstration authority](#), which extends through September 30, 2027, these practices are covered when delivered by or through Indian Health Service (IHS) facilities, Tribal facilities operating under the Indian Self-Determination and Education Assistance Act, and urban Indian organization facilities authorized under Title V of the Indian Health Care Improvement Act. Qualifying facilities determine which practitioners may deliver the practices, and CMS did not prescribe the practices to be covered, leaving their definition to the Tribes.

Taken together, the evidence indicates that culturally specific and tribal prevention is occurring across Oregon and receives dedicated state investment, especially tribal based efforts.

Innovative and Grassroots Prevention Practices

Most programs in the inventory do not name a branded curriculum. Beyond the 41 recognized programs described above, respondents described 37 locally developed, innovative, or grassroots primary prevention practices: approaches that an organization, school, campus, or state agency created or adapted to address conditions in its own community. Third Horizon identified these practices through open-response items in the provider survey, school survey, intercollegiate survey, key-informant interviews, and existing state records.

Locally developed prevention practice addresses need that Oregon's funded prevention system does not currently reach, and it does so on a foundation of recognized prevention approaches rather than ad hoc activity. This finding carries direct implications for how the state identifies, supports, and disseminates local practice. Of the 265 distinct prevention programs identified across this assessment, 41 use a recognized curriculum or named program. The remainder, including the 37 practices documented here, consists of work that a county, school, campus, or state agency designed or adapted for conditions in its own community.

The evidence does not characterize this work as untested. Most of these practices are evidence-informed rather than formally designated as evidence-based. They are locally developed or adapted, address recognized risk and protective factors, and in most cases build on approaches with an established research base, although few have been independently evaluated in their local form. Among the 82 provider respondents who classified their programs, 65 percent marked at least one program as evidence-based, while just under two in five marked a program as innovative, and a comparable share marked one as a promising practice. These categories are self-reported and are not mutually exclusive. Independent evaluation of a local adaptation is costly and is not routinely funded, so alignment with an established program is the practical basis on which most of this work is supported.

Each practice was sorted into one of six types according to what it primarily does. Table 8 gives the definition and count for each type.

Table 8. Locally developed, innovative and grassroots practices by type

Type	What it means	Count
Cross-sector or integrated	Prevention delivered through, or built into, another system such as health care, housing, education or justice	10
Innovative program or other	A locally created approach that does not fit a standard program category	8
Culturally grounded or specific	Work designed for and by a specific cultural community	7
Grassroots or community-led	Work started and run by a local community or organization	6
Youth-led	Work led by young people, such as youth advisory or peer models	3
Higher education	Practices reported by Oregon colleges and universities	3
Total		37

Note: This was derived from HB 3321 provider survey (18 practices), school survey (9), key-informant interviews (6), intercollegiate survey (3), and existing state records (1). Practices that fit more than one type were assigned the closest match.

Locally developed, innovative, and grassroots practices are delivered mainly by community organizations and school districts. Of the 37 practices, 18 are delivered by community organizations and nine by school districts. County government accounts for five, colleges and universities for three, and coalitions or statewide bodies for two. Several practices are co-delivered: Banks School District works with Washington County, Central Point School District with

the county health department, and the Regional Health Equity Coalitions (RHEC) with the Oregon Health Authority. Locally developed practice, therefore, operates within the funded system rather than parallel to it

Table 9. Who delivers locally developed, innovative, and grassroots practices

Type of organization	Practices
Community organization	18
School district	9
County government	5
College or university	3
Coalition or statewide body	2
Total	37

Each practice has been assigned one or more of the six CSAP strategies, which allows locally developed work to be compared with the funded programs described in Section 6 on the same basis. Prevention education and community-based processes account for most of the field, at 17 and 16 practices. Practices may use more than one strategy, so the counts exceed the number of practices.

Two comparisons show where locally developed practice supplies what the funded planning system does not. Six practices deliver problem identification and referral, which identify young people who require support and connect them to services. Counties separately reported approximately 5 percent of delivered resources supporting such work, and while a review of ADPEP workplans does note problem identification and referral strategies, the limited budget allocation suggests likely limitations in the ability to reach all youth in need of such services. Where the funded planning system does not formally plan for referral, locally developed practice is demonstrably delivering it.

One gap locally developed practice does not close is environmental and policy work, which includes measures such as regulating how alcohol and cannabis are sold. Environmental strategy is the least represented among these practices, with two, which follows the pattern in county delivery; a result consistent with the funded system, in which ADPEPs planned environmental and policy work in some of their workplans, but with reporting indicating that some efforts were abandoned or cancelled. Because the strategy is under-represented at every level at which it is measured, it constitutes a system-level gap requiring state action rather than a deficiency attributable to locally developed practice.

Table 10. Locally developed, innovative, and grassroots primary prevention practices, by CSAP strategy

CSAP strategy	Practices	Illustrative practices
Prevention education	17	• Work2BeWell — a curriculum written by teenagers for middle and high schools. • Lifeways — an integrated substance use, mental health and problem gambling curriculum across eight age-appropriate modules, K to 12. • Empoderando Familias — family-centered prevention for Latino and immigrant families.
Community-based processes	16	• Community Wellness Coalitions — grassroots groups of parents, educators, youth and local organizations. • School-based health center partnerships — Central Point School District with health centers and the county health department. • Oregon Coalition for Prevention Professionals — a statewide body convening the prevention field.
Information dissemination	8	• Positive Community Norms campaign — Tigard Turns the Tide, correcting misperceptions of youth substance use. • Song for Charlie — locally adapted digital education on emerging drug threats. • Y-Scenes — a youth mapping resource in Multnomah County.
Alternatives	8	• Skating IS Connection — skateboarding, music and art creating substance-free gathering spaces. • Dream Big City — a community activation model combining sport, music, art and gardening. • Substance-free social programming — alcohol-free campus events and late-night alternatives.
Problem identification and referral	6	• Upshift — screening and referral in Bend-La Pine, Redmond, and Sisters School Districts after a first substance use incident. • Salem-Keizer School District — a four-session cognitive behavioral therapy and motivational interviewing intervention delivered by school social workers. • Eugene School District — student intervention teams taking staff and parent referrals.

CSAP strategy	Practices	Illustrative practices
Environmental strategies	2	• Retail and dispensary engagement — Clackamas County works with cannabis dispensaries and with a Milwaukie retailer to shift its product mix away from tobacco. • Regional Health Equity Coalitions — a policy, systems and environment infrastructure named as a partner across eight to nine regions.

Note: This was derived from Provider, school, and intercollegiate surveys, key-informant interviews, and existing state records (n=37 practices; 57 strategy assignments). Practices may use more than one strategy. Strategy definitions follow the Center for Substance Abuse Prevention framework set out in the Introduction. The exhibit above is an illustrative list, and the full breakdown of programs by strategy can be found in Appendices A and B.

The prevention field has reached a consistent conclusion. Asked which single change would prove most transformative for the prevention workforce, 45 of 93 survey respondents selected dedicated funding for grassroots and community-led prevention, the second most frequently selected option. Given the scale and demonstrated contribution of locally developed practice, Oregon requires a standing capability to identify it, assess it, and support local, home grown and innovative practices. No entity currently holds that responsibility.

Workforce Analysis

Credentialing and professional standards

Primary Prevention programs are delivered by a wide array of youth and social service providers, the type of whom often depends on the specific strategy being implemented, and the environment it is being delivered in. In conducting this analysis, Third Horizon included an extensive list of credentials in its provider and school surveys, to ascertain the diversity of professionals who are engaged in primary prevention efforts. However, Third Horizon did focus additional attention on two specific credentials in the analysis that prevention professionals and OHA call out as being represented in the primary prevention workforce: The Certified Prevention Specialist and the Certified Health Education Specialist (CHES).

Certified Prevention Specialist (CPS)

The primary substance use prevention-specific credential. Administered in Oregon by the Mental Health & Addiction Certification Board of Oregon (MHACBO) on the IC&RC Prevention Specialist standard, which transfers between member boards in other states. The pathway is practice-based: 150 hours of prevention-specific education, 2,000 hours of supervised prevention work experience, 120 hours of supervised experiential learning, an ethics agreement, a national criminal history check, and the IC&RC examination. Renewed every two years with 40 hours of continuing education, including six hours of ethics and two hours of suicide prevention training.²⁹

Certified Health Education Specialist (CHES)

The credential most often held by public health staff.³⁰ Administered nationally by the National Commission for Health Education Credentialing (NCHEC); the pathway is academic rather than practice based. Eligibility requires at least a bachelor's degree, either in health education or with at least 25 semester credits (37 quarter hours) aligned with the Eight Areas of Responsibility, with no work experience requirement. Candidates sit a 165-item examination (150 scored); renewal is on a five-year cycle with 75 continuing education contact hours. An updated nine-area framework will serve as the examination basis beginning in 2027.

Historical Background

In assessing the volume of credentialed professionals in Oregon, and why additional credentials are worth attention, it is important to uncover the regulatory history of the two primary credentials tethered to the delivery of primary prevention services: the CPS and the CHES.

Over 10 years ago, most substance use prevention, financial management, and contracting in Oregon was moved from OHA's Behavioral Health Division to the OHA Public Health Division. In that shift, the requirement for CPS-certified county coordinators was removed from Oregon law, and contracts for primary substance use prevention services administered by Public Health do not require a CPS credential. Public Health does look to the CHES as a credential in public health contracting, which often has blended primary prevention funding flowing through those contracts. The one exception to the lapse of the CPS requirement is in tribal prevention funding, which is still administered by the Behavioral Health Division, and continues to require CPS credentialing for all tribal prevention programs they fund (including tribal tobacco prevention). Outside of that exception, prevention specialist certification became entirely voluntary, and the overall number of certified individuals fell as a result.

As federal COVID resources moved into the substance use field in Oregon, federal pandemic relief was utilized to cover registration, renewal, and exam fees. Those resources no longer exist, and even while it was available, uptake was reported as low. MHACBO attributed the low numbers to the exam's voluntary status and complexity. This account aligns closely with the survey finding that many respondents see no clear benefit to the credential, and it recasts that finding as the predictable result of a policy and financing change.

Despite this history, currently there has been a renewed effort to address the low levels of credentialed professionals. OHA has contracted with the Oregon Council for Behavioral Health, acting as fiscal sponsor for the Oregon Coalition of Prevention Professionals (ORCPP), to provide an expanded suite of professional development trainings for individuals seeking the CPS certification. The contract was approved in September 2025, with state agency and other field leaders identifying a robust response to program offerings to date.

While this development is an encouraging step in improving the number of CPS credentialed individuals in the field, key informant interviews identified the existence of the CHES as an available credential in public health that could ameliorate the administrative burden of requiring multiple credentials within the public health ecosystem, and surveys identified additional

credentialed professionals delivering primary prevention services. For this reason, Third Horizon took a broad lens in defining the workforce and includes in this section additional guidance on how Oregon should consider a workforce landscape that is inclusive of a diverse array of professionals and volunteers with a variety of different credentials and training background.

Credentialing Landscape

As noted, across the four surveys, both these and other credentials were asked about. The Workforce Survey asked in detail about CPS status and barriers, reported below, and included the CHES among other credentials (like CADCs, LCSWs, and LPCs), where 6 of 94 respondents reported holding it. The Provider Survey found seven of 62 organizations with CHES-credentialed staff against 19 naming the CPS, and the School Survey found four of 34 districts with CHES-credentialed staff and none naming the CPS. The Intercollegiate Survey did not list CHES as an option, though six of eight campuses reported that public health credentials were held by prevention staff.

Primary prevention activities are also often implemented by a variety of professionals and volunteers, some of whom would not self-identify as being in the "substance use prevention" field, and for this purpose will be referred to as "allied professionals" in this report. These can include, for example, teachers implementing a health curriculum with age and developmentally appropriate substance use prevention education components, or youth workers at a community-based youth serving organization (Boys and Girls Clubs, summer arts camps, etc.)

The following section assesses the size, geographic distribution, credentials, capacity, and sustainability of Oregon's primary prevention workforce, including the current and active CPS and the allied professionals who deliver prevention work alongside them. It also includes a crosswalk analysis of the CHES and the CPS. The assessment draws upon the following sources:

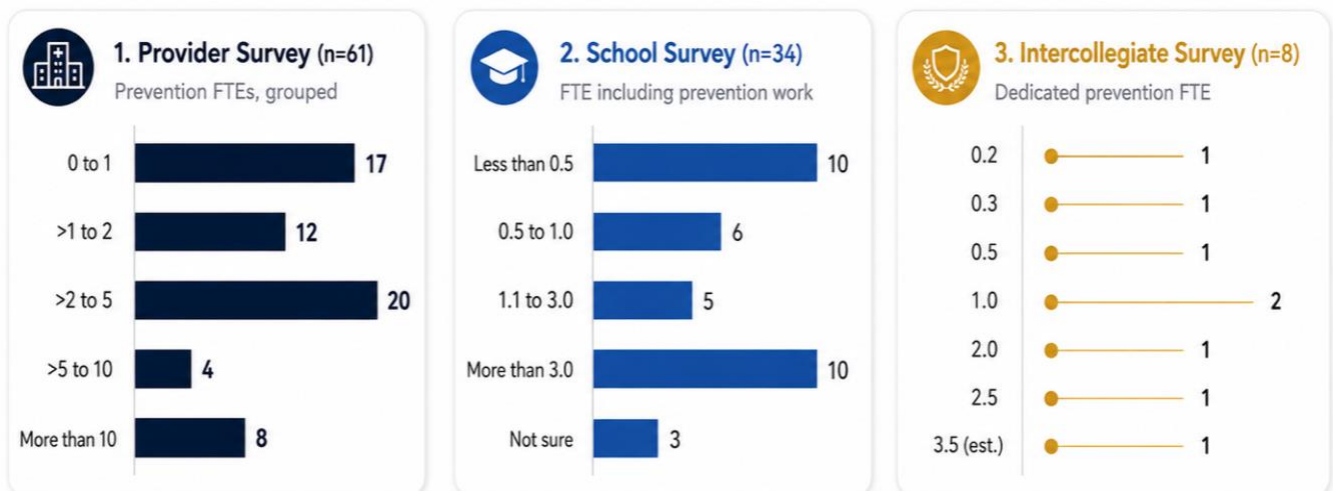
1. The Workforce Survey, Provider Survey, School Survey, and Intercollegiate Survey provided self-reported data on roles, staffing, credentials, and working conditions across individual, organizational, school, and campus settings.
2. The CPS registry is maintained and shared with Third Horizon by MHACBO and provides the total count of credentialed specialists to date.
3. Third Horizon conducted key informant interviews with MHACBO and other state agencies to learn more about the current credentialing procedures, workforce, and related systemic needs.
4. CPS and CHES credential requirements and regulations as they apply in Oregon.
5. Two corroborating analyses: the [Center of Excellence Workforce Analysis](#), which Third Horizon conducted for Washington State University in 2025, and the [2022 Oregon Substance Use Disorder Services Inventory and Gap Analysis](#), conducted by the Oregon Health and Science University and Portland State University School of Public Health (OHSU-PSU). Additional published sources and statutes are cited in footnotes where used.

Workforce size and composition

The MHACBO registry contains 62 CPS records, of which 5 list employers outside Oregon, leaving 57 Oregon-based credential holders. 48 hold currently active credentials. The Workforce Survey, by comparison, drew 101 respondents. This indicates that the credentialed prevention specialist workforce is small and that most of the workforce works outside that specific credential.

Credential counts capture only one dimension of workforce capacity. Staffing levels reported by organizations offer a second measure. Two responses were excluded from the staffing and vacancy figures from the provider survey: one of 800 that appeared to report an entire municipal agency rather than prevention staff, and one of 190 from a provider whose work falls outside primary prevention. Among the remaining 61 organizations that estimated prevention staffing, the median was about three full-time equivalents (FTE), and 29 reported two or fewer. Regarding vacancies, 41 organizations responded and reported 25 vacant prevention positions in total; most reported none, and the highest reported four. With the provider survey finding that prevention is often a fraction of a role, these figures describe thin, widely distributed staffing instead of concentrated prevention teams. The school and collegiate surveys reach the same conclusion in their settings: of the 34 school survey respondents who estimated staffing, 16 reported one FTE or less, with work that even includes prevention, and the eight campuses reporting dedicated staffing range from a fifth of an FTE to about three and a half FTEs per campus.

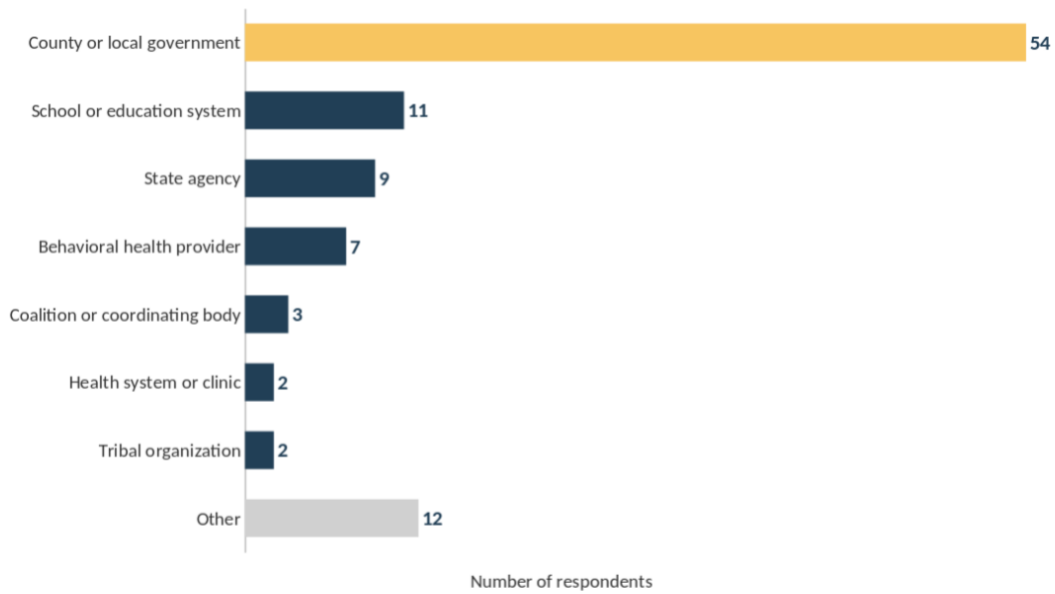
Figure 18. Prevention staffing across provider, school, and campus settings



Note: Provider Survey (n=61; two out-of-scope responses excluded), School Survey (n=34), and Intercollegiate Survey (n=8), 2026.

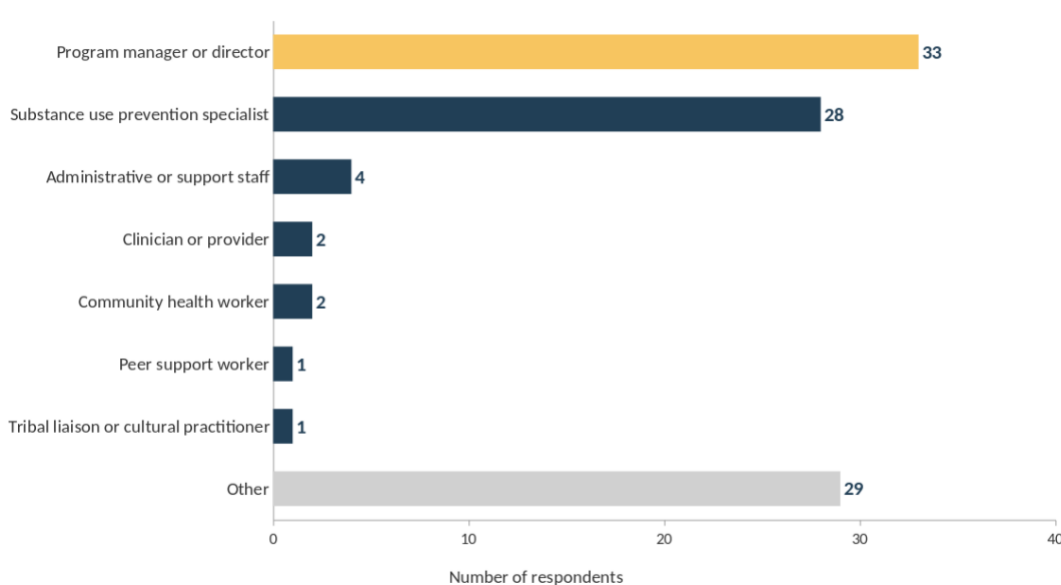
Respondents cluster in a few types of organizations. Of the 100 who identified an employer type, 54 (54 percent) work in county or local government. The remainder are distributed across schools or education systems (11), state agencies (9), behavioral health providers (7), coalitions or coordinating bodies (3), health systems or clinics (2), and tribal organizations (2), with 12 selecting other.

Figure 19. Employer type among Workforce Survey respondents (Workforce Survey, n=100)



Primary roles cluster in three categories. Of the 100 respondents who named a primary role, 33 identified as program managers or directors and 28 as substance use prevention specialists, while 29 selected other, the second most common answer, with small numbers in administrative, clinical, community health worker, peer support, and tribal liaison roles. More broadly, surveys validate that primary prevention services and strategies in Oregon are often carried out by people who would not identify themselves as members of a substance use prevention workforce, mentors, or volunteers at youth-serving organizations. Recognizing this, survey response counts reinforce that the total number of individuals professionally engaged in the delivery of primary prevention programs and strategies is likely an undercount of the total number.

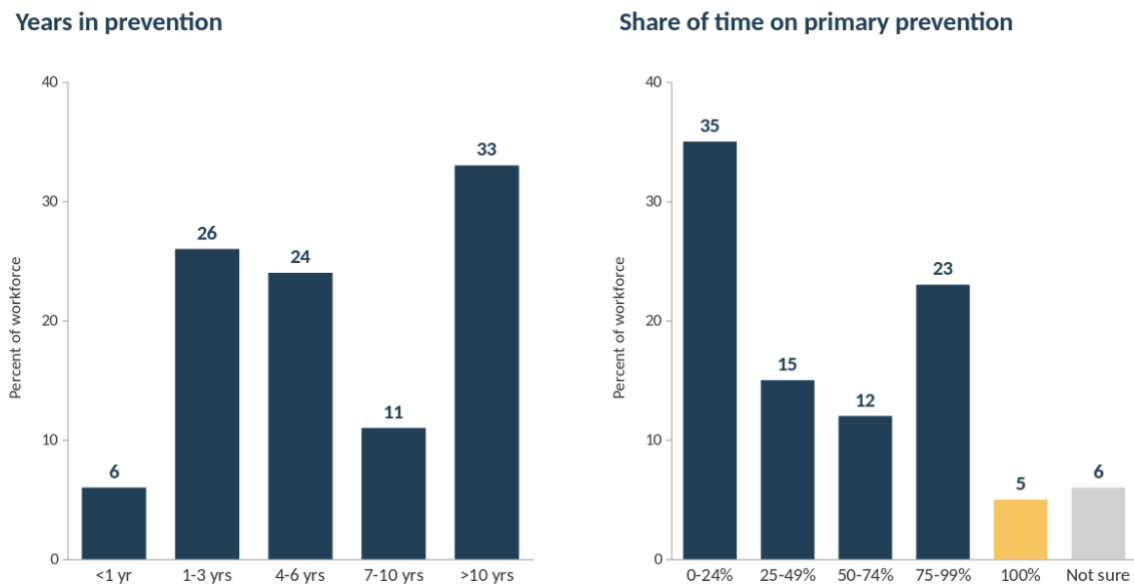
Figure 20. Primary role among Workforce Survey respondents (Workforce survey, n=100)



Most respondents are experienced, though a sizable group is new to the field. Of 100 Workforce Survey respondents, 33 have worked in prevention for more than 10 years, 26 for 1 to 3 years, and 6 for less than 1 year.

Headcount also overstates capacity, because prevention is rarely the whole of anyone's job. The Workforce Survey asked respondents what share of their own work time is spent on primary substance use prevention. Of the 96 who answered, only 5 reported that primary prevention takes all of their work time, and 35 (36 percent) put it at under a quarter. These are shares of each respondent's work time, not full-time-equivalent positions. The work is also rarely confined to substance use prevention. Asked whether they work in other parts of the substance use continuum, only 18 of 94 report none, and asked whether their work includes other prevention services, just 6 of 96 report none, with most also carrying mental health promotion (57), overdose prevention (51), or suicide prevention (50).

Figure 21. Workforce composition: years in prevention and share of time on primary prevention (Workforce Survey, n=100)



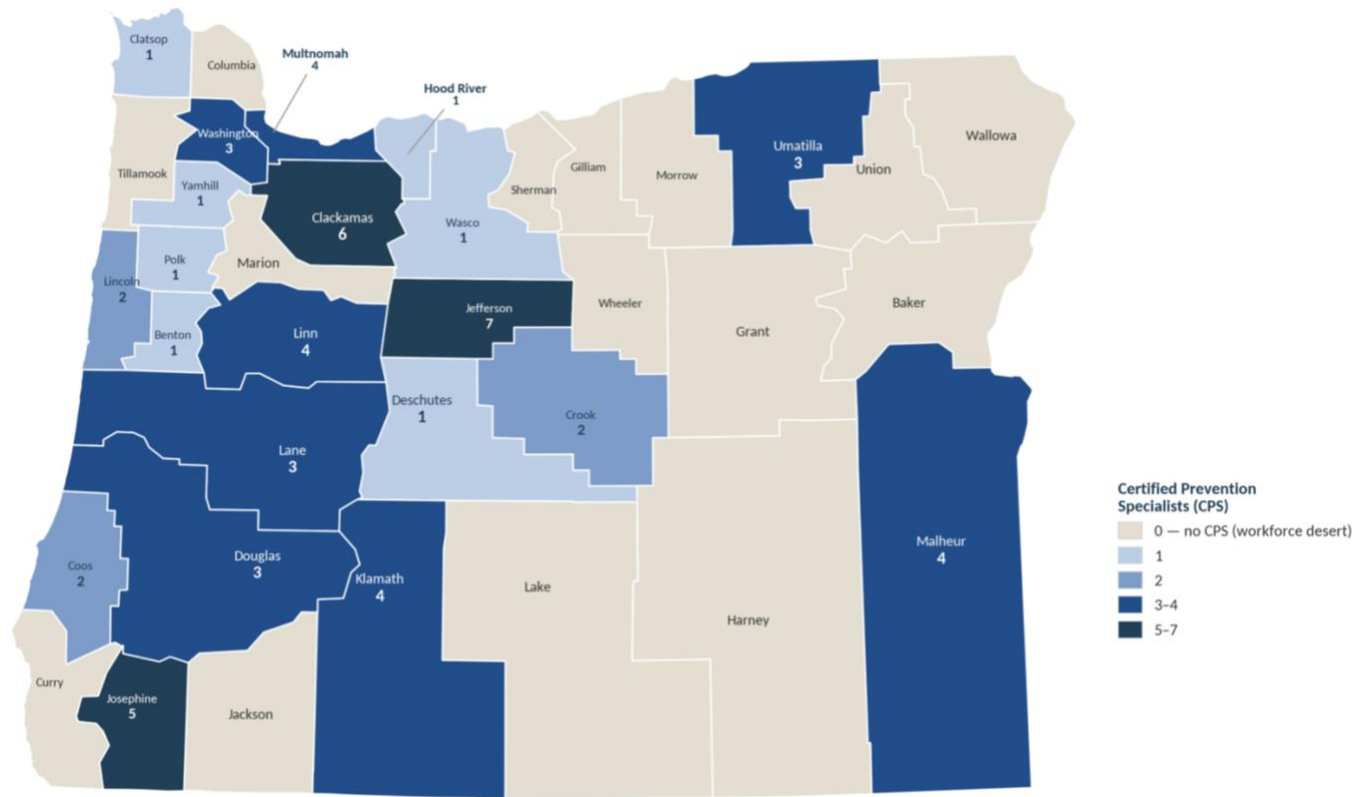
Geographic distribution

Workforce survey respondents work in all 36 Oregon counties, with the highest response volumes in Lane (24), Multnomah (21), Washington (16), Clackamas (16), and Coos (15). Because respondents could select more than one county, and some selected all of them, these tallies indicate the reach of the survey rather than workforce density.

The registry managed by MHACBO provides the distribution of credentialed specialists. Credentialed prevention specialists are concentrated in the Portland metro area and the Willamette Valley, and this concentration sharply declines across rural and frontier Oregon. CPS holders are registered in only 22 of 36 counties. The remaining 14, including Baker, Gilliam, Grant,

Harney, Lake, Morrow, Sherman, Tillamook, Union, Wallowa, and Wheeler, are disproportionately frontier and Eastern Oregon counties. Jefferson County carries the highest concentration at 7, almost entirely through the Confederated Tribes of Warm Springs, while Clackamas, Klamath, Josephine, and Washington each hold between 4 and 5.

Figure 22. CPS credential holders by county of employment (MHACBO CPS Registry)



Note: CPS counts reflect the primary county of employment as reported in the MHACBO registry

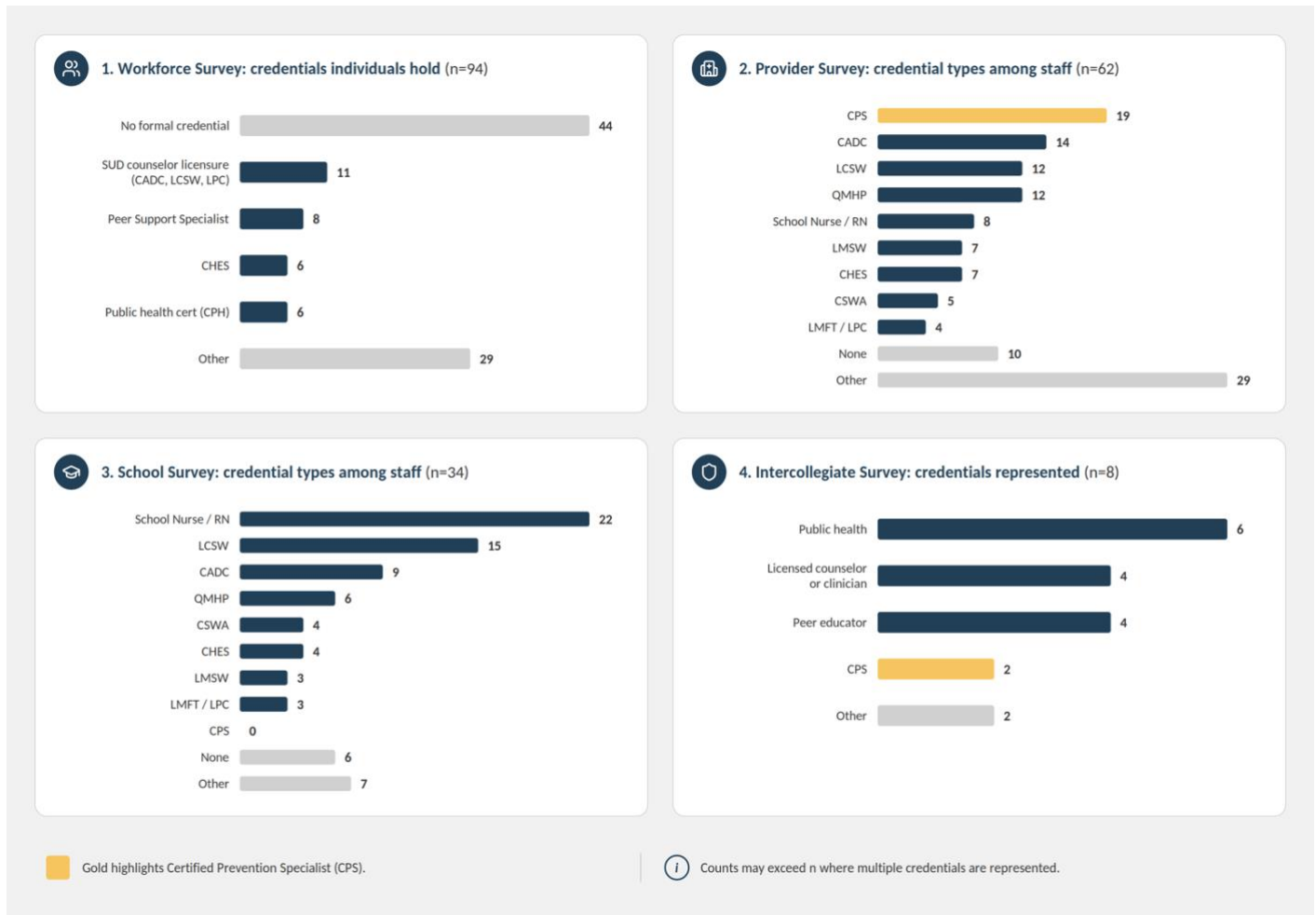
Credential status across the workforce

Of 101 Workforce Survey respondents, 19 (19 percent) hold an active CPS credential, and 14 (14 percent) are working toward it. A larger group is entirely disconnected from the credential, with 40 (40 percent) reporting they have not pursued it and 19 (19 percent) reporting they are not familiar with it. A further 5 held the credential but let it lapse, and 4 began the certification process but are not currently pursuing it.

The Provider Survey confirms the pattern of limited CPS capacity from the employer side. Of 69 organizations that answered, 41 employ staff who hold a prevention-specific credential, while 22 do not, and 6 were unsure. Among the organizations that do employ credentialed staff, the CPS is not the dominant credential. It was named by 19 organizations, alongside the Certified Alcohol and Drug Counselor (CADC) (14), the Licensed Clinical Social Worker (LCSW) (12), and the Qualified Mental Health Professional (QMHP) (12), with a large share selecting other. Prevention work is therefore carried out in many organizations by clinically credentialed staff rather than by

prevention-specific certificate holders. The School Survey and Intercollegiate Survey extend the pattern. Districts with dedicated prevention staff name health teachers, counselors, and nurses as the people doing the work, credentialed in nursing and clinical fields, with prevention specialists on staff in only 11 of 34 districts, and no district naming the CPS among staff credentials. On campuses, 2 of 8 respondents report a CPS, against 6 reporting public health credentials.

Figure 23. Credentials reported across the four surveys

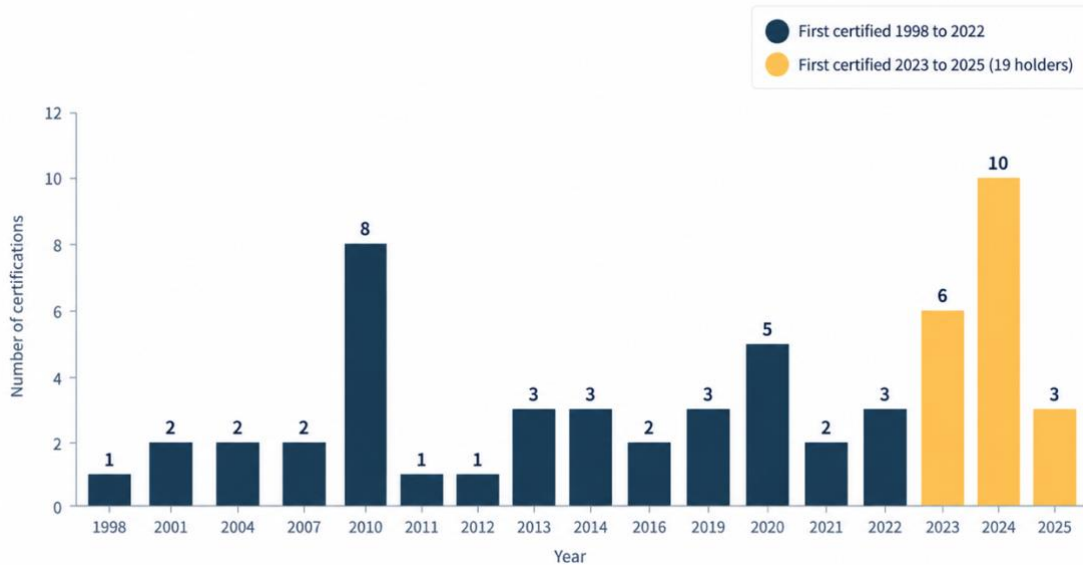


Note: Workforce, Provider, School, and Intercollegiate Surveys, 2026; select all that apply; n = respondents answering each item. CADC = Certified Alcohol and Drug Counselor; LCSW = Licensed Clinical Social Worker; QMHP = Qualified Mental Health Professional; RN = Registered Nurse; LMSW = Licensed Master Social Worker; CSWA = Clinical Social Work Associate; LMFT = Licensed Marriage and Family Therapist; LPC = Licensed Professional Counselor; CPH = Certified in Public Health.

The registry adds detail on who holds the credential. The credentialed workforce is predominantly female, at roughly 82 percent of records, and predominantly White and non-Hispanic, with a notable American Indian and Alaska Native cohort concentrated among tribal employers such as the Confederated Tribes of Warm Springs. Language capacity is almost entirely English, with only a small number of Spanish speakers. Nineteen of the 62 holders were first

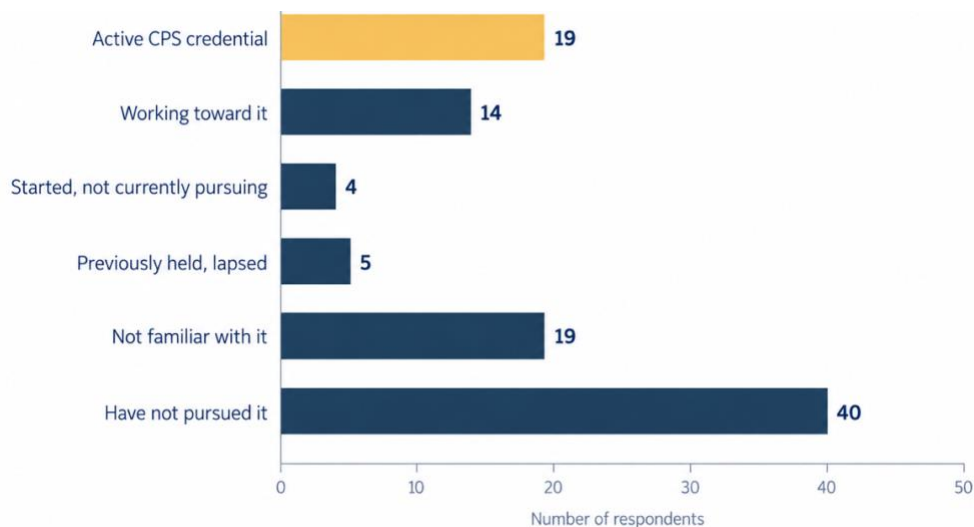
certified between 2023 and 2025, indicating a recent increase in new credentials, while a substantial share of holders is age 55 or older, indicating meaningful succession risk. The credential is drawing new entrants, though not yet fast enough to replace those nearing retirement.

Figure 24. First CPS certifications by year among current registry records (MHACBO CPS registry)



Other credentials follow the same pattern. Asked whether they hold any other professional credentials relevant to their prevention work, 44 of the 94 Workforce Survey respondents who answered (47 percent) reported none. Smaller numbers hold substance use disorder (SUD) counselor licensure, such as the CADC, the LCSW, or the Licensed Professional Counselor (LPC) (11), peer support certification (8), a CHES credential (6), or a public health credential (6).

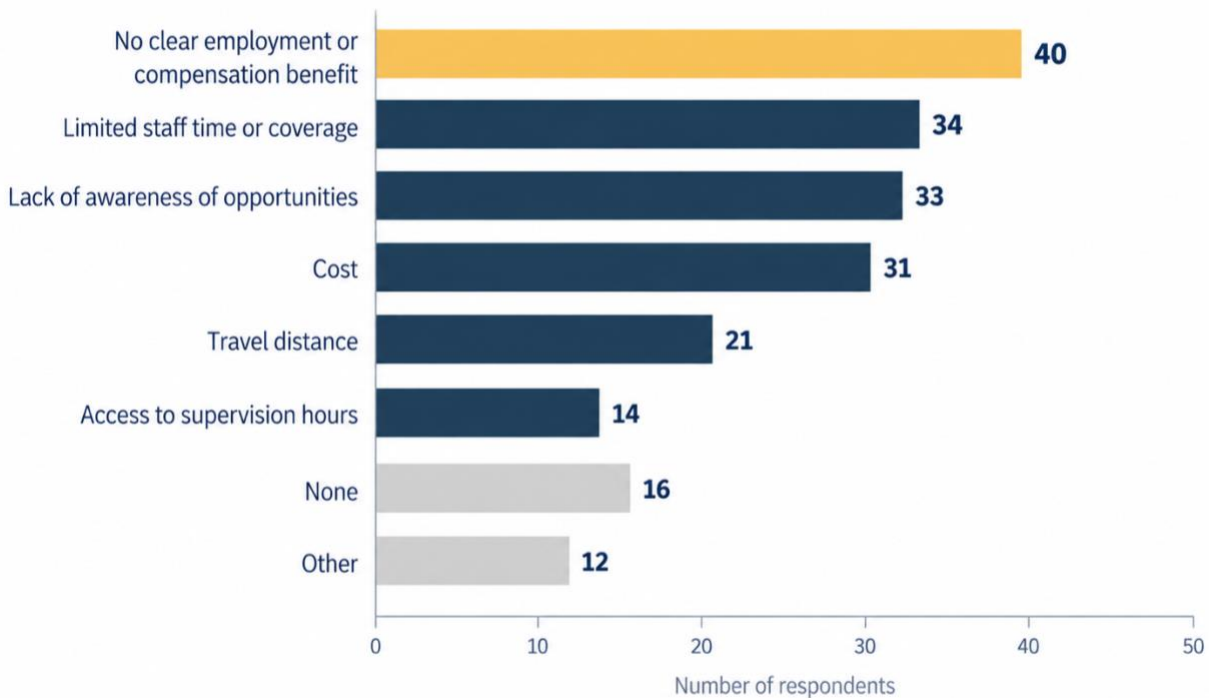
Figure 25. CPS credential status among the workforce (Workforce survey, n=101)



Barriers to professional credentialing

When asked what affects their ability to obtain or maintain CPS certification, the 94 respondents who answered pointed most often to the absence of a clear payoff. The leading barrier was the lack of clear employment or compensation benefits (40), followed by limited staff time or coverage (34), lack of awareness of opportunities (33), and cost (31). Travel distance (21) was registered as a secondary barrier consistent with rural access concerns. With the MHACBO account, these responses describe a credential seen as optional and unrewarded, not as a professional standard tied to role or pay.

Figure 26. Barriers to obtaining or maintaining CPS certification (Workforce Survey, n=94)



Sample Cross-Credential Competency Assessment

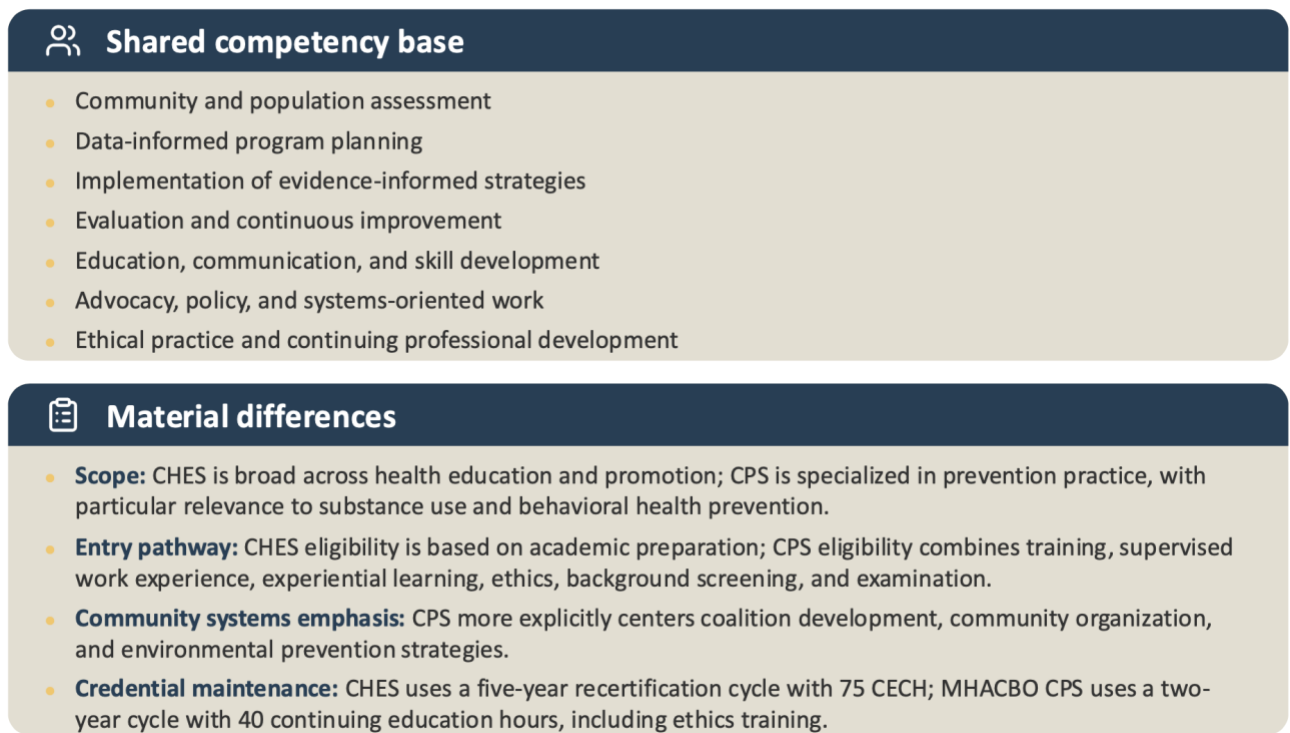
Given the diversity of professional credentials held by individuals who report working in primary prevention, including credentials other than the CPS, Third Horizon conducted a sample crosswalk of the CPS and CHES credentials to ascertain their alignment, and provide clarity on the extent to which these credentials do or do not align training and skills necessary to facilitate effective primary prevention services. While such a crosswalk was not requested through HB3321, Third Horizon provides this analysis as an example of an approach to further assessment that Oregon may wish to undertake in advancing the primary prevention workforce.

The two frameworks overlap substantially in assessment, planning, implementation, evaluation, communication, advocacy, and community engagement, and they differ mainly in scope and entry route. CHES broadly covers health education and promotion through academic preparation, while the CPS applies those functions within specialized prevention practice and adds supervised experience, prevention-specific training, and content on coalition and

environmental change. Competency alignment does not make the credentials interchangeable, and holding a CHES does not create an entirely equal level of training subject matter expertise to negate the need in some instances for the CPS.

The analysis points to several similarities and shared competencies across the credentials, while noting that there are specific differences that are material enough to treat the credentials as similar, but not the same. The high alignment of shared competencies, even if other materials differences existing in the credential, lends itself to a finding that professionals with either credential are generally qualified to delivery primary substance use prevention services, though there may be exceptions for interventions that require more specific expertise in substance use prevention science.

Figure 27. Shared Competencies and Key Differences Between CHES and CPS



While this crosswalk gives a sense of commonality that warrants inclusion of these credentials and professionals as vital parts of the primary prevention workforce, additional analysis of core competencies across other identified credentials, plus an overlay of the extent to which primary prevention program delivery is challenged by material differences in credential competency, education or training, would be warranted, given such a full crosswalk was beyond the scope for this report.

Training, technical assistance, and capacity building

Training needs are broad and consistent. Asked which training, supports, or resources are most important for strengthening the prevention workforce, workforce survey respondents who answered most often selected evidence-based prevention practices (76), community

engagement and outreach (76), culturally responsive prevention approaches (73), youth engagement and youth leadership (65), data collection and evaluation (59), and trauma-informed approaches (58). Demand is high across nearly every competency area, not concentrated in a single gap.

Figure 28. Most requested training and capacity supports (Workforce survey, n=95)



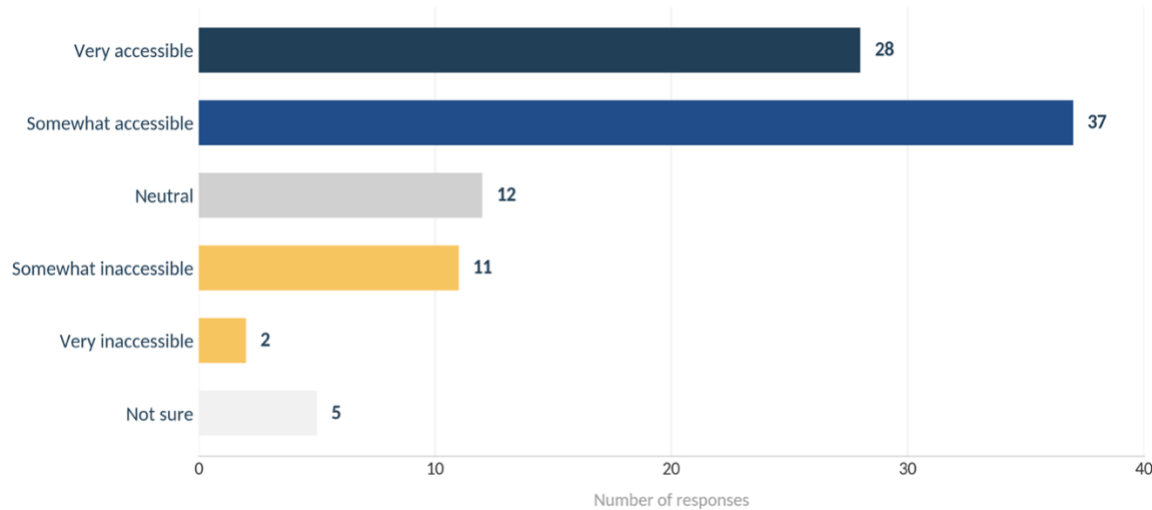
The Provider Survey shows that organizations are focused on ensuring their staff receive training, when possible, with 53 of 68 organizations reporting that prevention staff receive regular training in prevention science and best practices. Of the 50 organizations that estimated annual hours, however, 17 report 10 hours or fewer per person per year, 12 report 11 to 20, and 21 report 21 or more, so for roughly a third of those reporting regular training, regular means less than two working days a year. That training is largely sourced from outside the organization rather than delivered in-house. Asked who provides it, organizations most often named the Prevention Technology Transfer Center (PTTC) network and the Oregon Health Authority (OHA), along with online platforms and national bodies such as the Community Anti-Drug Coalitions of America ([CADCA](#)) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Only a handful described internal training capacity.

When asked what support would help most in the next 12 months, 40 of 60 organizations chose help identifying funding sources, well ahead of staff training in evidence-based programs (26) and connections to community partners (20). The prominence of funding echoes the sustainability findings below and suggests that capacity building is constrained less by the availability of training than by the resources to sustain the work around it.

Access to training is more mixed than a single figure suggests. Asked how accessible prevention-related training opportunities are for them, 28 of 95 Workforce Survey respondents found

training very accessible, 37 somewhat accessible, 12 neutral, and 13 inaccessible to some degree. For those who face barriers, the certification barriers reported above point to where the friction lies: limited staff time and coverage, cost, and travel distance, rather than a shortage of training itself. The Center of Excellence Workforce Analysis reaches a similar conclusion for rural and frontier areas, finding that access depends on hybrid delivery and sustained relationships rather than one-off training events.

Figure 29. Accessibility of prevention-related training opportunities (Workforce survey, n= 95)

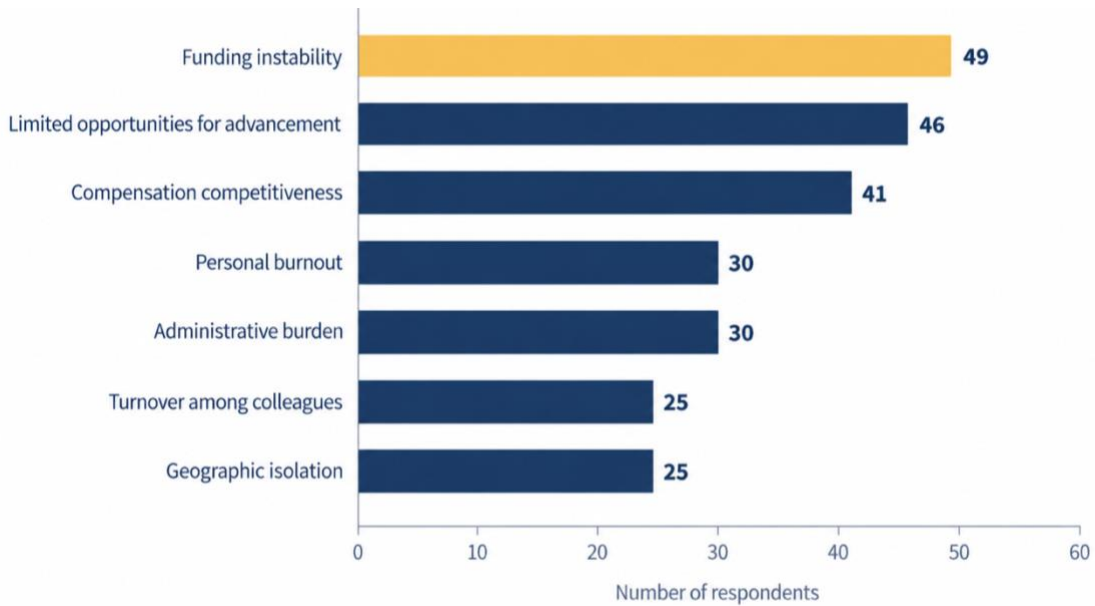


Workforce sustainability

Workforce Survey respondents find both recruitment and retention difficult. Of 89 respondents rating recruitment, 61 (69%) described it as moderately, very, or extremely challenging. Of the 90, rating retention, 65 (72%) said the same. The School Survey points in the same direction. Asked what most limits their ability to strengthen prevention, districts named staff capacity more often than anything else, 35 of the 49 districts answering, ahead of funding at 30.

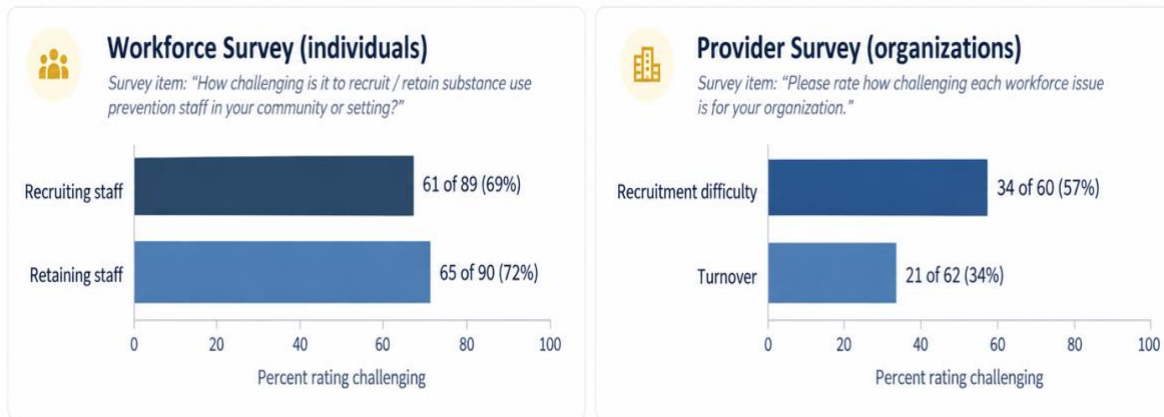
What most threatens respondents' ability to stay in the work is funding and advancement, not the work itself. Combining the two highest response options, "a lot" and "a great deal," among the 87 to 89 respondents to each item, the factors are ranked as set out below.

Figure 30. Factors with high impact on sustaining prevention work (Workforce Survey, n=87)



The Provider Survey asks the same question of organizations, and the two views do not fully agree. The Provider Survey and Workforce Survey look at the same workforce from two different vantage points. Organizations rated workforce issues as challenges for the organization, while individuals rated their own experience of working in the field. On recruitment, the two vantage points agree, with a majority of organizations calling it challenging, close to what individuals reported. On keeping staff, they diverge. Most organizations say turnover has not been a challenge for them, while most individuals say retention is difficult, and ADPEP activity reports name staffing and turnover as their most-cited implementation obstacle. This divergence is consistent with what each survey measured rather than a contradiction. Turnover counts departures that have already happened, while retention describes the effort it takes to keep people. Read together, the sources may reflect a perception gap in which most organizations do not experience turnover as a pressing problem, while the individuals doing the work report that staying in the field is difficult. Organizations may also be holding positions on paper while the people in them absorb the strain, or turnover may be concentrated in particular settings. Interviews with technical assistance leaders in the Center of Excellence Analysis similarly described turnover as most acute outside metropolitan regions, which may help explain the divergence. MHACBO reported that the loss of dedicated certification funding in 2025, when COVID financing ended, removed one of the few external supports for the workforce, which is consistent with funding instability ranking as the leading threat in the Workforce Survey.

Figure 31. Recruitment and retention, organizational and individual views



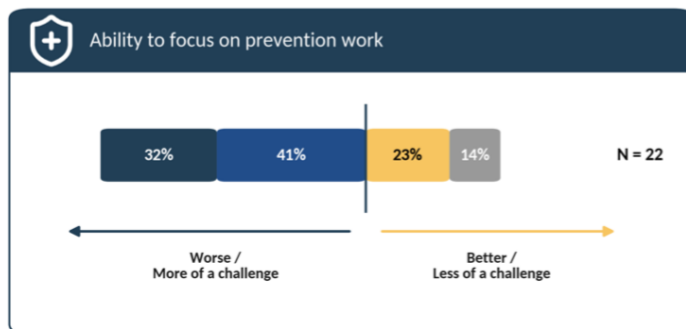
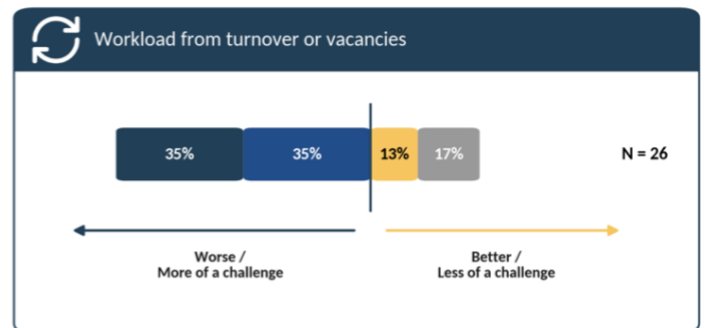
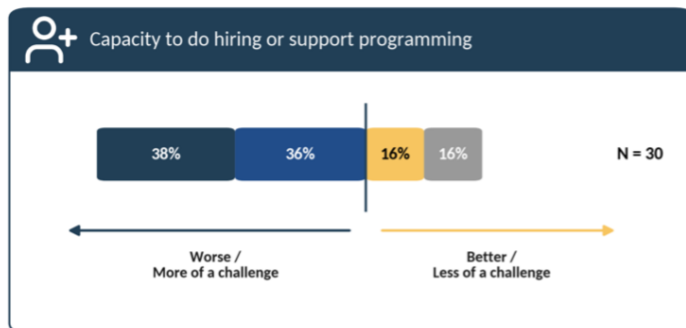
Workforce Survey respondents were also asked how four aspects of their work had changed over the past 12 months. On each one, most said conditions were about the same as a year earlier. Among those who did report change, decline outnumbered improvement every time. On the capacity to deliver or expand programming, 38 said conditions were worse, and 16 said better. On workload from turnover or vacancies, 35 said worse, against 13 better. On workload from turnover or vacancies, 35 said worse, against 13 better. On workload from turnover or vacancies, 35 said worse, against 13 better. On workload from turnover or vacancies, 35 said worse, against 13 better.

Figure 32. Change over the past 12 months across four working conditions (Workforce Survey, n= 88)



Workforce & Organizational Challenges

Respondents' perception of change over the past year (percent of respondents)



Wages and compensation

Compensation and salary competitiveness ranked among the top three threats to sustaining prevention work, and 16 of the 90 Workforce Survey respondents reported dissatisfaction with their compensation. Yet when asked directly about satisfaction, 56 of 90 (62 percent) reported being at least somewhat satisfied with their compensation, and satisfaction with benefits was higher still at 72 of 90 (80 percent).

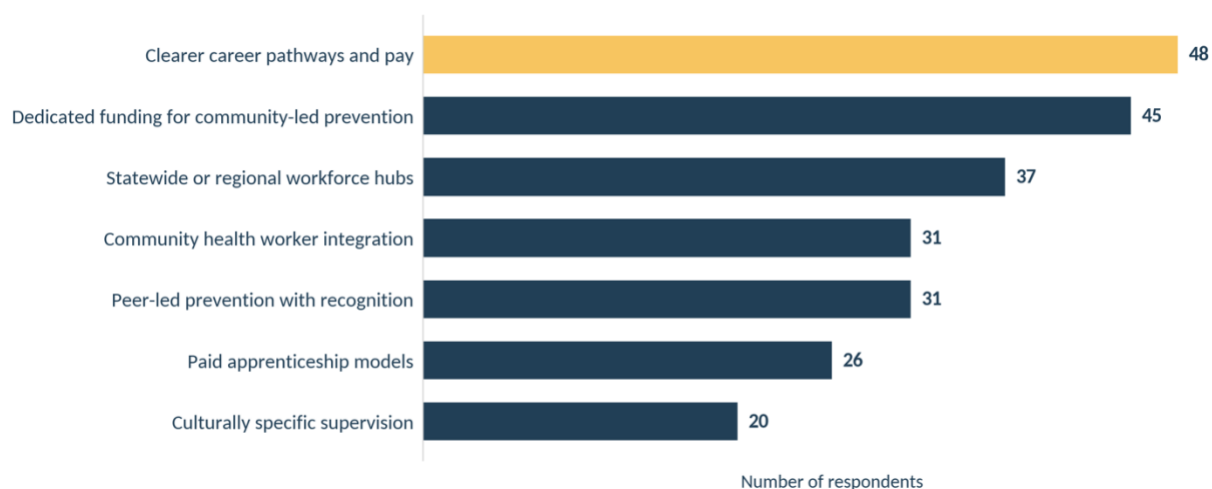
One reading is that current compensation is tolerable for those who remain, while the absence of raises, advancement, and stable funding is what drives people out or deters entry. This mirrors the certification findings above, where the leading barrier to pursuing the CPS was the absence of a clear employment or compensation benefit.

Placing a dollar figure on prevention work is difficult. The National Academies, in its 2025 report [Blueprint for a National Prevention Infrastructure for Mental, Emotional, and Behavioral Disorders](#), reports that most prevention workforce roles are not listed in the federal Standard Occupational Classification system, which limits the ability to count these roles, track their pay, and build formal career pathways.²⁹ No occupation code isolates prevention specialists, so no direct wage series exists. The closest available anchor is Oregon wage data for adjacent occupations. In the state estimates, annual mean salary runs from roughly \$58,000 for community health workers, to about \$66,000 for substance use and behavioral health counselors, to about \$83,000 for social and community service managers, the category that fits the program-director roles many respondents hold. These figures bracket prevention pay instead of measuring it. The same lack of professional recognition that prevents a clean wage estimate also drives the credentialing and advancement gaps described above.

Workforce pipeline

Workforce Survey respondents were asked which changes would be most transformative for the prevention workforce and could select up to three. Among 93 respondents, the leading choice is clearer career pathways and compensation incentives for prevention roles (48), followed by dedicated funding for grassroots and community-led prevention (45) and statewide or regional prevention technical assistance workforce hubs (37). Community health worker integration (31), peer-led prevention with formal recognition (31), and paid apprenticeship or earn-while-you-learn models (26) also drew substantial support.

Figure 33. Changes seen as most transformative for the workforce (Workforce survey, n=93)



The MHACBO interview described a new [baccalaureate-level license](#) associated with the Ballmer Institute at the University of Oregon, which has since been enacted. [Senate Bill 1547](#), signed into law in May 2026, created the licensed behavioral health and wellness practitioner, a bachelor's-level license issued by the Oregon Board of Psychology for graduates of approved behavioral health programs that include at least 700 hours of supervised practice, with a scope covering behavioral health promotion, prevention, and brief intervention. While this creates a formal, prevention-oriented entry route into the field, it remains unclear whether the addition of this new credential will provide benefit to the primary prevention workforce or further workforce confusion around appropriate credentialing pathways for those interested in a primary prevention career.

Financial Analysis

Funding Streams & Funds-Flow, Alignment, Barriers & Gaps

This section examines how primary substance-use prevention is funded in Oregon. It covers what dollars are available and how they flow from their origins to the organizations that deliver services, whether those dollars are used for their intended purpose, and where structural barriers limit upstream investment. The assessment includes analysis of the extent to which funding is “braided” (meaning that the specific funding sources are identifiable, traceable and monitorable from the fund of origin through to contracts and reporting of community-based organizations), versus “blended” (meaning that specific funding sources are not identifiable and able to be validated at every point of the appropriation, procurement, contracting and reporting stage of their use). The report checks that picture against what providers, school districts, and the prevention workforce reported in the surveys.

The analysis draws on direct meetings with agencies, seven agency-completed financial templates, over five hundred documents, and four surveys that closed in mid-2026, including 109 responses from provider organizations, 65 from school district representatives, 101 from

members of the prevention workforce, and 9 from intercollegiate institutions. The financial mapping covers the 2023–25 biennium, the most recent with reported actuals, and a forward-looking part that assembles the known 2025–27 changes so the findings describe the current system rather than a closed biennium. The basis for the dollar figures and the caveats that qualify them are set out at the end.

Funding Streams & Funds-Flow

The first part of this section covers funding sources and amounts. The second part covers how the money moves from federal and state origins through agencies to regions, counties, and local providers. Primary SUD prevention is funded by a large number of small streams. In the state’s financial reports, the flow can be traced with confidence only as far as the first agency recipient. Past that point, the trail continues only in program files, contracts, workplans, and progress reports, and at the community level, even those thin out.

The funding architecture

Prevention money enters Oregon in many small federal, state, tax-based, and settlement streams. There is no dedicated, recurring funding source exclusively focused on primary substance use prevention. The dedicated core is the federal Substance Use Prevention, Treatment, and Recovery Services block grant ([SUPTRS](#)). While SUPTRS is intended to finance services across the continuum of care, federal regulations require that states spend at least 20% of the funds on primary prevention. This amount is referred to as the “prevention set-aside”. SAMHSA awards the SUPTRS block grant to Oregon, with OHA as the recipient. Within OHA, the SUPTRS block grant is then administered by the Behavioral Health Division, with the exception of the prevention set-aside. The majority of those dollars are transferred from the Behavioral Health Division to the Public Health Division, which moves the set-aside out under contract to the ADPEP grantees and nine Tribes, which then deliver the programs.

In federal terms, OHA and its divisions are the *pass-through entity*, dispersing federal funds to community-based organizations, counties, and Tribes who are referred to in this analysis as subrecipients. SUPTRS dollars may also be used by OHA and its respective divisions on “contractors”, which Third Horizon defines for the purposes of this analysis as entities that are vendors who receive state contracts to support a state agency service or operational element (for example, a technology vendor managing a data system, or a media company developing a public awareness campaign). Lastly, though OHA is considered the pass-through entity, SUPTRS regulations allow states to use 5% of their total SUPTRS allocation on administrative and staffing costs to manage the block grant.

Though the set-aside percentage is a floor and not a ceiling, states rarely allocate more than 20%. In Oregon, the prevention set-aside is supplemented by marijuana tax dollars and, since 2024, one-time opioid settlement funds. Table 10 summarizes the major streams as agencies reported them for 2023–25, and, critically, shows for each stream how much of it is primary prevention, tagged by agencies or verified by contract review. The mapped column contains all dollars the seven agencies reported for 2023–25, whatever part of the continuum they assigned it to, less the exclusions noted below. The primary prevention column is the part of that total that carries

primary prevention: \$23.0 million, the agencies tagged as primary prevention themselves, plus \$8.2 million verified inside OHA-PHD's cross-continuum lines by contract-level review, for \$31.2 million. The difference between the columns is money the agencies assigned elsewhere on the continuum, which Third Horizon validated as not constituting investments in prevention as defined in HB3321: recovery supports, surveillance and evaluation, treatment, early intervention, and harm reduction.

However, it also includes cross-continuum dollars that the review could not verify as primary prevention, due to limitations in contract and reporting details. Given this, it is feasible that some of the total mapped does include additional dollars that are funding primary prevention efforts.

The recurring pattern is fragmentation. Fragmentation describes the structure of prevention funding, not any agency's conduct. Prevention is paid for by many separate streams: federal, state, tax-based, and settlement. Each stream is individually small and carries its own rules, funding cycle, and reporting requirements. Those streams reach communities through many separate small contracts and grants, and dollars from different streams are often blended within a single contract or program. The single largest source group, the State General Fund, overwhelmingly funds treatment and recovery, while the streams that do fund prevention are individually small and frequently blended before they reach a service. Federal Title IV-B child-welfare funding (\$14.7 million) has been removed from scope. Oregon's tobacco-prevention funding is the largest locally delivered prevention infrastructure in the state, but state law limits it to tobacco use. It is therefore not counted here. Funding sources in detail explain the rule and where tobacco money does appear.

OLCC's \$15.0 million should be read as the cost of regulatory work, not as an appropriation for prevention dollars flowing to communities. OLCC's work is anchored in a statutory duty to promote temperance and protect public health, and in two prohibitions it enforces directly: no sales to minors, and no sales to visibly intoxicated persons. As a control state, OLCC sets the retail price of distilled spirits through a statutory markup formula and a minimum-price floor, runs statewide retail compliance operations with paid minor decoys, and sets the server-education curriculum and strategies with a strong evidence base for reducing youth access. That work is authentic primary prevention. The money behind that work comes from OLCC's own regulatory accounts, the spirits markup plus licensing and permit fees, rather than from the General Fund, which is why OLCC appears in Table 10 as its own funding source. The figure itself is an estimated share of existing licensing, enforcement, and decoy staff time attributed to prevention, so it pays state staff who regulate the market rather than grants that reach communities. OLCC is therefore the largest single line in the prevention view because Oregon finances a strong regulatory system, not because Oregon earmarks alcohol revenue funds for community prevention, which it currently doesn't. As noted in the program inventory, OHA is the largest agency funder of primary substance use prevention programs in communities.

Table 10. Major prevention-relevant funding streams, 2023–25

Funding stream (normalized)	Administering agency	2023–25 mapped	Of which primary prevention (tagged or contract-verified)	Notes on flow, scope, and reliability
State General Fund	Multiple (ODHS, OHA, OYA, ODE, SOCAC, YDO)	\$17.3M	\$2.6M	The great majority funds treatment and recovery, not primary prevention. The tagged share is mostly ODE's one-time opioid campaign and coordinator. No dedicated prevention base.
Federal braided OD2A/SOR/SUPTRS pools	OHA-PHD	\$5.2M	\$1.3M	Programs paid from mixed federal sources (ODPEP, PDMP staffing and IT). Verified shares only, including PDMP quarter-shares (\$0.59M).
Federal CDC OD2A	OHA-PHD	\$3.8M	\$0.9M	Overdose Data to Action staffing and contracts. Largely overdose and surveillance work; only reviewed shares are counted.
Federal/state PDMP fund	OHA-PHD	\$0.6M	\$0.2M	Quarter-share convention (see Funding sources in detail). With the braided PDMP lines, the PDMP quarter-share totals \$0.75M of \$3.0M.
Federal SAMHSA SPF-PFS	OHA-PHD	\$0.45M	\$0.45M	Strategic Prevention Framework. Verified in full as primary prevention.
Federal SAMHSA SOR	OHA-PHD	\$0.3M	\$0.1M	State Opioid Response. Local prevention grants ended October 2023.

Funding stream (normalized)	Administering agency	2023–25 mapped	Of which primary prevention (tagged or contract-verified)	Notes on flow, scope, and reliability
Federal CDC Alcohol Epi	OHA-PHD	\$0.3M	\$0.3M	Alcohol Epidemiology award. Tagged primary prevention by the agency.
Other federal — ODHS (CAPTA)	ODHS	\$1.1M	\$0	CAPTA child-abuse prevention funds. The contract review verified none as SUD primary prevention.
Federal SUPTRS block grant (regular)	OHA-PHD (via BHD)	\$7.3M	\$4.3M	Carries the 20% set-aside. Agencies tagged all of it cross-continuum; the contract review verified \$4.3M as primary prevention (the county and Tribal ADPEP pass-through, matching the federal Table 7 itemization), plus \$2.2M prevention-supporting work counted separately. \$0.8M of county lines duplicated inside the ADPEP aggregate were removed.
SUPTRS COVID/ARPA supplements (expired)	OHA-PHD (via BHD)	\$3.4M	—	One-time supplements carried the standard terms, including the 20% primary-prevention minimum. The \$3.4M of prevention spending here is set aside from the recurring base rather than counted. Expired.

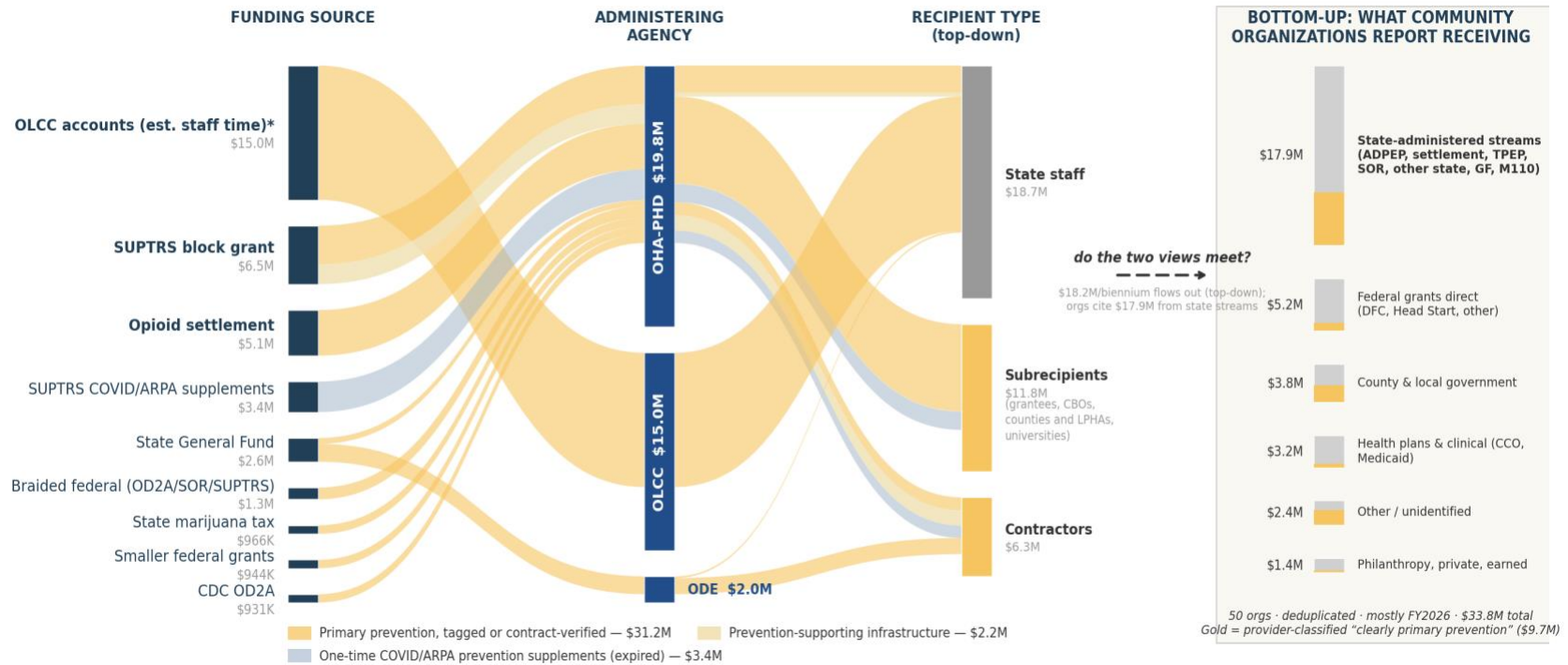
Funding stream (normalized)	Administering agency	2023–25 mapped	Of which primary prevention (tagged or contract-verified)	Notes on flow, scope, and reliability
State OLCC regulatory accounts (all OLCC lines)	OLCC	\$15.0M	\$15.0M	All OLCC lines combined, including those whose exact regulatory account OLCC could not identify. Minor-decoy and ID-check programs plus estimated shares of licensing and enforcement staff time. Estimates, not program budgets; totals overstate.
Opioid settlement (Layer A actuals)	OHA-PHD	\$7.3M	\$5.1M	One-time. \$4.1M tagged; the contract review verified another \$0.9M of settlement-funded prevention.
State school funds	ODE	\$3.2M	\$0	Recovery-schools funding. Districts' own prevention spending remains largely invisible.
State marijuana tax (5% M-account)	OHA-PHD	\$1.1M	\$1.0M	Braided with the Mental Health, Alcoholism and Drug Services account. OHA states it is “not possible to piece these apart.”
Total		\$66.6M	\$31.2M	Primary prevention = \$23.0M tagged + \$8.2M contract-verified. A further \$2.2M prevention-supporting and \$3.4M one-time COVID/ARPA are counted separately, not in this column.

Where the prevention dollars sit

Prevention-tagged dollars exist in only three of the seven reporting agencies. They are the OHA Public Health Division (PHD) (\$6.0 million), the Oregon Liquor and Cannabis Commission (OLCC) (\$15.0 million, estimated staff time), and the Oregon Department of Education (ODE) (\$2.0 million). The contract-level review adds a further \$8.2 million of verified primary prevention resources, all of it within OHA-PHD, bringing OHA-PHD to \$14.2 million on a tagged-or-verified basis. The other four agencies report real money to the continuum template, but none of it as primary prevention, and their own classifications explain why. Oregon Youth Authority's (OYA) \$1.0 million funds treatment programs inside its facilities (MacLaren, Rogue Valley). Youth Development Oregon's (YDO) \$425,000, including Juvenile Crime Prevention, despite the name, serves adjudicated and high-risk youth, which the agency tags as early intervention and treatment in terms of the substance-use continuum. The System of Care Advisory Council (SOCAC) reports \$409,663, which ADPC's own analysis splits across recovery supports (\$165,500), treatment (\$136,704), and early intervention (\$107,459), with nothing in primary prevention. The money covers System of Care staff time, youth advisory member stipends and grants, and its larger upstream prevention System of Care grants (\$4.8 million, including the tribal awards) belong to the 2025–27 grant cycle and therefore fall outside this biennium entirely. ODHS's remaining dollars (after the Title IV-B removal) are child-welfare and family-support funding, which the agency likewise tags as recovery supports.

Figure 32 presents a prevention-focused funds-flow map. The left side is the top-down flow, the \$36.8 million prevention view traced from source through agency to recipient type: \$31.2 million of primary prevention, tagged by agencies or verified by the contract review (gold), \$2.2 million of verified prevention-supporting infrastructure (pale gold), and \$3.4 million of one-time COVID/ARPA supplement prevention (blue-gray). The right side is a bottom-up view. This is what community organizations themselves report receiving, from which kinds of sources, built from the provider survey's deduplicated financial responses. These side-by-side views help determine whether what the state reports sending matches what the community reports receiving.

Figure 34. Two views of Oregon's prevention dollars: top-down funds-flow (2023–25) and what community organizations report receiving



Note: Left (top-down): 2023–25 agency-reported actuals in the prevention view. Gold = primary prevention, tagged or contract-verified (\$31.2M); pale gold = verified prevention-supporting infrastructure (\$2.2M); blue-gray = one-time COVID/ARPA supplements, expired (\$3.4M). OLCC figures are estimated staff-time shares. Right (bottom-up): the provider survey's deduplicated self-reported funding (50 organizations, mostly FY2026, \$33.8M, gold = provider-classified clearly primary prevention). The two sides are drawn at the same dollar scale but are different measurements of different periods and must not be summed.

In Figure 32, contract-level review identified and assigned the SUPTRS block grant prevention dollars to the following buckets: \$4.3M verified primary prevention (the county and Tribal ADPEP pass-through), \$2.2M prevention-supporting work, and \$3.4M one-time supplement spending, with duplicates and non-prevention shares removed from the view. At the recipient tier, \$18.7M (51%) stays inside government as state staff, dominated by OLCC's estimated staff time, while \$18.2M (49%) flows outward to grantees, contractors (vendors providing a service in support of state agency efforts), and counties. Communities cite \$17.9M from the same state-administered streams (e.g., ADPEP, Opioid Settlement, SOR, General Fund), plus \$15.9M from other sources (e.g., direct Federal grants, local government, CCOs, Medicaid, philanthropy). The dashed bridge cannot be resolved with current data, because no Oregon system can match a dollar sent to a dollar received, and the small gold fractions on the right repeat the alignment finding. Providers themselves classify less than a third of what they receive as clearly primary prevention.

What stays in state government and what reaches communities

Within the \$36.8 million in prevention funding utilized in 2023–2025 – during which time the remaining COVID/ARPA dollars were spent, roughly half the money never leaves the state government. Table 11 splits each band of the view by whether the recipient is state staff and operations or a community recipient (contractors, CBOs, grantees, counties, LPHAs, Tribes, universities).

Table 11. The 2023–25 prevention view split by recipient tier. Source: Oregon Prevention Funding Map v2 recipient types; HB 3321 cross-continuum contract review.

Prevention view band	Stays in state government	Flows out to communities	Total
Primary prevention (tagged or contract-verified)	\$18.2M	\$13.0M	\$31.2M
Prevention-supporting infrastructure	\$0.4M	\$1.8M	\$2.2M
One-time COVID/ARPA supplements	\$0	\$3.4M	\$3.4M
Total	\$18.7M (51%)	\$18.2M (49%)	\$36.8M

Four-fifths of the state-side total is OLCC’s estimated staff time (\$15.0 million of the \$18.7 million). Excluding OLCC, only about \$3.7 million of verified prevention stays inside the state government, mostly OHA-PHD staffing. The \$18.2 million that flows outward is the figure to compare with the receiving end: responding community organizations cite \$17.9 million from state-administered streams (see What communities report receiving). The two figures are different measurements of different periods and should be read as approximate agreement, not reconciliation.

Funding sources in detail

On the federal side, the SUPTRS block grant is the backbone, through its statutory 20 percent primary-prevention set-aside (about \$4.3 to 5.3 million per federal fiscal year). Around it sits smaller, shorter-cycle grants. These include CDC’s Overdose Data to Action ([OD2A](#)) and Alcohol Epidemiology awards, SAMHSA’s Strategic Prevention Framework ([SPF-PFS](#)) and State Opioid Response ([SOR](#)) grants, Child Abuse Prevention and Treatment Act ([CAPTA](#)) prevention funds, and the federal-state funding for the Prescription Drug Monitoring Program ([PDMP](#)). Several of these funds support overdose, surveillance, or harm-reduction work that may not fit the statutory definition of primary prevention. The PDMP is the clearest example. Oregon restricts PDMP access to health care providers and does not permit law enforcement access, which gives the system an authentic prevention function alongside its clinical and surveillance roles, but its

contracts contain no activity-level budget on which to base a precise split. Absent that detail, the review applies a one-quarter convention: where an investment plainly serves the whole continuum of care, and no document divides it, one quarter is assigned to each of the four parts of that continuum, prevention, harm reduction, treatment, and recovery. On that basis, \$0.75 million of the \$3.0 million in PDMP staffing and IT lines counts as primary prevention. Notably, the PDMP activities that most resemble prevention (prescriber education, academic detailing, prescribing-guideline work) are funded through separate OD2A lines, so the quarter-share represents the system's standing prevention value rather than identified prevention activities within these specific contracts.

Two federal supplements that briefly enlarged the set-aside, the COVID and ARPA supplements, have already expired. In FFY2023, the COVID supplemental prevention spend (\$6.25M) exceeded the regular set-aside (\$4.29M). Per OHA, the supplements carried the standard block-grant terms, including the 20 percent minimum primary-prevention set-aside and a 5 percent administrative allowance; this report treats their prevention spending as one-time, separate from the recurring base.

At the state level, Oregon has no general-fund line dedicated to alcohol-and-drug primary prevention. The \$2.7 million of General Fund that appears in the prevention view is one-time money, not a standing appropriation. The state's recurring contribution runs through the 5 percent marijuana-tax allocation for drug treatment and prevention, which OHA braids with the Mental Health, Alcoholism and Drug Services (MHA&DS) account and states plainly it "cannot be pieced apart." OLCC contributes environmental-prevention efforts funded from its regulatory accounts but reports them as estimated staff-time shares rather than program budgets. The OLCC entry in Table 10 (\$15.0 million, all OLCC lines combined) comes directly from summing OLCC's lines in the agency financial template: the minor-decoy and ID-check programs plus estimated shares of licensing and enforcement staff time attributed to SUD prevention, with the source account marked unclear where OLCC could not identify it. These are estimates of existing staff activity rather than grants that leave the agency, which is why nearly all OLCC dollars appear as state staff at the recipient tier. ODE's identifiable prevention money is two lines, one coordinator position, and a one-time K-12 opioid campaign.

Tobacco prevention is the largest locally delivered prevention infrastructure in Oregon, and it is excluded from the top-down figures in this section by law, not by scale. Voter-dedicated tobacco taxes (Measures 44 and 108) fund the Tobacco Prevention and Education Program ([TPEP](#)) at levels no other prevention stream approaches: TPEP grants to local public health authorities alone totaled \$19.7 million awarded and \$17.6 million spent in award year 2025, roughly twice what the entire county alcohol-and-drug prevention system (ADPEP) receives in a biennium – a striking sign of a funding gap for investment in broader substance use primary prevention. State law dedicates these funds to tobacco-use reduction (ORS 431A.153, 431A.155), so they cannot pay for all-substance prevention and are not counted in the \$31.2 million. The TPEP contracts, workplans, and county reports OHA provided show where integration nevertheless occurs: in several counties, the same staff coordinates both programs, Washington County links TPEP and ADPEP through a joint youth substance-use prevention collaborative with a shared community grant process, and at least one county's approved TPEP workplan carries an explicit shared

polysubstance-prevention strategy with ADPEP and overdose grantees. This is braided infrastructure where the dollars themselves cannot be braided. Consistent with the rule applied across this assessment, tobacco dollars are counted only where reported as part of integrated prevention, which is why they appear in this analysis from the bottom up, in the \$2.6 million of TPEP funding providers report in their prevention portfolios (see What communities report receiving), and nowhere in Table 10 or the prevention view.

For the opioid settlement, the Opioid Settlement Prevention, Treatment, and Recovery ([OSPTR](#)) Board has allocated more than \$90 million in state settlement funds, with \$13.7 million committed to primary prevention. That breaks down as \$9.5 million to counties through the existing county prevention avenues, \$3.756 million to culturally specific coalitions and CBOs, and \$450,000 to workforce credentialing. Its current allocations are one-time as structured, because the grants carry spend-down deadlines and no renewal commitments. However, the settlement fund itself will continue to receive payments into the late 2030s, and the Abatement Committee has a stated priority of consistent, equitable investment across the continuum, inclusive of prevention.

Below the state agencies, prevention money is administered mainly through county allocations, county-held prevention agreements that carry much of the block-grant set-aside, and settlement allocations that range from \$55,869 (Wheeler County) to \$1,382,731 (Multnomah County). Local subdivision spending of settlement funds directed only about 5 percent to primary prevention in FY2024.

The 20% SUPTRS set-aside

The 20 percent set-aside is the state's most important dedicated primary-prevention funding source. Oregon meets the federal requirement consistently, at exactly 20.0 percent in FFY2022 (\$4,856,105 of \$24,280,524), 21.2 percent in FFY2023, counting capacity-building, and a planned 20.0 percent again in FFY2026–27 (\$10,474,382 of \$52,371,908). The subrecipient spending detail Oregon reports to SAMHSA (Table 7 of the federal block-grant report) itemizes the FFY2023 set-aside to 49 named subrecipients, counties, and LPHAs, all nine federally recognized Tribes, and community organizations, totaling \$4,293,755. The one-time COVID and ARPA supplements carried the same 20 percent minimum and are treated throughout this report as one-time funds, separate from the recurring base.

Of the \$9.53 million of SUPTRS-family spending first classified as primary prevention, \$4.33 million is the ADPEP county and Tribal prevention pass-through, matching that federal itemization within one percent; \$1.53 million is contractor and evaluation work reclassified as prevention-supporting; and \$2.88 million is one-time COVID/ARPA supplement spending, set aside. The recurring SUPTRS primary-prevention figure carried in this analysis is therefore the amount Oregon itemizes to the federal government, about \$4.3 million per federal fiscal year.

While evidence suggests that Oregon meets the 20% set-aside requirement, it is worth noting that the policy sets 20% as the floor (minimum) and not the ceiling. Third Horizon conducted a national scan of prevention set-aside allocations by states and identified nine states that are

outlined in Table 12, which have opted to go beyond the minimum in leveraging SUPTRS to support primary prevention services.

Table 12. States investing more than 20% of SUPTRS funds into Primary Prevention

State	Share	Basis	Fiscal year or period	Source document
Rhode Island	39.77%	Actual expenditure (\$3,122,484 of \$7,851,556), Table 5b. The FFY 2026 plan is 37.64 percent.	10/1/2022-9/30/2024	RI FY 2026 SUPTRS Block Grant Report
Nebraska	32.9%	Actual expenditure (\$2,127,782 of \$6,463,793). Percentage computed from Table 4.	FY 2021 award; 10/1/2020-9/30/2022	NE UNIFORM APPLICATION FY 2024 SUPTRS Block Grant Report
Washington	approx. 31%	Actual expenditure (\$12,529,371 of approx. \$40.25M). Percentage computed.	7/1/2022-6/30/2023	WA UNIFORM APPLICATION FY 2024 SUPTRS Block Grant Report
Montana	27.12%	Planned, Table 5a (\$1,977,084 of \$7,290,296).	FFY 2023	MT 2023 SABG Application and Plan
California	25%	State allocation rule for the county prevention set-aside (\$57,848,095), raised from 20 percent.	SFY 2024-25 and 2025-26	DHCS Exhibit A, SUBG Final Allocation
Iowa	23.86%	Planned, Table 5b (\$3,368,803 of \$14,119,518). Printed as a percentage in the table. FFY 2024 is 22.84 percent.	FFY 2025	IA FY25 MHBG and SUPTRS Combined Block Grant Mini Application
North Dakota	23.5%	Actual expenditure (\$1,656,853 of \$7,061,663). Percentage computed from Table 4.	FY 2022 award; 10/1/2021-9/30/2023	ND UNIFORM APPLICATION FY 2025 SUPTRS Block Grant Report
Ohio	23.5%	Planned, from a plan summary pie chart. Not a Table 5a or 5b figure.	FFY 2024-2025	OhioMHAS 2024-2025 SAMHSA Block Grant Plan
Michigan	23.4%	Planned, Table 4 (\$13,454,050 of \$57,410,840). FFY 2024 is 20.00 percent.	FFY 2025	MI UNIFORM APPLICATION FY 2024/2025 Combined MHBG SUPTRS BG

Tribal prevention funding in the financial map

The nine federally recognized Tribes appear in this analysis's verifiable numbers in three places. First, inside the block-grant set-aside itself: all nine Tribes are named among the 49 subrecipients in the FFY2023 spending detail Oregon reports to SAMHSA, with primary-prevention awards ranging from \$61,250 (Grand Ronde; Coos, Lower Umpqua and Siuslaw) to \$98,385 (Coquille) and totaling \$685,939. Those dollars sit inside the \$4.3 million SUPTRS figure this report carries and must not be added to it. For FFY2026, OHA reports approximately \$785,600 directed to Tribal prevention programs, about 15% of the annual set-aside, consistent with the planned FFY2026–27 set-aside in the block-grant application. Second, ADPC's own SUD financial analysis records \$2.4 million of 2023–25 spending under a stand-alone "Tribal" designation rather than a continuum category (\$2.1 million administered by the Oregon Criminal Justice Commission (CJC), mostly General Fund; \$0.3 million by OHA-BHD, including about \$138,000 of SUPTRS). Third, in the 2025–27 outlook, SOCAC's tribal System of Care grants (\$200,000 to each of the nine Tribes, \$1.8 million), plus \$200,000 to NARA as an urban Indian organization, are already noted in Table 3, while noting that the SOCAC funding does not include investments in primary prevention.

Beyond these documented amounts, the financial map structurally understates Tribal prevention. Tribal prevention funding flows through OHA-BHD's consolidated behavioral health contracts with the nine Tribes and the designated Urban Indian Health Program (2026 block-grant application), not through the OHA-PHD. Tribes braid the state-administered dollars with direct federal grants, Juvenile Crime Prevention funds, Tribal opioid-response and tobacco-prevention funds, and contributions from their own budgets, which state financial records do not capture.

Consistent with the Tribal prevention system section of this report, this analysis does not compute a Tribal prevention total and does not aggregate spending across the nine Tribes. Tribal own-resource investment is confidential absent Tribal council approval, aggregation would double-count dollars already reported in the SUPTRS figures above, and it would fold the investments of distinct sovereign Nations into the state's totals. The figures reported here are limited to the state-administered dollars that can be verified in federal and state records.

How dollars flow and what cannot be traced

Agencies describe braiding, the combining of several funding streams to support a coherent set of services, as deliberate infrastructure. OHA's public-health leadership frames the tobacco program in particular as "a very braided system" whose dedicated revenue also carries the smaller alcohol-and-drug streams. **Some of what is called braiding may be closer to blending, in which prevention dollars lose their identity and end up supporting services that are not prevention-focused or may be utilized for expenses that are not allowed by that specific funding source.** The distinction between blended and braided financing matters, for example, because it determines whether the SUPTRS set-aside is reaching prevention at all. The contract review settled this question for the block grant. For the braided marijuana-tax and Mental Health, Alcoholism, and Drug Services (MHA&DS) accounts, it is still open. Contractors often cannot see which source funds their own work, and OHA has confirmed in writing both that the marijuana-tax and MHA&DS funds cannot be separated and that "there is no mechanism to assess how much of the MHA&DS funds go to individual communities and contractors."

From the financial templates alone, the state can say which agency received federal or state dollars and, broadly, what kind of recipient the agency paid. The templates cannot say which organization finally spent the money or on what. Getting that answer takes pulling contracts and program reports one program at a time. The provider survey now supplies some of that missing detail from the bottom up (see below), without reconciling the dollars. The 2024 Public Consulting Group (PCG) analysis hit the same wall, concluding that identifying the data source and utility “can be very difficult, if even possible,” and recommending a statewide reporting system that tracks investments through to service delivery. The Secretary of State’s December 2025 Measure 110 audit reached a parallel conclusion about the broader system, finding that [fragmentation](#) “reduces the efficiency and effectiveness of service delivery.”

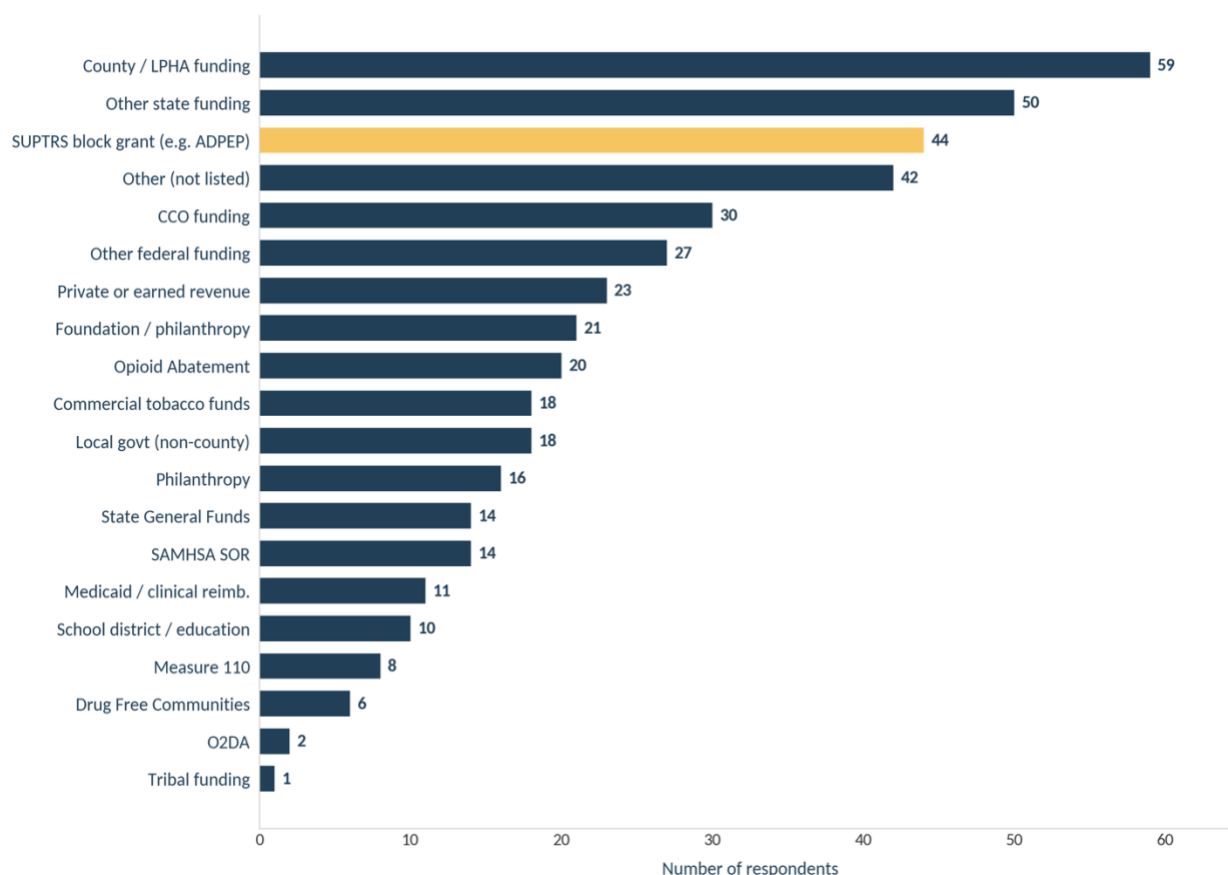
Dedicated fund balances and expenditures

On the whole, the materials do not support a fund-balance analysis. No agency provided beginning and ending balances for a dedicated prevention fund, because, with the partial exception of the marijuana-tax account, there is no dedicated prevention fund to report. Expenditure details exist at the line-item level for the biennium but are uneven. The practical consequence is that this section can report what agencies spent in total far more reliably than it can report what any dedicated stream held or carried forward.

What communities report receiving

The provider survey drew 109 responses from provider organizations describing their programs and, for each program, to select the funding sources that support it and enter dollar amounts. Fifty organizations documented \$33.8 million in program funding after deduplication (organization-level grants listed under several programs are counted once). As Figure 33 shows, the sources providers cite most often are county or local public health authority funding (59 programs), other state funding (50), and the SUPTRS block grant, explicitly named as ADPEP (44). This confirms from the ground that the county set-aside and county/LPHA pass-throughs are the backbone of front-line prevention. The typical program is supported by several sources at once, and 56% of organizations answering said their work relies on their ability to leverage, blend, and braid funding, in-kind staff, or shared infrastructure, the clearest direct evidence yet that braiding is the normal operating mode at the provider level, even if such financing architecture doesn’t manifest through the top-down procurement and contracting process. The median funding line is \$33,000. Front-line prevention is assembled from many small awards, each carrying its own application, reporting, and renewal cycle.

Figure 35. Funding sources cited across provider programs (Provider survey, n=78 respondents, program totals = 226)



The bottom-up ledger approximately matches what the state reports sending, where the two should overlap. Top-down, the three prevention-carrying agencies report sending \$18.2 million per biennium outward to communities in the verified prevention view. Bottom-up, responding organizations cite \$17.9 million from state-administered streams. The difference between them has identifiable causes. The bottom-up figure is mostly FY2026 amounts and therefore includes the settlement-funded county expansion that began after the 2023–25 actuals closed. It includes \$2.6 million of TPEP tobacco funding that providers count in their prevention portfolios, but the top-down prevention view excludes; providers split those TPEP-funded lines between clearly primary prevention (\$0.5M across six program-funding lines) and mixed prevention-related support (\$2.1M across six lines). And its “other state funding” includes streams such as problem-gambling prevention that sit outside this analysis's SUD scope. Each of those differences is one this analysis has already flagged, now visible from the receiving end.

WHAT NO STATE FINANCIAL REPORT CAPTURES

\$15.9M

47 percent of what responding organizations run on comes from sources outside state agency data: county and local general funds (\$3.8M), direct federal grants (\$5.2M), health-plan and clinical funding (\$3.2M), philanthropy and earned revenue (\$1.4M), and \$2.4M providers could not name a source for.

The larger finding is on the other side of the ledger. A further \$15.9 million, or 47 percent of what responding organizations run on, comes from sources no state financial report captures. These are county and local government general funds (\$3.8M), federal grants that go directly to community organizations (\$5.2M, dominated by Head Start and Drug-Free Communities awards), health-plan and clinical funding (\$3.2M, of which providers call \$0.3M clearly primary prevention and \$2.8M mixed prevention-related support), and philanthropy, private, and earned revenue (\$1.4M), plus \$2.4M providers could not name a source for, in most cases because the person answering the survey was not the person who manages the budget. Any accounting of Oregon prevention based solely on state agency data understates the community system by roughly this much. Conversely, community prevention is far more exposed to local budget cycles and philanthropic swings than the state-level picture suggests.

The same survey shows where those dollars are and are not. Every one of Oregon's 36 counties has at least one responding provider, but reported dollars concentrate in the metro and mid-valley counties, and in ten mostly rural and frontier counties, the responding organizations reported no dollar amounts at all. Prevention exists in those counties as an unfunded or invisibly funded effort, which is the financial expression of the prevention-desert finding.

The 2025–27 biennium

A comparable stream-by-stream accounting of actual spending is not yet possible for 2025–27. The biennium is underway, agencies have not reported actuals, and both this project's financial mapping and ADPC's own SUD financial analysis are 2023–25 instruments. But prevention funding in Oregon is overwhelmingly grant-cycle money, which means the forward picture is largely knowable now. Awards are announced, set-asides are planned in the block-grant application, expirations are dated, and the settlement rollout is published. Two parts of this section are already current-biennium evidence in any case. The provider, school, and workforce surveys were fielded in mid-2026 and describe operations and funding as they stand now (several providers reported FY26 amounts, including the one-time settlement-funded county expansion), and the opioid-settlement allocations in the funding map's Layer B are multi-year commitments that spend mostly during 2025–27. Table 13 assembles what is already known.

Table 13. Known 2025–27 changes to the prevention funding

Stream / change	Status for 2025–27	Known amount / detail	Bearing on this analysis's findings
Opioid settlement primary-prevention rollout (OSPTR)	New, one-time	\$13.7M multi-year. \$9.5M county expansion through the ADPEP chassis. \$3.76M culturally specific CBOs and RHECs (PHOCUS grants ≤\$193,430 each, spend by 6/30/2027). \$450K CPS certification cohorts	The largest dedicated prevention infusion on record. Current allocations are one-time as structured (spend-down deadlines mid-2027, no renewal commitments), but the settlement fund itself continues receiving payments into the late 2030s, and the Abatement Commission has expressed a priority of equal distribution of settlement funds across primary prevention, health and safety, treatment and recovery – so future prevention tranches are a policy choice, not an impossibility.
SUPTRS block grant, FFY2026–27	Continuing, flat	Planned set-aside \$10.5M of \$52.4M (exactly 20.0%)	The recurring base does not grow. The dollars and recipients are documented for 2025–27 in OHA's ADPEP guidance and grantee lists. What carries forward unchanged is the reporting gap: no instrument ties county spending to the services delivered.
TPEP tobacco-prevention grants to LPHAs	Continuing, dedicated	Award Year 2027 awards total \$15.8M across 35 LPHA grantees (AY2025: \$19.7M awarded, \$17.6M spent)	Restricted by law to tobacco-use reduction, so outside the prevention view. Remains the state's largest locally delivered prevention infrastructure and, in several counties, the staffing chassis braided with ADPEP.
COVID / ARPA block-grant supplements	Expired	FFY23 supplemental prevention spend (\$6.25M) exceeded the regular set-aside that year	The system has already gone over this cliff once. The 2025–27 base is thinner than the 23–25 actuals suggest.
SAMHSA SOR local prevention grants	Ended (Oct 2023)	Not stated	Already out of the base. Not returning in 2025–27.
SOCAC System of Care grants, '25–'27 cycle	New cycle	\$2.8M regional (14 grants of \$200K, mostly via CCOs) + \$1.8M tribal	Tagged as system, engagement and equity work, not primary prevention. The published scopes are mostly capital and infrastructure: property renovation, construction, paving and a vehicle purchase. Two are exceptions. Grand Ronde's Good Medicine Initiative funds culturally specific, evidence-based prevention for Tribal youth and families, and one further award funds prevention programming.

Stream / change	Status for 2025–27	Known amount / detail	Bearing on this analysis's findings
CDC OD2A-S and Alcohol Epi	Continuing, short cycles	Alcohol Epi year-5/6 workplan drafted through 2027. OD2A regional coordinators cover 23 of 36 counties	The contract review applied the same in-or-out test to the OD2A lines as to the block grant, counting \$0.9M of \$3.8M as primary prevention. The rural coverage gap persists.
SAMHSA SPF-PFS	Continuing	~\$1.25M/yr (implied)	State hiring bottlenecks (12 months to fill the coordinator role) slow deployment of even stable funds.
Oregon-Idaho HIDTA prevention	At risk	The FY2026 President's Budget request would cut the national HIDTA program by \$102M and move it from the Office of National Drug Control Policy to the Department of Justice, Office of Justice Programs	One of the few funders of rural prevention work. Its loss would deepen the frontier prevention deserts.
Measure 110 / BHRN network	Continuing	~\$800M awarded since 2021	The largest adjacent funding pool still contains no primary-prevention designation; ADPC's own SUD financial analysis tags BHRN dollars as \$163M recovery supports, \$83M treatment, \$25M harm/risk reduction, and \$0 primary prevention.
SB 1547 (2026 session)	Passed, in implementation	Bachelor's-level behavioral health licensure including prevention	Would add a parallel workforce track that interacts with the CPS credential question and may further complicate it.

The 2025–27 funding architecture is the 2023–25 architecture with the exception of the settlement infusion, which briefly makes dedicated prevention funding look roughly twice its recurring size and, under the current one-time allocations, falls away by mid-2027, unless the Abatement Commission prioritizes continuation funding for currently contracted or new primary prevention work. Nothing else structural changes. The block-grant base is flat, and its set-aside remains opaque. The recurring state streams are the same braided marijuana-tax and OLCC accounts. The System of Care cycle repeats the pattern, funding governance and engagement rather than prevention, and the largest adjacent pools still contain no prevention. Every finding in this section, therefore, describes the system the Legislature will be funding when the settlement money runs out, not a bygone biennium.

Alignment

The alignment question asks whether the dollars nominally available for prevention actually fund prevention, and whether funding from outside the SUD system is authentically directed toward it. The evidence points to a consistent gap between labels and uses, driven less by misconduct than by fragmentation, inconsistent definitions, and the traceability problems documented above.

How much reaches primary prevention

Based on financial reporting and service categorization of state agencies. \$23.0 million is self-tagged as primary prevention, and a further \$17.0 million arrived labeled “cross-continuum.” Because the project obtained the underlying contracts, an August 2026 contract-level review resolved that block, and the related surveillance and workforce lines, instead of leaving it unallocated. **The result: \$31.2 million is primary prevention, tagged or contract-verified;** \$2.2 million is prevention-supporting infrastructure (evaluation, media, training); \$3.4 million is one-time COVID/ARPA supplement prevention, set aside from the recurring base; and the remainder is recovery supports, surveillance, treatment, and other work as agencies reported it. The 2023-2025 Comprehensive Funding Report of the ADPC provides a slightly higher figure for Primary Prevention, which is accounted for with the inclusion of a specific program focusing on older adults that, given the youth focused nature of the HB3321 analysis charge, was deemed as out of scope to Third Horizon’s financial analysis. However, this subtle difference does not change materially the findings related to primary prevention investment at the community level. Of the \$31.2 million included in this analysis, \$18.2 million sits with state staff and operations, dominated by the OLCC share, and \$13.0 million goes out to community recipients.

When compared to the total funding Oregon spends on substance use services of any kind, less than 3% is used to invest in community-based primary prevention services.

Two cautions apply. The primary-prevention figure is dominated by OLCC’s estimated staff-time shares and includes partial shares of braided and surveillance-adjacent contracts counted at reviewed percentages (for example, one quarter of the county death-review agreements). Even after contract review, significant resources are left categorized as “cross continuum” without the ability to verify that those funds are funding elements of the continuum (including primary prevention) in ways that match the intent of the funding source(s). Meanwhile, the verified core that reaches communities is smaller still.

The provider survey corroborates this from the bottom up. When providers classified each of their own funded programs, they called 144 program-funding lines “clearly primary prevention” but flagged 125, or 46 percent, as only “mixed prevention-related support.” In other words, front-line organizations themselves judge that nearly half of what their prevention funding pays for is not purely primary prevention. It is evidence that the money is blended into broader work and that the primary-prevention share is genuinely hard to isolate, the same conclusion the agency data reached, confirmed by the people spending the dollars.

Analysis Findings

This section synthesizes major findings resulting from the review of Oregon's primary substance use prevention programs, financing, and workforce.

Funding Gaps

Less than 3% of Oregon's total SUD spend is spent on community-based primary SUD prevention

Oregon's non-tobacco related primary prevention ecosystem is under resourced, especially when considering consequence costs and disease burden that could be avoided with a more robust ecosystem. Significant prevention funding is retained at the state level in the form of state administration of contracts and services, including work done by OLCC. Third Horizon finds the allocation of those resources to be appropriate and vital to the state's ability to effectively support broader prevention efforts. However, it leaves limited funding available for community services which is demonstrated in both limited program saturation in communities, and ongoing concerns from providers around financial barriers to delivery of prevention services in schools and communities.

Geographic Program Inequity

Prevention is present everywhere in Oregon, but sufficient almost nowhere. Many regions are simultaneously short of programs, staff, money, and the capacity to expand delivery.

Nominal coverage is genuinely statewide. While there are prevention services in all 36 counties, and programs like Rethink the Drink and OLCC's retail compliance programs have statewide reach, Oregon does not have a region of the state that can be assessed as having a full, comprehensive, and robust primary substance use prevention system. There are four characteristics that the program and financial inventory process uncovered.

- **Workforce.** Fourteen to fifteen of Oregon's 36 counties have no Certified Prevention Specialist (CPS) in the workforce registry, and five certified prevention specialists serve all of Eastern Oregon. Frontier counties rely on professionals covering large multicounty areas, so a single departure can remove capacity from several counties at once.

- **Funding.** Rural and frontier counties receive the smallest allocations. Wheeler County's settlement allocation is \$55,869, and its COVID prevention grant was \$48,407. These amounts are too small to fund a position. The provider survey identifies ten counties with a prevention provider, but no reported prevention money, and several ADPEP contractors noted in quarterly reporting that base funding is inadequate to ensure their own capacity to deliver on their work plan.
- **Support infrastructure.** Technical assistance is in high demand, with mixed and inconsistent access available statewide.
- **Delivery conditions.** Eighteen districts named rural access or transportation as a barrier, raising the unit cost of every service in the counties with the least money and fewest staff.

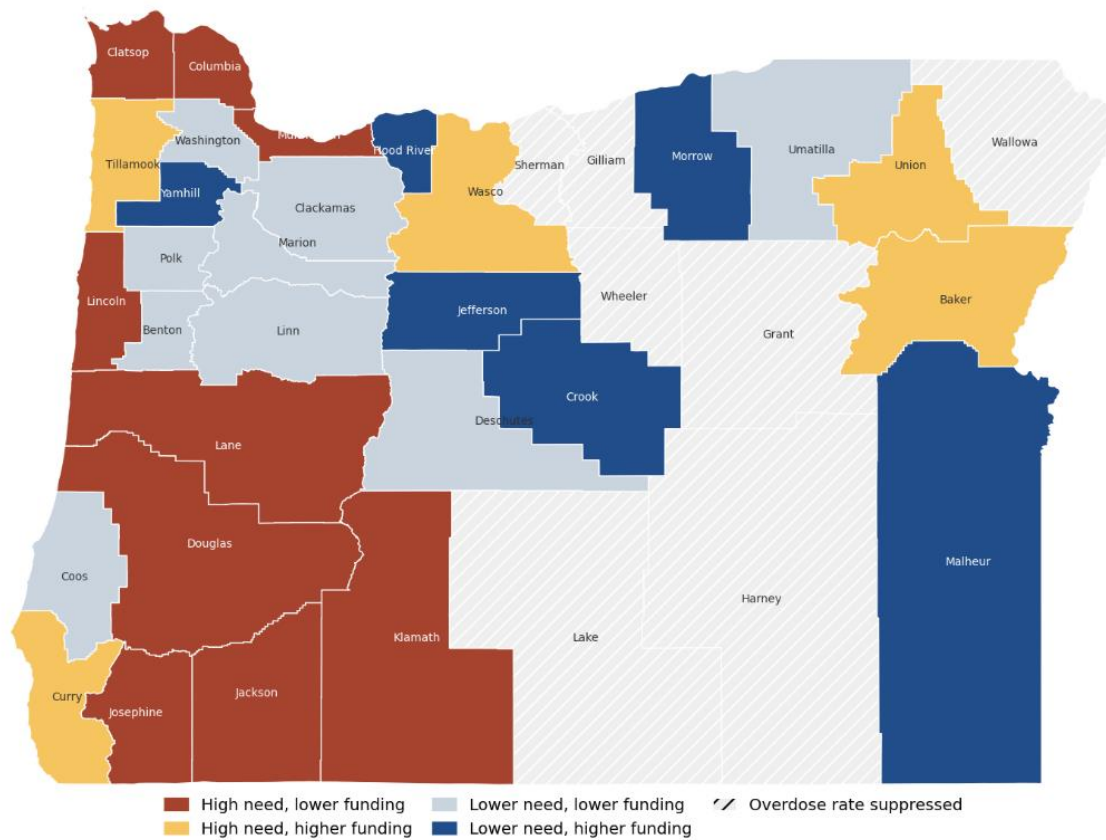
Need-Based Inequity

Strategic investment of resources based on local conditions and need has been attempted, but is not in uniform practice and lacks reliable, youth specific substance use risk and consequence data to inform decision-making.

While geographic breakdown is one measure to assess overall system strength, another is the extent to which investments and programs are targeted as communities and areas of highest need. In assessing Oregon's primary prevention program availability based on need, challenges arose that represent a gap in the potential for such strategic, data-driven investment.

As an example, Third Horizon cross-walked geo-mapping of financing to primary prevention through each ADPEP, and opioid overdose deaths in their respective county based on a 5-year average. Third Horizon is not suggesting that Oregon adopt this single metric to assess need: overdose mortality is a lagging, downstream measure. Deaths concentrate in adults 25-54, are dominated by fentanyl, and cannot move on any timescale that primary prevention controls. In frontier counties, the counts are single-digit, causing rates to be either suppressed completely or unstable year to year. However, a reduction in SUD-related death is a core metric of the state's Comprehensive Plan, making it at least one of the measures that should be utilized in a suite of factors to assess need. Figure 36A maps the relationship between overdose deaths as an indication of need and primary prevention investment through ADPEP contracts.

Figure 36A. Need Versus Funding Geographic Spread – Drug Overdose Mortality 2020-2024



Note: Drug overdose mortality and population are 2020–2024 five-year estimates ³⁰. Mortality reflects drug poisoning deaths, whether accidental or intentional, per 100,000 residents (National Vital Statistics System, Mortality (NVSS-M), CDC Wide-ranging Online Data for Epidemiologic Research (WONDER)³¹); population reflects average resident population (American Community Survey (ACS)³²)

Third Horizon also examined past 30-day alcohol use among 11th graders, reported through the Oregon Student Health Survey (SHS). Past 30-day use is considered a “core measure” in assessing the impact of primary prevention programs across several federal grant programs, including SUPTRS and the Drug Free Communities (DFC) Support Program.

SHS results are public. The SHS Data Portal publishes state and county results as weighted percentages or as raw counts. Results are viewable and exportable one county at a time. The survey uses branching logic: students are asked about age of first use and about past 30-day use only if they first report having ever had a drink of alcohol.

The portal reports past 30-day alcohol use through two variables. ALCDAY30X returns the item as administered, with a denominator limited to students who reported ever drinking. ALCDAY30X_CALC recodes the item across all students who answered both questions “yes” or

“no” and corresponds to the federal core measure. The portal presents them without signaling the difference. Distinguishing them requires reference to the portal’s variable list rather than to the results view:

Table 14: SHS Data Variables on Alcohol 30 Day Use

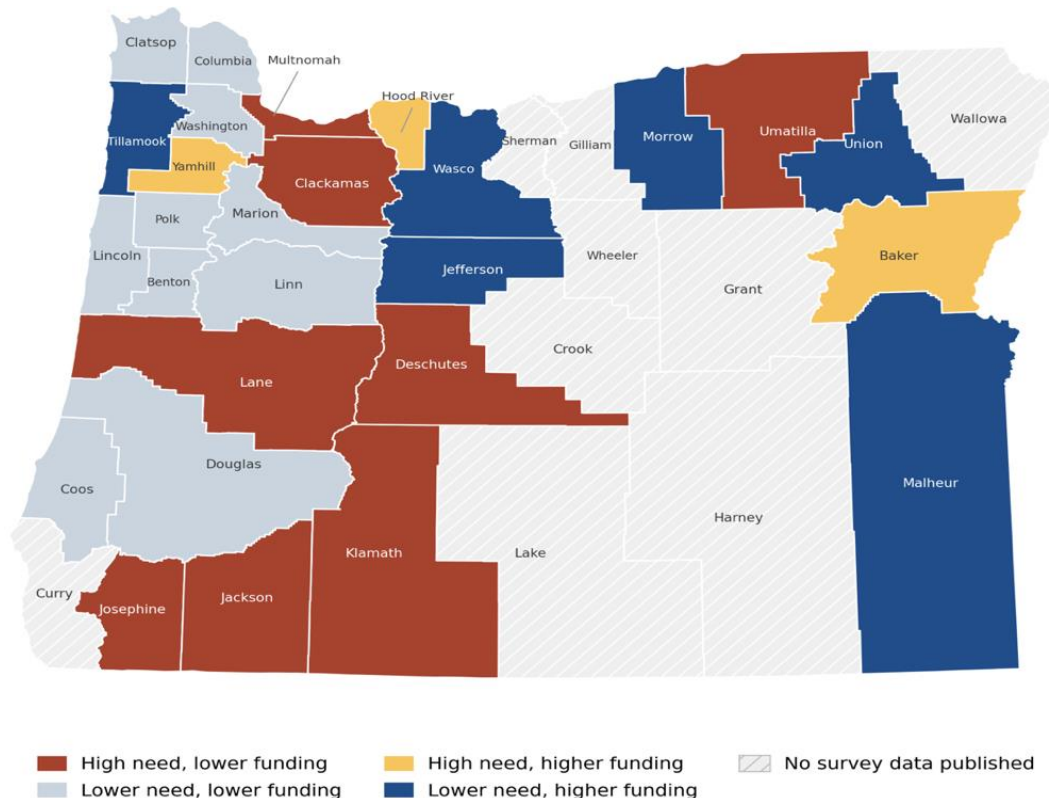
Question	Topic	Survey Text
ALCDAY30X	Substance Use	During the past 30 days, did you have at least one drink of alcohol?
ALCDAY30X_CALC	Substance Use	CALC: Past 30 day use — Alcohol

Source: [SHS Data Portal](#)

OHA provides contact information in the portal for assistance interpreting survey results. The county level reports available as downloadable pdfs report the ALCDAY30X_CALC measure.

Applying this measure, 10.6% of Oregon 11th graders reported alcohol use in the past 30 days in 2025. County rates are published for 27 of the 36 counties and range from 1.4% to 19.7%. Nine counties have no published rate. Figure 36B maps the same ADPEP funding measure against 11th grade past 30-day alcohol use.

Figure 36B. Need Versus Funding Geographic Spread – Past 30 Day Use (11th grade) 2025



Note: Need reflects the percentage of 11th graders reporting at least one drink of alcohol in the past 30 days, Oregon Student Health Survey 2025 (ALCDAY30X_CALC), measured against the 10.6% statewide average.

Of the 27 counties classified in both figures, 15 fall in the same quadrant. Jackson, Josephine, Klamath, Lane and Multnomah appear in the higher-need, lower-funding group on both measures. Clackamas, Deschutes and Umatilla appear in that group on alcohol use alone, and Clatsop, Columbia, Douglas and Lincoln on overdose mortality alone.

A review of ADPEP contracts, reports, and other documents from the OHA does indicate attempts to disperse resources based on need, as in the case of the one-time investment in primary prevention through the Opioid Abatement Commission. In this example, OHA convened a group of community “Ambassadors” to inform the distribution process. All funds were distributed using the standard Public Health Modernization Formula, which factors in equity and overall health status of each county, as well as staffing considerations. Prior to its utilization with Opioid Abatement dollars, the formula has been used to allocate broad public health resources through [Local Public Health Authorities \(LPHAs\)](#). The Modernization Formula includes both a fixed floor amount and a county-specific amount based on a variety of county health indicators.

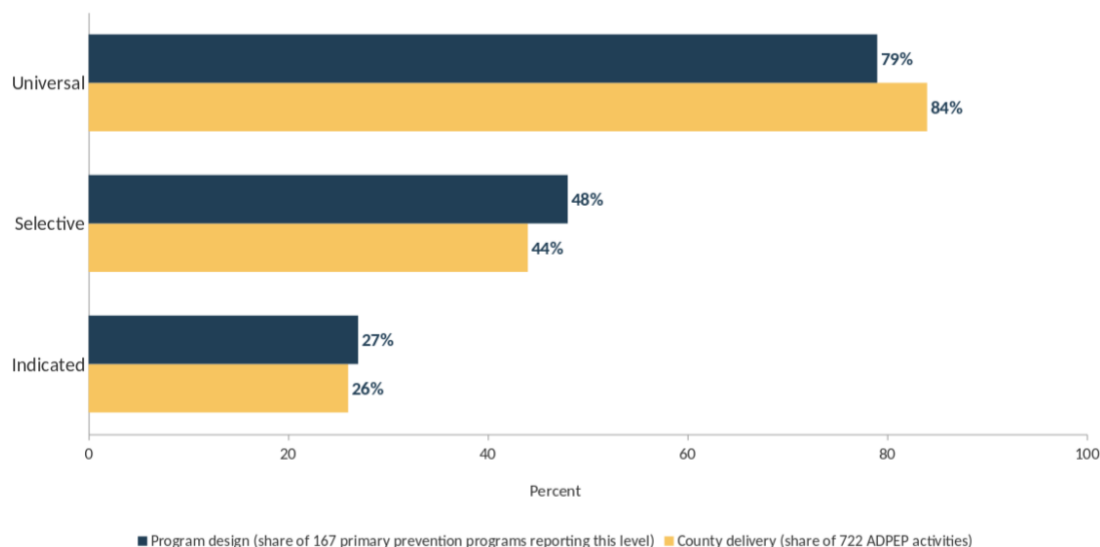
While the over-arching methodology for a needs-based approach is sound (a fixed floor amount with an accompanying bolus based on need), Third Horizon notes that the data sources referenced in the formula’s justification lack utilization of recognized core measures around youth based primary prevention, particularly youth use rates (often captured as 30 day use of alcohol, marijuana, opioid and other drugs) and other risk and protective factors, opting instead to rely on broad public health measures and consequence data that focus on adults. Two specific data resources illustrate this gap: the [Behavioral Risk Factor Surveillance Survey](#) (BRFSS) is a survey targeting adults 18 and over. The [American Community Survey](#) and other data sets from the US Census do include youth-related data, but not specific to behavioral health or substance use. Premature death data was also utilized, which does place greater weight on deaths at a younger age. However, the data sets look at all premature death, and the formula does not indicate a closer look at deaths more specifically attributable to substance use-related causes, which at times are hard to track (overdose, accidents while under the influence, etc.). Given that strong primary prevention systems have a youth focus, this is a notable disconnect in both age range and consequence data specific to substance use. It further reinforces the finding that a comprehensive needs-based approach specific to primary substance use prevention is not widely utilized across Oregon’s primary prevention funding streams.

Limited Prevention Services for Youth at Risk

Most primary prevention strategies implemented are Universal. Oregon communities lack access to appropriate and needed levels of Selected and Indicated prevention strategies, increasing the likelihood that youth with identified risk for problems associated with substance use are unlikely to be receiving proper services.

Of the 167 primary prevention programs reporting a prevention level, 141 (84%) include universal work aimed at a whole community or population, and 91 (54 percent) work only at that level. Seventy-six (46%) include selective or indicated work: 74 (44 percent) selective prevention for groups at higher risk, and 43 (26%) indicated prevention for individuals already showing early warning signs. Most targeted work sits alongside universal programming. 60 programs operate at two or more levels, while only 16 work exclusively at the selective or indicated level. Only 3% of 722 activities in the county ADPEP progress reports were indicated. Table xx visualizes this disconnect.

Figure 37. Prevention levels in program design compared with county delivery



Note: Design: primary prevention programs reporting a level in the provider survey. Delivery: activities recorded in county ADPEP progress reports. (Sources: HB 3321 provider survey; county ADPEP progress reports).

What Selected or Indicated prevention efforts are in place are often not funded by the state.

Survey responses point to the fact that, to the extent there are Selected and Indicated activities being delivered, they are often funded through local funding and philanthropy, with lesser amounts of state/public funds. While leveraging such funding for the sustainability of services is a generally sound approach, it reinforces the conclusion that the state of Oregon is not making adequate, equitable investments in Selected and Indicated strategies, which inhibit capacity development and increase the financial vulnerability of what services exist in these categories.

A comprehensive primary prevention system would have a balance of selected and indicated strategies, designed and financed in response to data indicating higher-risk populations in need of such services. With limited exception, Oregon's system lacks in this area.

Strategy Gaps

Oregon's prevention system is broad but thin. While there is local implementation of established programs it relies heavily on locally defined activity and operate no program at the statewide scale besides public awareness campaigns and state operated retail compliances

Only 29 of the 375 distinct programs identified are a recognized curriculum or named program. The remainder is locally defined activity, including 37 locally developed, innovative, or grassroots practices that respondents described in their own terms. No curriculum operates at a statewide scale. County delivery reports show adoption is somewhat wider than surveys capture, LifeSkills in seven counties, QPR in nine, but neither approaches statewide coverage. The absence of well-studied classroom programs is striking: the PAX Good Behavior Game, one of the most-researched elementary prevention programs available, appears exactly once in all data collected, named by a single school district.

Problem identification and referral, the sixth CSAP strategy, was reported with about 5 percent of delivered resources going to it, and a limited number of ADPEP workplans include a focus on this strategy.

There is no unified, single definition of prevention that is utilized across the system, and providers reflect a mixed understanding of Primary Substance Use Prevention.

While the National Academy of Medicine framework of Universal, Selected, and Indicated prevention, as well as the 5 CSAP strategies, is in use by the ADPC, HB3321, and OHA, stakeholders within the ecosystem have inconsistent definitions of what constitutes substance use prevention services. This was a significant observation in survey responses, where directions

provided clear guidance on these definitions, and yet respondents from both school and community-based organizations often reported programming that does not fit the definition.

This lack of understanding of primary prevention definitions limits the ability to ensure consistent strategic approaches to the prevention of substance use at the local, state, and national level through accurate planning, implementation, and evaluation of services.

Systemic coordination and support are lacking, but possible

To the extent Oregon has a prevention system, it remains disjointed and inconsistent. A funding backbone reaches every county, ADPEPs plan and report on a schedule, a board certifies the workforce, and conveners and implementors exist at every level — yet these pieces run on separate tracks, with inconsistent definitions and evidence that on the ground, partnership across the prevention system is inconsistent at the local level.

However, there is an opportunity in the existing structure to strengthen linkages, streamline governance and planning, and develop improved pathways for financing, program implementation and reporting, and field support, that would further promote a defined, coordinated, and aligned comprehensive primary prevention infrastructure.

Funding is Blended, not Braided

Prevention has no dedicated general-fund base. The resulting mismatch is visible in recent decisions: a behavioral health build-out of more than \$1 billion arrived “with almost no new funding allocated to substance use prevention,” and the phrase “primary prevention” does not appear in the Secretary of State’s Behavioral Health Resource Network (BHRN) audit, against roughly \$800 million in behavioral health network awards. According to the recent ADPC 2023–25 analysis, primary prevention is 2.6% of substance use disorder-related funding, and much of even that is estimated staff time or one-time money. Additionally, despite robust document collection, significant resources administered by OHA in cross-continuum contracts are impossible to verify as being used to deliver primary prevention services.

Fragmentation is itself a barrier. Many small contracts with, in one participant’s words, “no fiscal controls on any of it,” raise the administrative cost of every prevention dollar and make coordination difficult.

The data systems cannot trace dollars, so advocates cannot show what the money returns, and oversight is inconsistent. A finding that audits from the Substance Abuse and Mental Health Administration have repeated every year since 2022. No standing structure championing

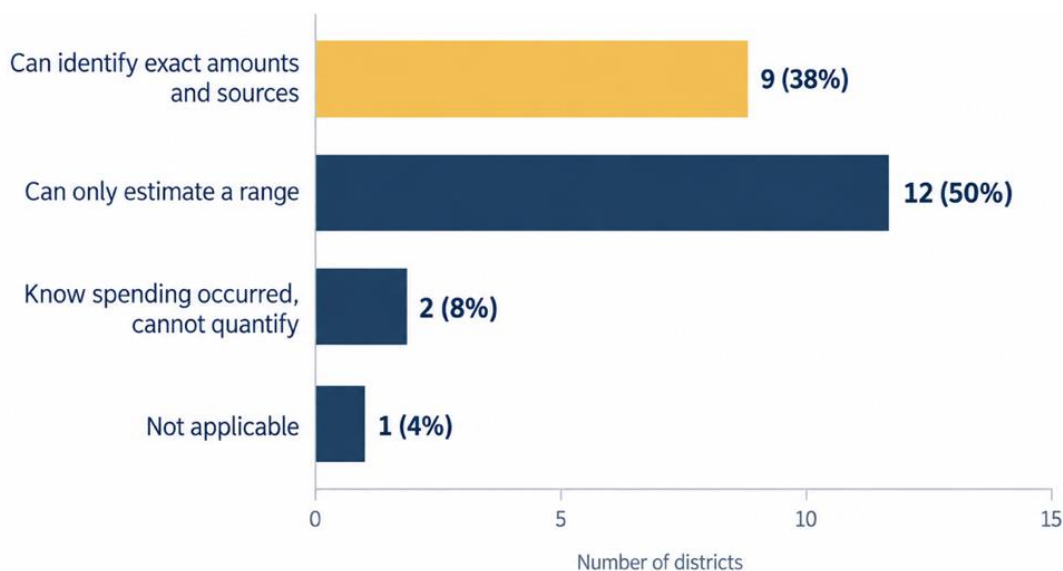
prevention funding across agencies, so there is no venue in which these problems are anyone's responsibility to solve.

Schools struggle with mandates without support to comply

The clearest coordination challenge is between state mandates and local capacity. Schools carry prevention mandates, Division 22 plans, and SB 238 opioid lessons. With no dedicated money, no requirement to submit plans to the state, and minimal enforcement, newer requirements added no reporting either. ODE's entire identifiable prevention budget for the biennium is a single coordinator position (\$188,595) and a one-time \$1.8 million campaign.

Districts are nonetheless trying to comply. Of the 65 districts responding, 19 report a completed Division 22 prevention plan and 30 are actively developing one (75 percent done or underway); 6 report no plan, and 10 do not know their status. Districts named staff capacity (35 of the 49 answering) and funding (30) as their main limits, followed by intervention support (23), competing district priorities (21), and rural access or transportation (18). Their most-requested support is a plan template and policy guidance, which points to implementation help, not willingness, as the binding constraint. Focus group participants separately emphasized the need for certified prevention specialists in schools. Because the mandate carries no money, districts fund it themselves: of the 24 districts reaching the spending questions, 13 said all or nearly all of their Division 22 prevention work is paid from general district resources.

Figure 38. Whether districts can identify their own prevention spending (School district survey, n=24)



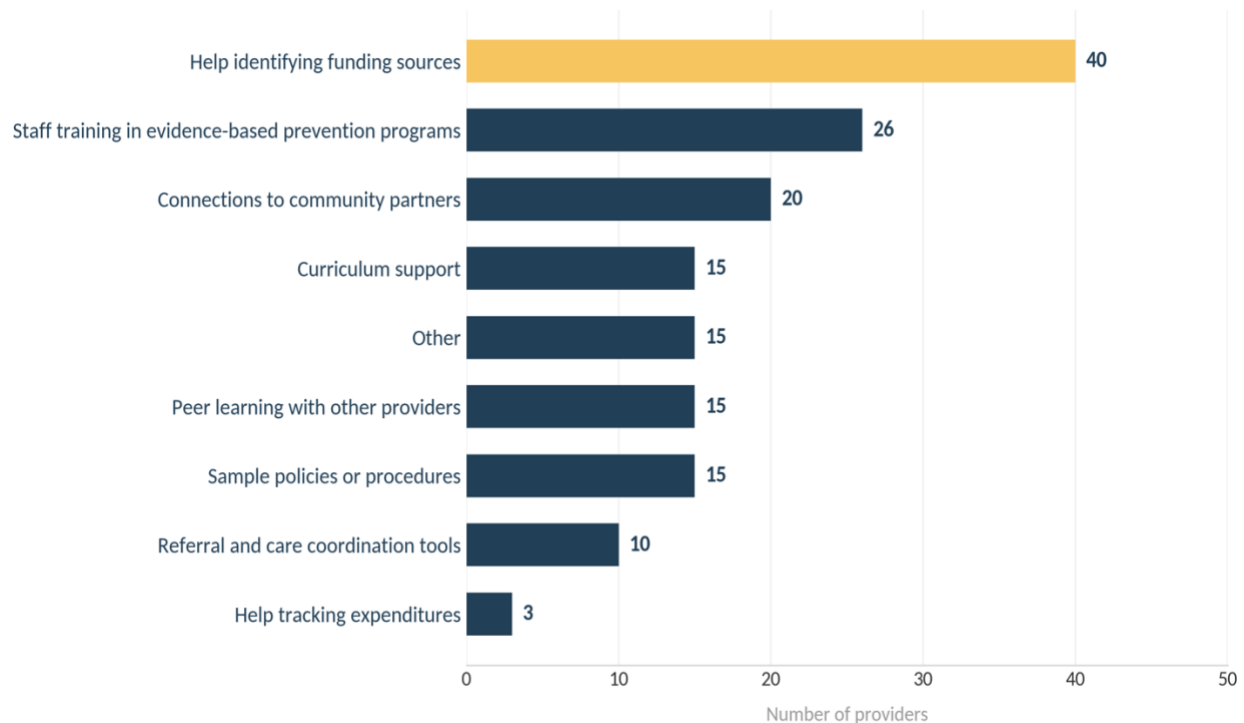
The significance of Figure 36 extends beyond school finance. If districts cannot identify their own prevention spending, no state-level data system can aggregate it, and the education sector, which carries statutory prevention duties, cannot be represented accurately in any statewide funding picture. The data gap and the coordination gap are the same gap seen from two directions. Coordination also fails on the state side: the SPF-PFS coordinator position took roughly twelve months to fill, and OHA acknowledges six-to-twelve-month hiring timelines even when funding is in hand.

Oregon's prevention system is reliant on one-time or time-limited funding, sowing instability and preventing growth

Even where money exists, its fragility prevents anything durable from being built. Nearly every stream in the funding map carries an expiration or a political risk, and this is true both of state and federal funds. The COVID and ARPA block-grant supplements have expired. SAMHSA State Opioid Response support for local grants has ended. The \$13.7 million settlement prevention investment is one-time as currently structured, with Promoting Healthy Outcomes with Culturally Unique Solutions (PHOCUS) and Regional Health Equity Coalition (RHEC) grants that must be spent by mid-2027. The settlement fund itself continues for years, and renewal is a choice available to the OSPTR Board, which has expressed a desire to equitably fund prevention services. CDC's OD2A runs on short cycles that local coordinators say limit reach and sustainability.

The structural consequence is that prevention leaders spend scarce capacity re-securing money rather than delivering services and cannot commit to multi-year strategies. The workforce data show the same fragility in staffing: prevention rides on fractions of positions funded by fractions of grants, so workforce money that is itself one-time cannot change that arithmetic. This is also why the field's top technical assistance request is help finding money rather than help doing the work.

Figure 39. Technical assistance providers most want over the next 12 months (Provider survey, n= 60)



There is no federal or CDC adequacy standard for alcohol and drug primary prevention against which to size Oregon's shortfall precisely. The 2024 PCG report improvised one from Oregon's fully funded tobacco program and estimated a community prevention gap of about \$122.84 million per year, plus \$5.47 million per year for a school-based planning hub. That estimate should be presented as a benchmark derived by analogy rather than a validated requirement; it is the only quantified target currently available.

Equity Gaps

In addition to geographic and programmatic inequities, certain special populations and limitations on culturally responsive prevention programming are notable.

The workforce analysis identifies population gaps that the program inventory cannot see. The credentialed workforce is overwhelmingly White, non-Hispanic, and English speaking, against populations that include tribal, Latino, and lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) communities. The 2022 OHSU-PSU gap analysis found the same pattern system-wide: fewer than one in five surveyed organizations could tailor services to LGBTQIA+ clients, and one in four could not offer language interpretation. A program can appear in the

inventory as serving a county without being able to serve everyone in it. Campus populations are a further blank space. The state collects no systematic picture of what colleges and universities spend on prevention.

Five dimensions of inequity appear across the workstreams. They are distinguishable but not independent. A rural, tribal, limited-English-proficiency community sits at the intersection of four of them.

- Geography. Rural and frontier counties receive the smallest allocations, have the fewest or no certified staff, and fall partly outside the regional support structure (Section 1).
- Race, ethnicity, and language. The credentialed workforce is overwhelmingly White, non-Hispanic, and English-speaking; the OHSU-PSU gap analysis found that one in four surveyed organizations could not offer language interpretation.
- Culturally specific and tribal communities. The workforce does not mirror the tribal and Latino communities it serves, and no statewide mechanism documents whether culturally grounded local practice reaches them effectively.
- LGBTQIA+ communities. Fewer than one in five surveyed organizations could provide tailored services.
- Institutional resource base. Districts with weaker general funds absorb an unfunded state mandate out of local money, so the prevention a student receives depends on the wealth of the district rather than the student's risk.

Workforce Challenges

While improving, statewide infrastructure has curtailed the growth and sustainability of the primary prevention workforce

While OHA has begun investing in expanded training opportunities for individuals seeking to achieve or sustain the CPS credential, there continues to be a gray area around defining the workforce, its pathways, and support mechanisms. Except for tribal related primary prevention and tobacco related prevention contracts, there are no requirements tethering the workforce to the CPS credential, and a perceived lack of value continues to plague members of the workforce who may be well-positioned to attain the credential but have disconnected from the process. While professionals with other credentials are engaged in primary prevention efforts – many of which share core competencies with the CPS – it is not certain that training and supervision requirements with adequate subject matter expertise in prevention science are equal across credentials.

Additionally, organizations, professionals, and systems all note that unmet needs around training, technical assistance, and support are an added barrier for both the workforce and the providers, schools, and organizations that wish to engage them.

Recommendations

Third Horizon recommends the following actions Oregon can take to better capture, support, finance, grow, and stabilize the delivery of primary prevention programs and strategies. These recommendations are inclusive of commonly used strategies that states across the country have considered. While the recommendations are centered on their benefit to expanding and sustaining primary prevention services, certain recommendations are recognized to have potential benefit across the entire SUD service continuum.

As with all recommendations, state policymakers, agency leaders, community partners, and others should consider these recommendations against the backdrop of an ever-changing local, regional, state, and federal funding and regulatory environment.

Universal Definition of Primary Prevention

Oregon should adopt a single definition of Primary Substance Use Disorders Prevention, grounded in the definitions set forth in HB3321 and the current framework in use through the ADPEP infrastructure.

HB3321 sunsets on January 2, 2027. The Oregon Legislature should consider the passage of new legislation to permanently codify a definition for primary substance use prevention. The definition should be based on the prevention definition as presented in HB3321 and as adopted by the ADPC Prevention Committee. In addition, the definition should include the six CSAP Strategies overlaid with the National Academy of Medicine Framework (Universal, Selected, and Indicated). Codifying this in regulation will ensure that state funds allocated, in whole or in part, to primary prevention, oversight bodies addressing substance use prevention, state agency procurement, and Division 22 requirements, can be aligned under the statutory definition. Further, agencies, schools and organizations that receive funds through these contracts should be required to adopt the definition as well, with reporting infrastructure ensuring that funders can monitor for compliance with the definition. Such a mandate would match with both the approach to this analysis and current definitions utilized by the Oregon Health Authority relative to its ADPEP program, and the ADPC, ensuring consistent application of these definitions across the ecosystem.

Fiscal Policy

Set a goal, over time, to increase the allocation of total funding to community-based primary prevention from less than 3% to a minimum of 20%, like the approach used in SUPTRS.

The current total amount of funding going to communities to support primary prevention services is insufficient to ensure a robust, sustained, equitable, and accessible prevention system. Several ADPEPs note in their report that current investment levels are insufficient to meet even current workplan requirements. Approximately \$15 million in non-state resources were identified in this report as supporting local primary prevention efforts, indicating that local communities are leveraging almost dollar-for-dollar state investment. However, even with those resources, the system remains severely under-resourced.

Third Horizon does not suggest that the apportioning of existing resources across harm reduction, treatment or recovery be reduced to achieve this goal – on the contrary, if adopted, this goal should be achieved while appropriately and adequately addressing all parts of the SUD continuum of care. To increase primary prevention funding, Oregon should consider the following strategies:

A dedicated fund for primary substance use prevention should be developed from proceeds generated through the sale of distilled spirits.

Many states with a control framework for some or all alcohol sales will dedicate a portion of resources towards substance use related services. Given focused attention on concerns related to youth alcohol consumption and over consumption of alcohol by adults in OHA's prevention investments, it is notable that Oregon's control system does not have such a fund. Taking a portion of proceeds generated from the sale of a legal substance to prevent the negative consequences of the substance in communities is not only responsible business practice; in the case of Oregon and its role over the retail sales of alcohol, it is an untapped funding source that could bring new revenue to primary prevention services. Third Horizon further recommends that such a fund, if created, should be limited to use for primary prevention services as defined in this report; and that the fund not be restricted to alcohol-only primary prevention efforts, which can undermine the impact of prevention services that need to be responsive to all substances of concern as informed by local data.

For funds that can be used across the continuum of care, Oregon should develop a consistent framework permanently dedicating a portion of broad funding pools to prevention and move away from drug-specific funding restrictions wherever possible.

Oregon's Opioid Abatement Fund has a vision of equitable financing across the continuum, but the current prevention investment commitment is time limited. Given that primary prevention is financed through several funds with multiple purposes, Oregon should adopt a fiscal strategy that provides a consistent roadmap for the financing of prevention services over the long term. Such a methodology should be applied to all state funding sources where such an apportioning can be made, including SUD-related state general funds, CCO special fund balances, etc.

Additionally, as many states learned in the deployment of State Opioid Response (SOR) funding, funding sources that restrict prevention services to a single substance can undermine a comprehensive, nimble prevention ecosystem that needs to be able to respond to emerging drug trends and changes to the substance use profile of youth. Oregon should ease restrictions on tobacco and other opioid or drug-specific funding to encourage better integration at the community level.

OHA should work, over time, to increase utilization of the SUPTRS block grant for primary prevention beyond the 20% set aside.

As noted elsewhere in this report, the 20% set aside is the minimum required. As indicated earlier in this report, nine states exceed this minimum, with Rhode Island dedicating almost 40% to primary prevention.

Reallocation of more SUPTRS funds towards primary prevention can be achieved by advancing payment reforms that require mental health and substance use disorders coverage at parity in both commercial insurance and Medicaid and leveraging Alternative Payment Models (APMs) through commercial and public payers to enhance care coverage, quality and sustainability. While Third Horizon did not undertake a financial analysis across the continuum of care as a part of this report, many states still utilize SUPTRS dollars to cover services that, in theory, can be covered by insurance. Oregon should similarly work to reduce the use of state SUD funds used to cover clinical services for redeployment in this area. While the current climate regarding Medicaid work requirements and health care costs may make this step difficult at this time, OHA and its partners should adopt a collective goal to decrease the use of SUPTRS funds towards clinical services, and deploying those funds to prevention, health and safety, and community-based recover support services that are not coverable by insurance.

While working to increase resources, Oregon should adopt a more specific Primary Prevention Funding Formula to ensure equitable distribution of primary prevention funds.

While states often struggle to balance fairness, funding equity, and need, a true, data-driven public health response cultivates funding appropriation based, in part, on where the consequences of disease are most acute. Though such an approach was utilized in the recent release of Opioid Abatement funding through the ADPEP system, using the Public Health Modernization Formula. While conceptually this is precisely the type of approach Third Horizon recommends, the formula relied on high level, generic public health indicators that largely focused on adults, with little focus on substance use specific consequence data relative to youth, the population largely targeting by primary prevention services. An investment model should be designed that looks at both needed operational capacity based on geography and population size (the “floor” level of investment), in addition to specific, substance use related use and consequence data vital to inform programs, strategies and the resources needed to achieve outcomes.

Funding should be prioritized to support school districts in Division 22 compliance, school-based prevention implementation, and reporting.

Through its Division 22 regulations, Oregon is uniquely well positioned to advance school-based primary prevention efforts. However, that opportunity is challenged by no significant funding being allocated to support schools in their primary prevention efforts, leaving districts to support a limited array of service through the district budget, or looking to community partners who also face financing challenges in the delivery of primary prevention programs. Improving Division 22 compliance, transparency and service delivery can be accelerated by focusing on school-focused funding efforts, including leverage of Medicaid to Schools, to expand sustainable delivery of youth focused primary prevention.

Programmatic Strategy

Oregon should consolidate current infrastructure into a single, “Regional Primary Prevention” system

Prevention services broadly (tobacco, substance use, problem gambling, etc.) are often siloed at the community level. While contracts and state agencies strongly encourage and monitor for alignment and partnership, as a practical manner, Oregon does not have a unified system; instead having a variety of programs and structured inconsistently across regions. This challenges the ability to achieve desired activities, leaving it difficult to fully capture the breadth and depth of services being delivered, impacts being garnered, or gaps that need to be filled.

Third Horizon recommends that Oregon undergo a transformation to a single, regional prevention infrastructure, aligned to the ADPC infrastructure (including the allowance for “Regional ADPCs”) that ensures uniformity of financial and strategic planning, fiscal management, and reporting. All services focused on coordinating and supporting primary substance use disorders prevention delivery through schools and community partners should sit under one organization or system in each region, with unified integrated staffing, workplans, contracts and reporting. While each region may need a different structural solution to arrive at the goal, a Regional Primary Prevention system would ensure better accountability, strategic leverage, and adaptability.

Public awareness, as one type of universal strategy, should have more of a youth focus; and efforts should be undertaken to expand access to selected and indicated primary prevention strategies across Oregon.

The most widely identified universal approach in use in Oregon is the Rethink the Drink campaign. The campaign is focused on adult overconsumption of alcohol. Given that alcohol remains the most used substance by youth, there remains a gap in youth focused media campaign as an upstream strategy to deter adult overconsumption later in life.

The program inventory and regional ADPEP reports noted a limited focus on selected and indicated primary prevention strategies. While universal strategies are inherently less expensive and able to impact a broad audience, gaps in selected and indicated prevention strategies means that youth at higher risk for substance use disorders cannot access the specific types of primary prevention programs they need. This all but ensures an ongoing pipeline of youth who will need higher levels of care should their risk not be adequately addressed. Existing selected and indicated strategies identified in the inventory should be reviewed to assess opportunities to expand such services, and expansion of all strategies should continue to focus on strategies that are culturally responsive.

A centralized, well financed technical assistance and data monitoring resource for the primary prevention system in Oregon should be stood up.

The ADPC has prioritized the creation of a “Center for Excellence” to coordinate and make available low-barrier training and technical assistance to the primary prevention field. Given findings around inconsistent program delivery, the school district’s desire for more support in Division 22 compliance, as well as gaps in workforce and provider readiness and support, the development of such an infrastructure is further justified. In addition, given the findings demonstrating the significant role promising practices and local innovation have in the prevention ecosystem, such a technical assistance resource could help rapidly bolster the ability

of innovative approaches to be further reviewed and potentially replicated in communities where the innovation matches local conditions and needs.

Workforce

Oregon should continue efforts to clarify, strengthen, and grow the number of CPS professionals in Oregon.

Oregon has recently made meaningful investments in increasing the number of professionals with the Certified Prevention Specialist Credential. Those investments should continue as a meaningful tool to both increase the CPS pipeline and support the existing CPS workforce in its professional development.

At the same time – Oregon should develop a “Core Competency Framework” that clarifies the common required competencies to deliver primary prevention services across all credentials in use.

Growing the CPS workforce to a level that ensures comprehensive delivery of services is likely unrealistic, given the sizeable gaps in prevention capacity. Additionally, Oregon has recognized and leveraged a wide array of credentialed professionals to deliver primary prevention services. A crosswalk of credential competencies, like the CPS and CHES crosswalk included in this report, should be conducted across certifications and licenses, highlighting areas of alignment, creating “professional development pathways” for those whose credential competencies may have gaps that require additional training or support to delivery primary prevention services, and to identify what, if any, specific programs or services defined as primary substance use prevention should only be done by individuals with a CPS.

To ensure that such a process is grounded and led by experts with specific training and expertise in substance use primary prevention, Third Horizon recommends this task be lead through a partnership with the APDC Prevention Committee, OHA (including both the Behavioral Health Division and the Public Health Division) and the Oregon Coalition of Prevention Professionals.

Oversight and Accountability

The Alcohol and Drug Policy Commission Governing Comprehensive Plan ([ORS 430.223](#)) should be amended to include both prospective and retrospective oversight of all strategic funding decisions that utilize state or federal funds to address substance use disorders, as dictated by the Comprehensive Plan.

Currently, the ADPC conducts bi-annual, retrospective analysis of state agency spending on substance use-related services. Third Horizon relied on the prevention elements of this reporting process as a vital input to this analysis. To further strengthen transparency and accountability, state agencies and other fund-controlling entities should be required to engage the ADPC in prior approval of spending plans specific to resources that are invested by state agencies to address substance use disorder prevention, risk reduction, treatment, and recovery.

This should be inclusive of proposed spending of all state funds, as well as spending plans for federal funds that the state receives to invest in community efforts. The ADPC should be actively involved in the development, submission, and monitoring of the Substance Use Prevention Treatment and Recovery Services (SUPTRS) Block Grant and provide active review and approval for state submissions for additional federal funds (such as State Opioid Response Grants, etc). State agency requests for approval should demonstrate alignment with the Comprehensive Plan and be inclusive of monitoring and contracting methodologies to ensure the ability of the ADPC to meet its biennial fiduciary reporting duties.

Further, Oregon should consider disbanding or realigning related commissions to fall under the oversight control of the ADPC, such as the Opioid Abatement Commission and any other state entity with strategic decision-making authority over substance use related funding, so the entity with statutory authority for the development of a comprehensive statewide SUD plan has the equal ability to oversee and monitor for all aspects of the plans implementation across state government.

Such realignment and demarcation of authority will ensure that primary prevention, along with other parts of the substance use disorders continuum, are more easily able to be transparently monitored, supported and sustained.

Oregon should improve its youth substance use data accessibility, to that community based providers have easier, direct access to measures critical to data driven primary prevention planning, and efforts to seek, receive and sustain direct-to-community federal, philanthropic and other grant funds.

The National Survey on Drug Use and Health (NSDUH), while it includes youth focused substance use data, has inherent challenges around its survey design and consistency that make it a difficult data tool to rely upon for data driven planning at the state and local level. While the Oregon Student Health Survey has the potential to solve for those challenges, the publicly available SHS portal is unclear, and provides no easily accessible methodology document that can prevent data misinterpretation. The data as presented requires significant analytics capacity and expertise to be able to make meaningful use of the information in a way that is consistent, locally viable and usable as a practical planning, evaluation and reporting. The system is not well situated to ensure that local partners, ADPEPs and others have access to youth-specific data indicators around substance use that are reliable and, in the case of federal grant programs like the Drug Free

Communities Support Program, are required in order to receive and maintain funding. Several ADPEP organizations also reported directly the extent to which the lack of local, usable data is harming their ability to implement youth focused primary prevention. Current data collection strategies should be reviewed, and priority should be given to developing a more robust solution to identify and share youth related substance use data at the local, regional and state levels as appropriate.

Oregon should adopt an improved “braiding” methodology for financial management, contract procurement, and reporting.



With a variety of funding sources being used to finance primary prevention – often through broad contracts that may also entail non-primary prevention or cross-continuum activity – regulations should be developed that ensure specific funding sources and their respective requirements are traceable from the source within the Oregon state budget, through to state agencies, to the contracts delivered to community-based organizations, and back through contractor reporting to state agencies. Providers should have direct access to the specific funding sources in their contracts; inclusive of any specific requirements or limitations around those funds that would impact their budgetary use, alongside financial and programmatic reporting forms that ensure organizations in receipt of such funds can clearly report compliance with all rules and regulations specific to those sources.

Third Horizon does not suggest in this report that funds are currently being utilized for purposes that are outside of their allowable use. However, the lack of transparency in contracting and procurement prevents a complete and accurate accounting of the finances and services being undertaken, and limits accountability for compliance with fund purposes and legislative intent.

Contracts and reporting across primary prevention services should include requirements around the identification and implementation of culturally specific activities, and inclusion of the extent to which implemented programs are able to reach all in need, and more clearly and uniformly require reporting based on state adopted prevention definitions.

While some improvements could be undertaken to improve consistency in response tracking across the contractors, a revised ADPEP reporting form inclusive of these elements could be a model replicated for use across all primary prevention contracts at both OHA and other state agencies. Reporting across agencies should also entail more specific reporting from organizations on culturally responsive programming and strategies, as well as barriers to implementation of such strategies with recommendations on how to address them.

Conclusion

HB3321 recognized that the primary prevention field is an important part of the continuum of care. However, the field is plagued with inconsistent and inequitable service capacity, workforce shortages, opaque funding mechanisms, and a lack of a cohesive, statewide fiscal and programmatic approach that can reduce risk factors and increase protective factors for Oregon's youth.

However, throughout this inquiry, the deep commitment of schools, providers, state agencies, coalitions, and policy leaders were clear. Moving forward, Oregon has an opportunity to make a clear, robust, and long-term commitment to expand the reach and impact of youth focused primary prevention services at the local, regional, and state levels, leveraging financial innovation with strategic vision and program delivery that can truly meet the needs of communities. In doing so, Oregon can see both social and economic benefits, alleviating the burden caused by substance use while supporting youth towards healthy, vibrant lives.

References

- ¹ The Social Development Model. (1996). Cambridge University Press. Retrieved from: https://www.researchgate.net/publication/232604091_The_Social_Development_Model_A_Theory_of_Antisocial_Behavior
- ² Oregon Legislature. HB 3321. (2025), Enrolled. Retrieved from: <https://olis.oregonlegislature.gov/liz/2025r1/Measures/Overview/HB3321>
- ³ Oregon Alcohol and Drug Policy Commission. 2026–2030 Comprehensive Plan, “Opening Doors: Achieving Access, Belonging and Connection Across Oregon”. (2025). Retrieved from: <https://www.oregon.gov/adpc/Pages/Plan.aspx>
- ⁴ SAMHSA. 2023–2024 NSDUH: State Estimates of Substance Use and Mental Health. (2025). Retrieved from: <https://www.samhsa.gov/data/report/2023-2024-nsduh-state-estimates-substance-use-and-mental-health>
- ⁵ Oregon Health Authority. Oregon Student Health Survey, State of Oregon 2024. (2024). Retrieved from: <https://www.oregon.gov/oha/ph/birthdeathcertificates/surveys/pages/shs-2024-results.aspx>
- ⁶ Oregon Health Authority. Oregon Student Health Survey, State of Oregon 2022. (2022). Retrieved from: <https://www.oregon.gov/oha/ph/birthdeathcertificates/surveys/pages/shs-2022-results.aspx>
- ⁷ Oregon Public Broadcasting. “Addiction experts raise alarm about cannabis use among Oregon’s youth”. (2025). Retrieved from: <https://www.opb.org/article/2025/05/14/addiction-experts-raise-alarm-about-cannabis-use-among-oregons-youth/>
- ⁸ Oregon Health Authority. Fentanyl Facts. (2024) Retrieved from: <https://www.oregon.gov/oha/ph/preventionwellness/substanceuse/opioids/pages/fentanylfacts.aspx>
- ⁹ Oregon-Idaho HIDTA. 2027 Threat Assessment. (2026), Information Sharing and Analytical Coordination Center. Figures reflect 2025 calendar-year data. Retrieved from: <http://oridhidta.org/reports>
- ¹⁰ CDC. Morbidity and Mortality Weekly Report: Adverse Childhood Experiences (Vol. 72). (2023). Retrieved from: <https://www.cdc.gov/mmwr/volumes/72/wr/mm7226a2.htm>
- ¹¹ Willamette Week. “Oregon’s homeless population is 8th largest in the nation, HUD count shows”. (2024). Retrieved from: <https://www.wweek.com/news/2024/12/28/oregons-homeless-population-is-8th-largest-in-the-nation-hud-count-shows/>
- ¹² Oregon Youth Authority. Social characteristics figures derived from OYA Risk Needs Assessment 2.0 for youth supervised as of July 1, 2026. (2026). Retrieved from: <https://www.oregon.gov/oya/aboutoya/pages/stats.aspx>
- ¹³ Oregon Department of Education. Graduation cohort and dropout data, 2024–25 school year, as reported by Willamette Week and Jefferson Public Radio. (2026). Retrieved from: <https://www.oregon.gov/ode/reports-and-data/students/pages/cohort-graduation-rate.aspx>
- ¹⁴ Oregon Public Broadcasting. Oregon chronic absenteeism. (2026). Retrieved from: <https://www.opb.org/article/2026/04/15/oregon-chronic-absenteeism-university-of-oregon-research-solution/>
- ¹⁵ Oregon Department of Human Services. Child Welfare Data Book. (2024). Retrieved from: <https://www.oregon.gov/odhs/data/pages/cw-data.aspx>
- ¹⁶ Trust for America’s Health. Oregon state details, alcohol-attributable deaths. (n.d.). Retrieved from: <https://www.tfah.org/state-details/oregon/>
- ¹⁷ Oregon Health Authority / ECONorthwest. Alcohol Harms and Economic Burden, Interim Report. (2021). The final report, Economic Analysis of Excessive Alcohol Consumption in Oregon (November 2021, publicly released January 2024), models excise-tax scenarios and does not update the burden estimate. Retrieved from: <https://www.bizjournals.com/portland/news/2021/02/24/cost-of-excessive-drinking-oregon.html>
- ¹⁸ Oregon Health Authority. “Oregon overdose deaths declined in 2024, 2025” and the 2025 Oregon Opioid Overdose Report (2026). Retrieved from: <https://www.oregon.gov/oha/erd/pages/oregon-overdose-deaths-declined-in-2024-2025-05.13.2026.aspx>
- ¹⁹ CDC / National Center for Health Statistics. Drug Overdose Mortality, 2022–2023. (2023). Retrieved from: <https://www.cdc.gov/nchs/data/hestat/drug-overdose/drug-overdose-2022-2023.htm>
- ²⁰ Oregon Health Authority. Oregon overdose deaths declined in 2024, 2025. (2025). Retrieved from: <https://www.oregon.gov/oha/erd/pages/oregon-overdose-deaths-declined-in-2024-2025-05.13.2026.aspx>

-
- ²¹ Centers for Disease Control and Prevention, National Center for Health Statistics. Vital Statistics Rapid Release: Provisional Drug Overdose Death Counts (Oregon; 12-month period ending September 2025). <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.
- ²² Oregon Health Authority, Public Health Division. Opioids and the Ongoing Drug Overdose Crisis in Oregon — report to the Oregon Legislature under ORS 432.141, 2026 edition (2025 data); announced May 13, 2026. <https://www.oregon.gov/oha/ERD/Pages/Oregon-overdose-deaths-declined-in-2024-2025-05.13.2026.aspx>. Report series (prior edition, executive summary): <https://www.oregon.gov/oha/PH/PreventionWellness/SubstanceUse/Opioids/SiteAssets/Lists/FentanylFactsAccordion/AllItems/Executive%20Summary.pdf>
- ²³ Oregon Health Authority. Opioids and the Ongoing Drug Overdose Crisis in Oregon (ORS 432.141), 2026 edition — drug-involvement, drug-seizure, and polysubstance data. <https://www.oregon.gov/oha/ERD/Pages/Oregon-overdose-deaths-declined-in-2024-2025-05.13.2026.aspx>.
- ²⁴ Oregon Health Authority. Overdose mortality by race and ethnicity, 2023, reported in Opioids and the Ongoing Drug Overdose Crisis in Oregon (ORS 432.141). <https://www.oregon.gov/oha/ERD/Pages/Oregon-overdose-deaths-declined-in-2024-2025-05.13.2026.aspx>.
- ²⁵ Oregon ADPC / Washington State Institute for Public Policy. Cost-Effectiveness findings. (n.d.) Retrieved from: <https://www.wsipp.wa.gov/benefitcost>
- ²⁶ National Institute on Drug Abuse. “Investing in Prevention Makes Good Financial Sense”. (2022). Retrieved from: <https://nida.nih.gov/about-nida/noras-blog/2022/04/investing-in-prevention-makes-good-financial-sense>
- ²⁷ Oregon Alcohol and Drug Policy Commission. 2023–25 Substance Use Disorder Financial Assessment (draft report). (2025). Retrieved from: <https://www.oregon.gov/adpc/pages/reports.aspx>
- ²⁸ Oregon Department of Education, Office of Indian Education. Map of Oregon Tribes. (n.d.). Retrieved from: <https://www.oregon.gov/ode/students-and-family/equity/nativeamericaneducation/pages/tribal%20curriculum.aspx>
- ²⁹ National Academies of Sciences, Engineering, and Medicine. Blueprint for a National Prevention Infrastructure for Mental, Emotional, and Behavioral Disorders. (2025). Washington, DC: The National Academies Press. Retrieved from: <https://www.nationalacademies.org/projects/HMD-BPH-23-07/publication/28577>
- ³⁰ U.S. Census Bureau. Using 1-Year or 5-Year American Community Survey Data. (2024). Retrieved from: <https://www.census.gov/programs-surveys/acs/guidance/estimates.html>
- ³¹ CDC. Multiple Cause of Death by Single Race 2018–2024. (2024). Retrieved from: <https://wonder.cdc.gov/wonder/help/mcd-expanded.html>
- ³² U.S. Census Bureau. American Community Survey Multiyear Accuracy of the Data (5-year 2020–2024). (2025). Retrieved from: https://www2.census.gov/programs-surveys/acs/tech_docs/accuracy/MultiyearACSAccuracyofData2024.pdf