Objective
Process Objective 1: Create a clear definition of Primary Prevention (in statute and rule). Definitions will ensure resources are directed appropriately, ensure state and local partners have agreed upon parameters, and promote investment in upstream primary prevention vs other types of prevention.
Process Objective 2: Perform a study or studies that analyze the following: primary prevention programming gaps, inventory of existing state and local programs, map of Evidence-Based Programs (EBP), and a Financial Analysis of state and federally funded programs. These analyses will be cross-sector and provide a landscape of prevention programming across the state, how those programs are financed (and where funds are lacking), and how revenues from regulated substances might provide additional resources for those efforts.
Process Objective 3: Ensure that the ADPC Comprehensive Plan is threaded, linked, and coordinated with other state strategic plans and local plans related to behavioral health.
Process Objective 4: Ensure coordination with the Oregon Youth Addiction Alliance (formerly ADPC-SOCAC Youth Collaborative created under House Bill 4002) through regular community and collaboration on primary prevention strategies.

K-12 Objective 1: Ensure all K-12 education students and their families have access to evidence and community informed primary prevention education and programming, assessment (existing data like attendance and population surveys like Student Health Survey), and screening. Components: (1) Upstream prevention (focused on protective factors, program focus rather than curriculum focus) (2)Education and curriculum (similar, but different than upstream prevention) (3) Screening (4)Assessment (5)Schoolwide plans

K-12 Objective 2: Ensure all grade 6-12 education students receive evidence based or evidence informed comprehensive health education that meets ODE standards inclusive of substance use and misuse prevention curriculum.

K-12 Objective 3: Ensure all grades K-12 students receive comprehensive health education that meets ODE Health Education standards inclusive of substance use and misuse prevention curriculum, in alignment with OAR 581-022-2045 and their school district's annually updated Substance Use Prevention and Intervention Plan.

Higher Ed Objective 4: Develop a formal financial support program for institutions of higher education (that bolsters/builds on an existing state-wide college coalition) to support selection, uptake, and ongoing implementation of evidence-based primary and indicated prevention programs for substance misuse on college and university campuses. Financial support for such a coalition would include:
(1) hiring and supporting a least one substance misuse prevention specialist on each college campus with financing to support more based on size of campus
(2) technical assistance for these professionals in providing education and indicated interventions
(3) Increase collaboration and coordination between college campuses and public/behavioral health community organizations.

Higher Ed Objective 5: Increase funding for availability and utility of state-funded overdose reversal kits on college and university campuses

Higher Ed Objective 6: Develop a college population health assessment/survey to understand the unique challenges of Oregon college students.
Higher Ed Objective 7: Placeholder goal to address that college students use alcohol and cannabis at an exponentially greater rate than any other substances.
Higher Ed Objective 8: Support institutions of higher learning in partnership with local public health authorities to evaluate their alcohol and drug policies at least once a decade.
Culturally and Population Specific Services Objective 9: Expand Culturally Responsive Prevention Programs

Culturally and Population Specific Services Objective 10: Integrate primary prevention into youth foster care settings, with the objective of reducing disparities in substance use documented among youth who have been involved in foster care.
Workforce Objective 11: Expand the Prevention Workforce of Certified Prevention Specialists.
Workforce Objective 12: Establish prevention best practice training and technical assistance provision, including program evaluation, implementation science, and shared risk and protective factor expertise provided to prevention professionals from OHA contracted-provider or NWPTTC or similar.
Workforce Objective 13: Increase the presence of prevention specialists and prevention scientists in Oregon's public health and behavioral health institutions.
Hub Objective 14: Establish a statewide primary prevention hub

Public Awareness Campaigns and Education Objective 15: Launch a Public Awareness Campaign: Implement a sustained public awareness campaign to educate the public, stakeholders, and service providers about the importance of delaying substance use. **Could these all be combined?**
Public Awareness Campaigns and Education Objective 16: Expand Rethink the Drink campaigns to other substances.
Public Awareness Campaigns and Education Objective 17: Maintain Revisit, Revamp and Make Actionable/Measured Progress for ADPC 2020-2025 objectives: Increase perception of harm of ATOD use/misuse across the lifespan
Research Objective 18: Ensure universal evidence-based prevention programs offered in Oregon public institutions are responsive to the most relevant upstream risk and protective factors in the local context.
Regulatory for Legal Substances for Adults Objective 19: Maintain Revisit, Revamp and Make Actionable/Measured Progress for ADPC 2020-2025 objectives (see some of the other goals below): **•2.a. Decrease retail and social access to alcohol, tobacco, and marijuana to underaged persons** **•2.b. Decrease over service of alcohol in restaurants and bars and retail sales of alcohol to alcohol-impaired adults ages 21+** **•2.c. Decrease family and community norms permissive of ATOD use/misuse across the lifespan**
Regulatory for Legal Substances for Adults Objective 20: Maintain and strengthen Oregon's control model for the distribution of distilled spirits.
Regulatory for Legal Substances for Adults Objective 21: Improve efforts to prevent use of alcohol and cannabis by people under 21
Regulatory for Legal Substances for Adults Objective 22: Update and improve OLCC education services for licensees and permittees with a focus on public health
Regulatory for Legal Substances for Adults Objective 23: Maintain a high level of coordination among state agencies on matters related to harmful substance uses and support a high level of engagement with public health and recovery community partners in OLCC rules-making processes

Regulatory for Legal Substances for Adults Objective 24: Ensure that alcohol and tobacco retail compliance checks also include vaping products and Nicotine.
Miscellaneous Objective 25: Mandate that CCO provide a base per member per month payment for primary prevention.
Parenting and Community Norms Objective 1: Goal to be defined.

What issues does this goal aim to address (describe in magnitude, severity, trend, and changeability)

Defining primary prevention in statute and rule addresses fragmented and misaligned prevention efforts in Oregon, ensuring resources are used effectively to mitigate rising substance use and mental health challenges. It promotes consistent parameters, statewide coordination, and investment in upstream solutions. **Magnitude:** Oregon has recognized the lack of a clear definition as a barrier, as evidenced by resource allocations (e.g., recent opioid settlement funding). However, there is no comprehensive data quantifying the exact extent of misallocated resources or inconsistencies caused by the absence of a definition. ***Oregon needs*** a statewide review of existing prevention efforts to identify inconsistencies in how "primary prevention" is interpreted and applied and data on current resource distribution between primary prevention, harm reduction, and treatment to assess whether funds are appropriately allocated. **Severity:** Without a clear definition, Oregon's prevention infrastructure is fragmented, which diminishes the impact of primary prevention efforts. This contributes to high substance use rates and untreated mental health challenges. National models demonstrate that unclear definitions lead to misalignment of goals, inefficiencies, and missed opportunities for upstream prevention. ***Oregon needs*** - Data demonstrating the tangible consequences of fragmented prevention efforts (e.g., missed opportunities for upstream prevention, inefficiencies in funding distribution). Analysis of youth substance use rates and mental health outcomes that could improve with targeted upstream efforts. **Trend:** Prevention efforts in Oregon have declined in focus over the last decade, with a shift toward harm reduction and treatment rather than upstream primary prevention. Legislative and stakeholder reports show that prevention funding has not kept pace with rising substance use rates or the need for culturally responsive, community-based prevention approaches. ***Oregon needs*** - Historical data on how resources have been distributed over time (e.g., trends in primary prevention funding vs. other categories like harm reduction). Trends in youth substance use, mental health, and overdose rates to connect gaps in prevention efforts to worsening public health metrics. **Changeability**: Examples from other states (e.g., Connecticut, Massachusetts) demonstrate that defining primary prevention in statute and rule is feasible and impactful. Oregon has engaged stakeholders to address prevention gaps, indicating the potential for collective action and change. **Oregon needs** - A feasibility study or stakeholder analysis to identify potential barriers to implementing a clear definition. Success stories from other states that can be used as models for defining primary prevention and aligning efforts.

Decrease K-12 age Substance Use/Substance Use Disorder and Death by: 1) Primary universal: education to provide an element of informed decison making and increase understanding/perceptions of potential harm. 2.) Primary universal: Assessment and Screening to understand where students are drawing strength and resilience (protective factors), where students and families are connecting to resources, and build on those protective factors that decrease liklihood of use/problematic use. 3.) Indicated/Early intervention: use data school already collects (attendance, population surveys such as SHS/SEEDs/other climate, etc) + screening to provide an early intervention system with youth and families to prevent use or prevent escalating use.

HOW - See K-12 Objective 1

HOW - See K-12 Objective 1

Goal is to reduce the prevalence of problematic substance use/substance use disorder and overdose for higher ed students through the addition of trained staffing capacity and tools on every Oregon college campus. Oregon Prevention Coalition (any work that touches AOD on College Campuses) is a resource for AOD staff on colleges and universities. It provides professional development, individual technical support, and increases implementation of evidence informed initiatives on Oregon's campuses. Funding would provide OPC with capacity, technical assistance to increase profession competence (Mid-America Prevention Technology Transfer Center, NIAAA CollegAIM, campus/local strategic prevention guide from DEA), support state standardized population health assessment. OPC is not currently funded and colleges do not have standardized levels of capacity (AOD professionals wear many hats/are understaffed) so financial support would allow for more collaboration, strategic initiatives, and assessment.

Reduce overdose rates for Oregon young people aged 18-25 by supporting those enrolled in Oregon institutions of higher learning.

Goal is to reduce the prevalence of problematic substance use/substance use disorder and overdose for higher ed students through supporting assessment of college student behavior, risks, and protective factors for planning and program design/implementation. There is no standardized assessment of Oregon college students with state level results trasparent to the public - so their specific needs are lost in national data sets and data sets for the age group as opposed to the setting. National College Health Assessment offers national data on college students but those data are not aggregated or disseminated at state level. State model: Missouri Partners in Prevention created the Missouri Assessment of College Health Behaviors (MACHB) to understand the roles that alcohol, tobacco, drugs (illegal and prescription), mental health, suicidality, and interpersonal violence have on students' health and well-being. Missouri analyzes the survey data and works with campuses to implement evidence-informed strategies for prevention.

see Higher Ed Objective 4

see Higher Ed Objective 4

The goal is to reduce inequities in substance use, substance use disorders, and overdoses in communities disproportionately harmed by these outcomes with community based/informed capacity and training. Without using culturally responsive methods, it's possible entire slices of the population will be missed or recieve ineffectual prevention programming and education. Most "evidence-based" research is normed to the majority of the population (i.e. white cis/het

The goal is to reduce inequities in substance use, substance use disorders, and overdoses in communities/families disproportionately harmed by these outcomes and disproportionately experiencing the child welfare system - use prevention/preventative intervention to break chain of a leading contributor to child welfare cases. Substance use contributes to a disproportionate share of child/family seperation. Substance misuse is a generational issue, and kids who are removed from their parents due to abuse and neglect related to substance misuse are at a high risk of growing to misuse the substance themselves. Breaking this generational cycle is paramount to preventing substance use disorder in the next generation.

Goal is to reduce the prevalence of problematic substance use/substance use disorder and overdose for Oregonians through providing tools to every community and profession touching prevention. This inclusdes the compilation and dissemination of data/assessment/evaluation/best practices, workforce training/capacity, and shared strategic initiatives and collaboration with the Oregon Alcohol and Drug Policy Commission. See Process Objective #1. See workforce objective 12: Establish prevention best practice training and technical assistance provision, including program evaluation, implementation science, and **shared risk and protective factor expertise** provided to prevention professionals from contracted-provider or NWPTTC or similar.

Decrease youth substance use by increasing perceptions of harm, particularly of cannabis. Public awareness strategy must be coupled with other interventions to be effective. 2) Address specific youth risk factors for prioritized populations. I.e. Problem=Youth substance use.

Decrease substance use disorder by addressing adult norms related to substance use (through substance specific campaigns and general education on harms of particular substances). Problem=Adult perceptions of low harms of legal substances leads to use disorder.

Reduce youth and adult substance use and substance use disorder throug increasing perceptions of harm to reduce substance use disorder. Public awareness campaigns alone have a short-lived effect and are very expensive. Best used with other strategies, particularly strategies targeting parents, clinicians and other influencers that may be directed at educating on protective factors. Problem=Community and family norms lack appreciation of harms associated with substances and risk of disorder.

What data are we using to say we need these things?

Oregon faces high rates of youth substance use and mental health challenges, as shown in surveys like the Oregon Healthy Teens Survey. Prevention funding, including federal block grants and opioid settlement funds, is fragmented between prevention, harm reduction, and treatment, lacking clear guidelines for allocation. Stakeholder feedback highlights inefficiencies and inconsistencies in prevention efforts due to the absence of a unified definition. Over the past decade, legislative priorities have shifted toward harm reduction and crisis intervention, leaving upstream prevention underfunded. Successful examples from states like Connecticut and Massachusetts demonstrate that defining primary prevention leads to better resource alignment, cohesive strategies, and improved outcomes. Together, these data underscore the urgent need for a clear statutory definition to enhance prevention efforts and address youth substance use effectively.

NSDUH 2021-22: 12.5 percent of youth 12-17 (38,000 oregonians) have a SUD - higher than the national average of 9%. SUDORS: Youth deaths due to overdose in Oregon have increased from 14.4/100,00 in 2020 to 19.3 in 2023. Lund Report: 60 percent on Oregon's 197 districts do not use evidence based prevention curricula or programs at any grade level.

HOW - See K-12 Objective 1

HOW - See K-12 Objective 1

Preveleance: NSDUH 2021-22: 36 percent of youth 18-25 (148,000 Oregonians) have an SUD - higher than the national average of 27%. 83% of those young people do not recieve services. SUDORS: Youth (15-24) deaths due to overdose in Oregon have increased from 14.4/100,00 in 2020 to 19.3 in 2023. **Capacity:** Anecdotal data from members sharing how OPC benefits them professionally. Many campuses also collect data on students so we have the opportunity to potentially combine all data to get a better idea of OR college student sub use.

see Higher Ed Objective 4 - Prevalence

see Higher Ed Objective 4 - Prevalence - as mentioned we have a gap in assessment for colleges students so this would be the point in the goal.

see Higher Ed Objective 4

see Higher Ed Objective 4

We know certain some communities are disproportionately impacted by overdose: Black and African American Oregonians are more than twice as likely to die from an overdose than all races and ethnicities. Oregonians who are American Indian and Alaska Native are more than three times as likely. Demographic data is generally easy to come by

An estimated 50% to 80% of children subjected to abuse and neglect and involved in the child welfare system have a parent with a significant substance use problem, which poses substantial safety risks for the child and family (Hall, Wilfong, Huebner, Posze, & Willauer, 2016; Semidei, Radel, & Nolan, 2001; Young, Boles, & Otero, 2007).
Substance Use Among Current and Former Foster Youth: A Systematic Review (2013) reports: “Overall, youth who are currently receiving services through the foster care system seem to report rates of alcohol and marijuana use frequency similar to that of their same aged, normative peers. [HOWEVER] Use of “hard” drugs, however, may be pronounced among this underserved population. Indeed, lifetime use of opiates, amphetamines, crack/cocaine, and hallucinogens were substantially higher in the two studies reporting such use when compared to national prevalence rates […] Results also suggest that youth currently in care evidence higher rates of substance use disorders (particularly lifetime) compared to norms, with more individuals reporting problems with drugs other than alcohol.”

What is the workforce gap? How are people getting trained as CPS? What is our capacity for this? Part of the answer is Oregon Substance Use Disorder (SUD) Services Inventory & Gap Analysis: Oregon has 62 Certified Prevention Specialists, and estimates Oregon needs 968, a gap of 906 professionals. County level estimates. There would need other data sources for other types of professionals doing prevetion work. Also need an understanding of workforce competency and support for new professionals. Lund Report also highlights a lack of support for workforce but also incomplete.

Utilize Student Health Survey to identify youth use and risk patterns in order to prioritize population to target. Additional data that would be helpful to identify prioritized population and how to influence: School districts currently using evidence-based curricula; Youth ED data, including cannabis;most recent research on efficacy for particular audiences (research from the truth initiative);

BRFSS and OLCC data on consumption patterns; RTD evaluation: https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/excessivealcoholuse/Pages/RTDCampaignEvalFinal.pdf would like more data on efficacy of RTD campaign.

Combo of Objective 16 and 17

Is there infrastructure that would help support the collection and retenti
Oregon should initially focus on building a centralized data system as the backbone of its prevention data infrastructure. This system will provide a single repository for statewide data, ensuring consistency and facilitating data sharing. Implementing standardized tools like surveys or reporting templates will further align efforts by enabling consistent metrics and reliable analysis across regions. In addition, fostering cross-sector collaboration between schools, healthcare providers, law enforcement, and community coalitions will broaden the scope of data collection and build stakeholder buy-in for future developments. To determine the best starting point, Oregon should assess its current resources and gaps, identify sectors ready to collaborate, and explore funding opportunities, such as federal grants or opioid settlement funds, to support initial steps. Over time, other components—such as regional data hubs, regular reporting mechanisms, and legislative support—can be phased in to fully address the state's fragmented data infrastructure and achieve statewide impact. Example of Centralized Data System: Washington State's Prevention Systems (Division of Behavioral Health and Recovery, DBHR). WA State Dept of Social and Health Services operates a centralized data system that tracks prevention program implementation and outcomes -- combining youth survey data, community prevention activity tracking, and statewide outcome metrics. Oregon should consider engaging with PTTCs and HIDTA as primary partners to assess and improve its data infrastructure. Both organizations have a strong track record of supporting states with technical assistance for prevention-related data systems. In addition, CADCA and SEOW could provide targeted support for coalition alignment and epidemiological expertise.

1.) Identify and inventory of school data collection systems with an emphasis on correlaries to risk and protective factors. 2.) Development or broad availability of a short mental health screening/SBIRT or other screener (Reclaiming Futures/Teen Intervene). 3) Changes to design of Student Health Survey and SEEDS. 4.) workforce development need with respect to education and screening.

HOW - See K-12 Objective 1

HOW - See K-12 Objective 1

Yes - the OPC exists and provides a foundation for this work - but additional funding would be helpful in increasing capacity of staff through hiring someone (either FTE or graduate employee) or training/professional development in data collection. Additional infrastructure could be a study or scan of staff competency/training and development needs, transition planning, policy infrastructure. A well funded coalition could create a best practice standard for campuses (for alcohol) - could build that out - see competentcies in the first section.

See Higher Education Object 4

Some-yes but also dependent upon each campus. Infrastructure of Higher Education Object 4 could also support this goal.

see Higher Ed Objective 4

see Higher Ed Objective 4

As mentioned before, there are population assesssments and capacity studies that already exist. Would we be able to tap into that/build on those to better understand culturally responsive prevention programs? Is it something we will likely need to commission?

Oregon Department of Human Services collects a lot of case information that could be built upon with other studies of the system. Oregon Department of Human Services is also currently taking on two initiatives that might support the collection of additional information and support retention of data. 1.) Family First Prevention program which is a pre-case intervention program aimed at preventing family seperation/promoting maintenance of family unification - with a heavy a heavy emphasis on EBP for family SUD - these programs could be a vital source of information for enhancing understanding of this issue. 2.) ODHS is doing a systems mapping process on ODHS interaction with SUD continuum of care - this could provide information on data and assessment systems.

Yes - see Process Objective 2. The study (potentially continuous) could also yield answers to the following: What recources (nationally, regionally, locally) are already available? Would an Oregon Hub be duplicative? What would be unique about an Oregon Prevention hub? What are the various discipine and funding siloes (Public health, SUD, other BH, Developmental disability, Education, juvenile justice, suicide, violence, domestic violence, gun violence)? How could a hub break down or help leverage these siloes to really accomplish comprehensive goals? What are the specific practices across various disciplines that we can learn from or incorporate. theathenaforum.org nhcenterforexcellence.org

aditional SHS questions related to perceptions of and how they access cannabis and alcohol (CO has done this); regional data essential (example of community access to cannabis in So OR).

Additional evaluaiton and study of ReThink the Drink

Combo of Objective 16 and 18

Is this something we can bring to the legislature, or should it be included in the “infrastructure” bucket of the C
To determine whether defining primary prevention should be brought to the legislature or included in the infrastructure bucket of the Comprehensive Plan (CP), Oregon must evaluate existing and proposed legislation for 2025. House Bill 3321 provides a foundation by addressing primary prevention within the context of substance use and establishing a statewide strategy, but its scope is limited to this specific area. To decide the best path forward, Oregon should review other proposed legislation to identify whether gaps exist in addressing broader prevention infrastructure. If current or proposed bills, including HB 3321, sufficiently cover primary prevention needs, further legislation may not be necessary, and efforts can focus on supporting their implementation. However, if gaps remain—such as addressing prevention infrastructure beyond substance use or coordinating cross-sector efforts—this broader work may be more effectively included in the CP. By assessing legislative efforts and existing gaps, Oregon can determine whether the legislature or the CP is the better vehicle for advancing comprehensive prevention goals.

We are not creating something new - potentially using tools that are already in statute and developing out infrastructure to support it. OAR 581-022-2045 requires annually updated substance use prevention and intervention plan. Legislation passed last year requiring annual lesson plans on synthetic opioids and overdose and requiring schools to participate in SEEDs and SHS. Other laws dictate data that schools are required to collect. Potential legislative ask around funding. **Important to note that both on plans and assessment - compliance vs competence - schools often do the bare minimum due to lack of resources, time, or expertise.**

HOW - See K-12 Objective 1

HOW - See K-12 Objective 1

Legislature for financing, but we could also provide infrastructure support in scanning and developing health surve

See Higher Education Object 4

Could be either

see Higher Ed Objective 4

see Higher Ed Objective 4

This likely needs to be a part of the infrastracture. Putting a clause regarding cultural competency into a statute really does little to nothing for the broader scheme of things. The system needs to be built on cultural competency.

This could be brought to the legislature as an addendum to the Foster Children's Bill of Rights - a right to a future free of substance use disorder - as an idea. The Foster Care Bill of rights covers a lot of rights about the case itself but not necessarily trauma and subsequent substance use that might occur as the a result of the case or a result of the interaction with the system. Could be an opportunity to provide clarity in the duty of systems to assess and support these pieces.

Potential legislative guidance to engage folks in collaborative work; Potential funding for a feasibility study and/or to build the hub. Prompting work with the counties, CLHO, AOCMHP, OJDDA, Early Ed/K-12/Higher Ed.

Could be either - but likely infrastructure ask - using resources allocated to these types of campaigns and ensuring other interventions include a campaigns component.

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Could be either - but likely infrastructure ask - using resources allocated to these types of campaigns and ensuring other interventions include a campaigns component.

Are we creating new data sources, or just bolstering the data sources we currently have to be better and more accurate?
Oregon should prioritize bolstering existing data sources to make them more accurate, comprehensive, and relevant. Current tools like the Student Health Survey and Behavioral Risk Factor Surveillance System (BRFSS) already provide valuable insights, but they could be enhanced by including additional metrics that address protective factors, environmental influences, and upstream prevention outcomes. Fragmented local data collected by coalitions, schools, and organizations should be integrated into a centralized system to improve coordination and analysis. However, if current data sources cannot adequately address gaps—such as metrics related to community prevention readiness, protective factors, and root causes of substance use or other public health challenges—Oregon may need to create new data tools to complement existing ones. By assessing the capabilities and limitations of current data sources, the state can determine whether enhancements are sufficient or if new tools are necessary to fully support the objective of defining primary prevention. The PTTCs and HIDTA are well-suited as primary partners due to their extensive experience in providing technical assistance for prevention-related data systems. They can assist in evaluating current data collection tools, identifying gaps, and recommending strategies to enhance or integrate existing data sources. Additionally, CADCA and SEOW can provide targeted support by offering expertise in coalition alignment, epidemiological analysis, and standardizing data collection efforts across local, regional, and state levels.

Both: Our group believes that we might not be currently collecting data in a way that youth are willing to engage with the data collection mechanism. Anecdote that SEED survey might not be accurately capturing what is happenign in a youth's life and on campus. How can we gain more knoweldge with less questions? Do schools have the staffing capacity to support both surveys and screeners? Finally, districts have to buy into existing mechanisms. So we need infrastructure to support data collection (capacity/funds) and changes to existing data collection methods. Decentralized tools like this may help to support this: https://lookerstudio.google.com/reporting/efd38262-9cb2-4193-8dbf-ba86c80289ea/page/p_2q6byihd0c

HOW - See K-12 Objective 1

HOW - See K-12 Objective 1

Both

Both

Both - bolstering existing questions (Missouri, et al) and partnerships to design new sur

see Higher Ed Objective 4

see Higher Ed Objective 4

We likely need to do both. There is research broken down into demographics, but we also need to have sufficient research to create "evidence-based" processes that are normed with cultural competency - likely a different process for each group.

We can bolster the data sources we already have. The trends are pretty clear.

Study to inform the HUB and the HUB's collection of information might be a combination of new data sources (study) and resources to have better and more accurate data. See some of the commentary for Process Objective #1.

Bolstering

Bolstering

Bolstering

Are sub-populations with BH inequities that are identified that t
The assumed goal of **establishing a cohesive, evidence-based prevention infrastructure in Oregon that reduces the onset of behavioral health issues, addresses inequities, and promotes public health through consistent and targeted primary prevention strategies** serves as the foundation for defining this objective. Sub-populations with behavioral health inequities that this goal addresses include racial and ethnic minorities, rural populations, youth from low-income families, LGBTQ+ youth, American Indian and Alaska Native communities, immigrant and refugee populations, and youth in foster care or justice systems. By defining primary prevention, Oregon can create strategies that target the unique risks and barriers faced by these groups, promoting equitable access to prevention resources, building protective factors, and reducing behavioral health disparities.

Schools don't have the anayltics capacity to disaggregate data and at a district level SEEDs and SHS don’t really do a great job of supporting analysis of inequities between groups of students. We do know there are disproportionate impacts of attendance and disciplinary actions.

HOW - See K-12 Objective 1

HOW - See K-12 Objective 1

Not currently do to lack of data infrastructure - but careful design of program could support connection to student afirmation groups, culturally specific orgs serving college students to support more responsive programming.

Black and African American Oregonians are more than twice as likely to die from an overdose than all races and ethnicities. Oregonians who are American Indian and Alaska Native are more than three times as likely. However, we do not have that data teased out by college attendance/college attendance - would need more analysis and community engagement to support understanding of inequities in higher ed.

See Higher Ed Objective 4

see Higher Ed Objective 4

see Higher Ed Objective 4

Yes - see previous commentary.

There are sub-populations withing foster kids including communities of color and LGBTQIA+ individuals who are subjected to higher rates of trauma while in foster care due to the lack of culturally competent foster homes. This compounds their already traumatic upbringing, risk factors for futures SUD.

Assessment for the design and practice of the HUB would need to reflect specific needs, practices, values, and resources for communities of color, tribal communities, LGBTQIA2s+, and various geographies (rural/urban).

Evaluation and population assessment (BRFSS/SHS) need greater granulariy, context, and engagement with communities of color and others to understand the effectiveness of public awareness campaigns.

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Evaluation and population assessment (BRFSS/SHS) need greater granulariy, context, and engagement with communities of color and others to understand the effectiveness of public awareness campaigns.

Are there data gaps with respect to sub-populations facing other
There are data gaps with respect to sub-populations facing substance use-related behavioral health inequities, even if HB 3321 defines primary prevention within this scope. These gaps include insufficient data on protective and risk factors for racial and ethnic minorities, rural communities, LGBTQ+ youth, and American Indian and Alaska Native populations, especially as they relate to the onset of substance use. Additionally, fragmented local data collection makes it difficult to assess specific community needs or track disparities in access to prevention resources. If HB 3321 passes, the state should prioritize addressing these data gaps through comprehensive gap analyses and the integration of existing and new data sources into a centralized system. This would ensure that prevention efforts are equitable, evidence-based, and responsive to the needs of diverse sub-populations. There are significant data gaps with respect to sub-populations facing behavioral health inequities, particularly when primary prevention is considered beyond substance use. These gaps include limited data on mental health and trauma in marginalized groups, intersectional risks (e.g., rural LGBTQ+ youth), and the effects of structural inequities such as poverty, systemic racism, and housing instability on behavioral health. Without comprehensive and inclusive data, it is difficult to create targeted prevention strategies that address the root causes of inequities. To address these gaps, Oregon would need to enhance existing data sources, integrate local data into a centralized system, and ensure that data collection includes a

See answer to G.

HOW - See K-12 Objective 1

HOW - See K-12 Objective 1

Yes

Yes

Yes

see Higher Ed Objective 4

see Higher Ed Objective 4

Yes - there are likely data gaps. Historically, race is one of many demographic types that data has been broken into, along with gender, age, etc., but to actually have culturally competent/informed/driven data collection, study/analysis is not something that we have most of the time.

Yes = there are likely data gaps. More understanding is needed of ODHS systems and the additional work ODHS is doing this year.

Yes - particularly in workforce needs, culturally specific evidence-based practices.

Yes

Yes

Yes

Is there community engagement or plans for communi
While community engagement for sub-populations with behavioral health inequities is important, Oregon has not yet conducted a comprehensive evaluation of its entire population in the context of primary prevention. Plans for community engagement should prioritize establishing a clear and actionable definition of primary prevention to address the fragmented infrastructure and lack of clarity that currently hinder statewide efforts. At this stage, focusing too narrowly on sub-populations without first addressing the broader systemic issues could divert attention from the larger objective of organizing resources and infrastructure. Once a cohesive framework is in place, community engagement efforts can more effectively target sub-populations identified in the data or where data is lacking. This phased approach ensures that engagement is strategic, equitable, and aligned with Oregon's long-term prevention goals.

Not specific to substances use at a district or education service district level that we know of.

HOW - See K-12 Objective 1

HOW - See K-12 Objective 1

Not at a state level - unsure from campus to campus

Not at a state level - unsure from campus to campus

Not at a state level - unsure from campus to campus

see Higher Ed Objective 4

see Higher Ed Objective 4

Some community engagement by OHA on larger behavioral health systems - more engagement needed.

Yes - as part of ODHS system assessment.

OHA has done some community engagement on culturally specific primary prevention efforts and the funding streams from OSPTRB support openings for those convos in the future potentially? Think about this in terms of culturally specific outcomes but also applicable to other systems outcomes (attendance, crime prevention)- adapting EBP messaging to support other goals.

Maybe with respect to ReThink the Drink

Maybe with respect to ReThink the Drink

Maybe with respect to ReThink the Drink

Has there been a readiness assessment for this goal?
There does not appear to have been a formal readiness assessment conducted for the goal of creating a clear definition of primary prevention in Oregon. A readiness assessment is critical for evaluating the state's capacity to implement and sustain this objective effectively. This process would assess stakeholder understanding of primary prevention, the existing infrastructure's ability to support data collection and resource alignment, and the willingness of key sectors to collaborate. Key components of a readiness assessment could include evaluating stakeholder engagement, infrastructure and resource capacity, policy and organizational support, data systems and gaps, and community engagement, particularly with sub-populations facing behavioral health inequities. Tools like the Community Readiness Model (CRM), CADCA's Coalition Capacity Checklist, a customized Prevention Readiness Index, or SAMHSA's Strategic Prevention Framework assessment tools can provide structured approaches to this process. Conducting a readiness assessment would offer valuable insights into gaps, strengths, and opportunities, ensuring the efforts to define primary prevention are informed by the state's current capacity and preparedness. This process would also help prioritize capacity-building and resource allocation, laying the groundwork for successful implementation of this goal.

No
HOW - See K-12 Objective 1
HOW - See K-12 Objective 1
Yes
Yes

Yes
see Higher Ed Objective 4
see Higher Ed Objective 4
Unknown

Unknown
Not yet: A feasibility study would be useful. Preparatory planning for a feasibility study was started in a grant proposal last spring (Julie Dodge has info)

Maybe with respect to ReThink the Drink

Maybe with respect to ReThink the Drink

Maybe with respect to ReThink the Drink