Executive Summary

Note: this will be written last, after the main report is finalized. Will be included in the report and also as a stand along document.

Introduction

In 2025, the Oregon Legislature passed House Bill 3321, directing the Oregon Alcohol and Drug Policy Commission (ADPC) to conduct a strategic financial and programmatic review of primary substance use prevention in Oregon.[1] 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 in the access, availability, and financing of 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 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:

- 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 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

touch 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 onset of substance use.

Risk factors are conditions, characteristics, or experiences that increase the probability that a person will use substances or develop a substance use disorder. Protective factors are conditions that decrease that 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 — and their influence shifts with developmental stage. Table 1 provides an overview of the risk and protective factors.

Table 1: Risk and Protective Factors in Substance Use Prevention

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
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; 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 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.

Comprehensive primary substance use prevention often includes 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 building health and resiliency, fostering substance-free environments while reducing toxic stress and other challenges that can contribute to substance use.

However, none of these examples are activities that are 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 is sufficiently focused primary substance use prevention efforts underway in their communities.

Legislative and Policy Context

With this context 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)

House Bill 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.[1]

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."[1] Further, the legislation includes the classification framework created by the National Academy of Medicine (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.[2]

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.[3] 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%).[3]

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%.[3] 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.[3]

Table 1. 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%

Source: SAMHSA NSDUH model-based state prevalence tables, 2023–2024 (ref. 3); 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.

Youth carry the highest risk, and use is declining

Young adults aged 18–25 carry Oregon's heaviest use burden. 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%. Among adolescents aged 12–17, roughly 10.2% met SUD criteria, above the national 8.1%.[3] Alcohol remains the substance Oregon youth use most, though cannabis, legal for adults in Oregon, is a significant and growing concern. Self-reported youth use, however, is falling. 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 in both grade levels, extending a longer drift down from the pre-pandemic peak, when 11th-grade cannabis use sat near 20% in 2019.[4,5] 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.[22]

Table 2. 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%**	▼

Source: OHA Student Health Survey state data tables, 2022 and 2024. 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.[6] 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.[7] 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, a clear opening for intervention.[22]

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%. Among 12–17-year-olds both rates sit below 0.3% and near national levels, so the stimulant gap opens after adolescence rather than during it.[3]

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.[8] 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.[9]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.

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 3 sets out the mortality, acute-care, and public-cost side of that toll. The human cost appears earlier, in the systems that serve children and young people. Substance use disorder is close to universal among justice-involved youth: Oregon Youth Authority 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..[10] Among adults, 63% of the roughly 12,300 people in Oregon Department of Corrections custody in 2025 had a substance use issue.[22] Oregon also recriminalized some drug possession in September 2024, after which statewide drug arrests rose about 20% the following year.[22] 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.[11,16] 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.[17]

Table 3. The cost of inaction: 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 (ref. 12); Centers for Disease Control and Prevention / National Center for Health Statistics (CDC/NCHS) overdose mortality (ref. 13); Trust for America's Health (ref. 14); OHA/ECONorthwest Alcohol Harms interim report (ref. 15); 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.[12,13] Fentanyl was involved in roughly 71% of 2023 deaths.[7] 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.[12]

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

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.[3] 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.[4] 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 rate.

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.[18,19] However, compared to the return on investment for treatment, investment in primary prevention demonstrated far larger economic return, as Table 4 sets out.

Table 4. Return on investment for prevention and treatment (benefit per $1 invested)

Program / approach	Return per $1 invested
Good Behavior Game (school-based)	~$63
Communities That Care (community prevention)	~$12.88
Nurse–Family Partnership (early childhood)	~$2.88
SUD treatment (justice-cost savings)	$4 to $7
SUD treatment (incl. health & productivity)	up to ~$12
Comprehensive tobacco prevention	>$5

Sources: Oregon ADPC / Washington State Institute for Public Policy benefit–cost findings; National Institute on Drug Abuse.

The ADPC's 2023–25 substance use disorder financial assessment found that of roughly $1.5 billion in SUD spending across eleven state agencies, $25.5 million, or 1.70%, went to primary prevention, while treatment accounted for 73% of the total.[21] 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.[20] The Financial Analysis that follows examines these figures in detail.

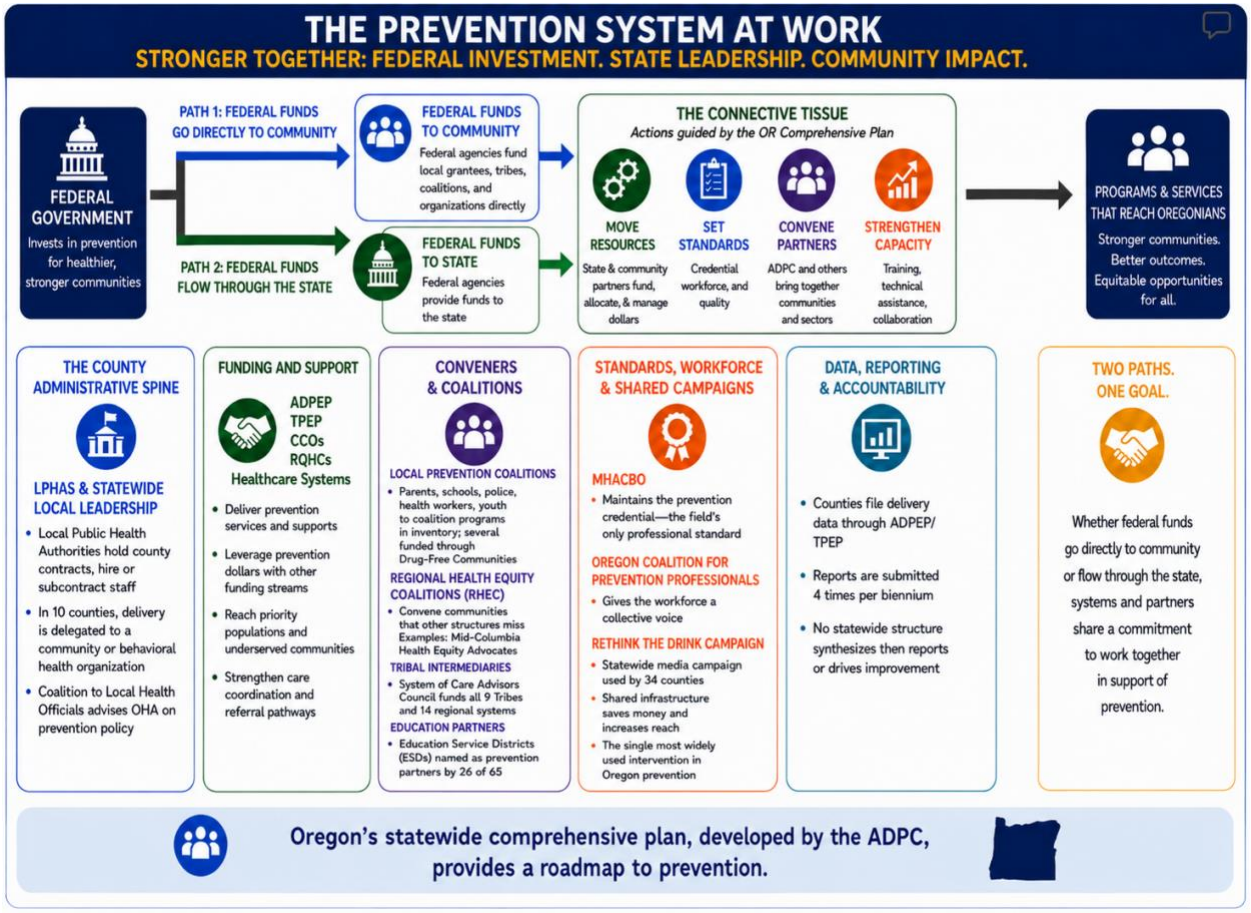
Prevention Infrastructure in Oregon

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 people receive.

While community-based organizations do receive direct funding from federal and state agencies to delivery 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 xx 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.



As the figure represents, there are several Infrastructure elements that serve to as a potential bridge between community programming, cross-sector engagement and planning, financing, contracting and reporting. Three represents 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 (ADPEP) exist in every county in Oregon, with the goal of preventing alcohol, tobacco and other drug use and associated efforts 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, County Behavioral Health, or in some instances are operating via contracts with community-based organizations to serve the function.

Tobacco Prevention and Education Programs (TPEP) provide similar efforts that are tobacco focused, leveraging Tobacco Prevention and Control Funding. They share operating infrastructure with ADPEPs, but more often existing 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 delivery primary substance use prevention programs in Oregon.

Beyond these elements of infrastructure, primary prevention services are delivered and supported in a number of community settings, including schools, community base organizations, 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 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 included alignment with the 6 CSAP Strategies articulated earlier in the report to validate program inclusion. In instances where an investment, system or activity were not entirely aligned with the statutory definition, those elements were further reviewed for alignment to generally understood best practices in substance use prevention. Some of these related activities were still listed to show the full prevention landscape, but they were labeled as prevention-adjacent rather than primary prevention, and were excluded from further analysis. Programs that might have a secondary benefit of preventing substance use but do not have such a result as a primary goal, services that are geared towards those already exhibiting a clinical substance use disorder, or those which might serve a broad public health or wellbeing purpose not directly tied to the prevention of substance use, were excluded from the report. Examples of

excluded programs and strategies include harm reduction and related safety efforts, overdose prevention, 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 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 programs are often administratively and fiscally disconnected from other primary prevention efforts, and focus specifically on tobacco rather than all substances of concern. 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 (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 also report receiving resources from the fund to delivery gambling prevention programming. As states increasingly loosen restrictions on gambling, including through online sports betting and other means, there is an increasing trend towards leveraging substance use prevention infrastructure to include prevention of problem gambling, particularly in adolescent and college-aged youth. However, like tobacco, fund 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 analysis of gambling prevention to providers who reported such services existing as part of a comprehensive substance use prevention strategy.

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

- Programs: what is offered, who provides it, who it serves, where it operates, and whether the provider described it as evidence based.

- **Funding:** how prevention dollars move through federal, state, regional, county, and local systems, and whether the spending supports primary prevention.
- **Workforce:** who carries out prevention work, where workers are located, what credentials they hold, and what training and support they need.
- **Innovative practices:** 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 school districts; prevention providers and 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 3 local coalitions (See Appendix xx 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 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 models presented, researchers with deep experience in substance use prevention reviewed provider responses to validate efficacy claims against known, nationally recognized programs and practices and best practice standards.

For the financial analysis, Third Horizon conducted a top-down review of federal and state funding sources, state agency administrative process, 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 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-PHD 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, 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) were identified to fall under 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.

Every program in the inventory was matched by its reported name against a catalog of branded prevention curricula and named prevention strategies. Programs that did not name a model 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 curriculum or formal model. Accordingly, counts of named evidence-based models should be treated as minimum counts, not as proof that no additional organizations use those approaches. County delivery records confirm that some named models are more widely used than survey responses alone indicate.

Of 96 state funding lines, 47 supported direct program delivery and are counted. The other reflected financing, administration, staffing, or duplicate programs are reported 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 14 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 37 are counted.

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 6 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 XX lists every practice with its reporting organization and source, and the technical appendix describes the sorting process.

Finally – Third Horizon cross referenced fiscal, programmatic and outcomes data to understand the extent to which financing, programming, and geographic/population focus sits relative to the

consequence 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, and exclusion and inclusion criteria can be found in the details technical methods section (Appendix xx).

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 was 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 review of the findings.

- 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 preventions 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 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 fiscal 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.
- County program counts may overstate local coverage because every program was linked to all counties served by its organization.
- Federal rules suppress overdose death rates for nine small counties, so those counties could not be included in some comparisons of need and funding.
- 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.

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. Where programs were identified that don't directly align with HB3321, Third Horizon uses the term "prevention-adjacent", and were only included in this report when those practices met other established criteria that constituted direct benefit in the prevention of use by the population.

The statewide prevention landscape

House Bill 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

In this inventory the analysis showed several programs and branded models.

A program is one prevention activity that an organization delivers to people. Each program is counted once, even if it is delivered in many places. 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.

A model is a recognized, named approach, like a branded curriculum, a named campaign, or a named state program. A model is also counted once, no matter how many organizations report using it.

Every model is also a program, but most programs are not models. Most are local activities that organizations described in their own words, such as a mentoring group, a parent night, a community education series, without naming a set curriculum. Of the 268 programs, 29 use the name of a recognized model. The two numbers answer two different questions. The 268 explains how much prevention work is happening. The 29 explains how much of the programming uses a recognized, named approach.

Several organizations reported the same brand-named curriculum separately. The inventory removes this duplication: where the same curriculum was reported at several sites, it appears as one program with every site recorded. For example, Sources of Strength, reported by seven organizations, is one model at seven sites, not seven different models.

Figure xx illustrates that through surveys, provider organizations named 215 programs, schools name 14, college campuses name 21, and state agency records show 18 programs. Schools name all 14 of their programs as models, because districts were only counted when they named a specific program. Provider programs were counted either way, so most of them carry no model name.

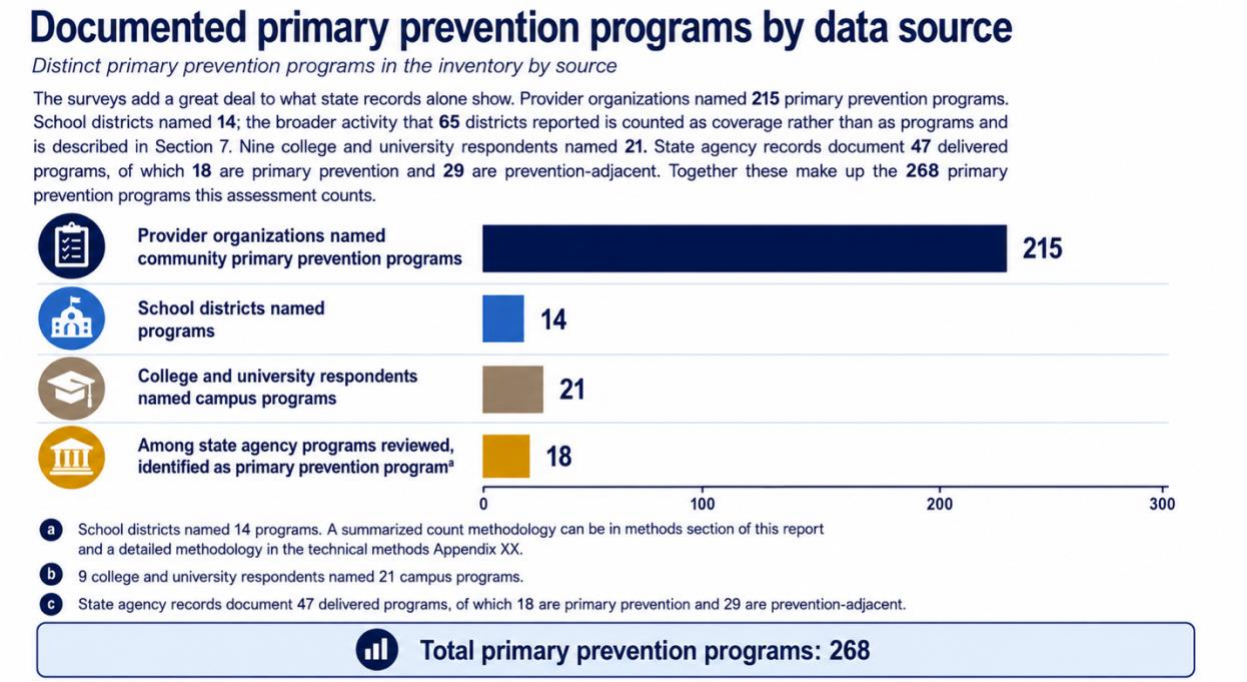


Figure xx. Documented prevention programs by data source. *Each source is counted separately and uses its own unit (programs, districts, campuses. Source: HB 3321 Provider, School District, and Intercollegiate surveys; state agency records (2023–25).*

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 state government, however, the largest funder of community base primary prevention is the Oregon Health Authority.

The Alcohol and Drug Prevention Education Program (ADPEP) is the one primary prevention structure that touches every Oregon county, through contracts administered by OHA and their Public Health Division. The profile below is informed by documents sourced from state agencies and provider input collected by Third Horizon during this analysis.

What it is. 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. In 26 counties, the local public health authority runs the program itself. In ten counties, a community or behavioral health organization delivers the county's contract instead. These are New Directions NW (Baker), ADAPT (Douglas), Symmetry Care (Harney), Best Care (Jefferson), KBBH (Klamath), Lifeways (Malheur), Community Counseling Services (Morrow), Tillamook Family Services (Tillamook), Building Healthy Families (Wallowa), and YouthThink (Wasco).

What counties plan to do with it. OHA's own analysis of the 2023–25 county workplans identified 183 objectives statewide. In reviewing the OHA analysis, Third Horizon notes significant alignment between the identified objectives and the six CSAP strategies, validating that the ecosystem is properly engaged in primary prevention efforts. However, OHA analysis only cross referenced the objectives against the CSAP strategies after utilizing a in-house methodology of categorizing the objectives into "themes" that ultimately created inconsistency in the alignment of ADPEP work against the CSAP strategies. As an example of this, one ADPEP workplan reports significant focus on Upshift, and evidence based indicated prevention strategy of screening and referral – and yet, OHA's analysis did not identify any theme matching to Problem Identification and Referral (the sixth CSAP strategy), suggesting that the ADPEP ecosystem was not engaged in that strategy, when in fact it is.

The state sets one required priority. All ADPEP grantees must address excessive alcohol use. The program guidance gives the state's reason. Alcohol-related deaths in Oregon rose 47% from 2011 to 2022, to just over 3,000 deaths a year. The estimated cost to the state economy is $4.8 billion per year.

Quality guardrails. The guidance steers counties toward evidence-based programs and registries, requires data to inform local priorities, and clearly discourages one-time speakers and assemblies unless they are tied to a comprehensive plan.

What the activity reports show. Third Horizon analyzed the 135 reports. Counties devoted about 30% of ADPEP resources to prevention education, 26% to information dissemination, 20% to community-based processes, and 13% to drug-free alternatives. These shares stayed stable across all four reporting periods. This is evidence that ADPEP's required planning discipline shapes real delivery. The exception is environmental and policy work, which was delivered (6%) well below planned levels (14%).

Not all ADPEP funding is coded as clearly primary substance use prevention. ADPEP appears on five entries in the state agency records: one coded squarely primary prevention, one as including primary prevention alongside other work, and three as cross-continuum, spanning several stages of the prevention-to-treatment range. The delivered activity, however, is overwhelmingly universal. Counties reports indicate programs spanning universal at 85 percent, selective at 12 percent, and indicated at 3 percent. The funding labels are broader than what counties actually deliver.

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

- Local public health authorities and 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 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.

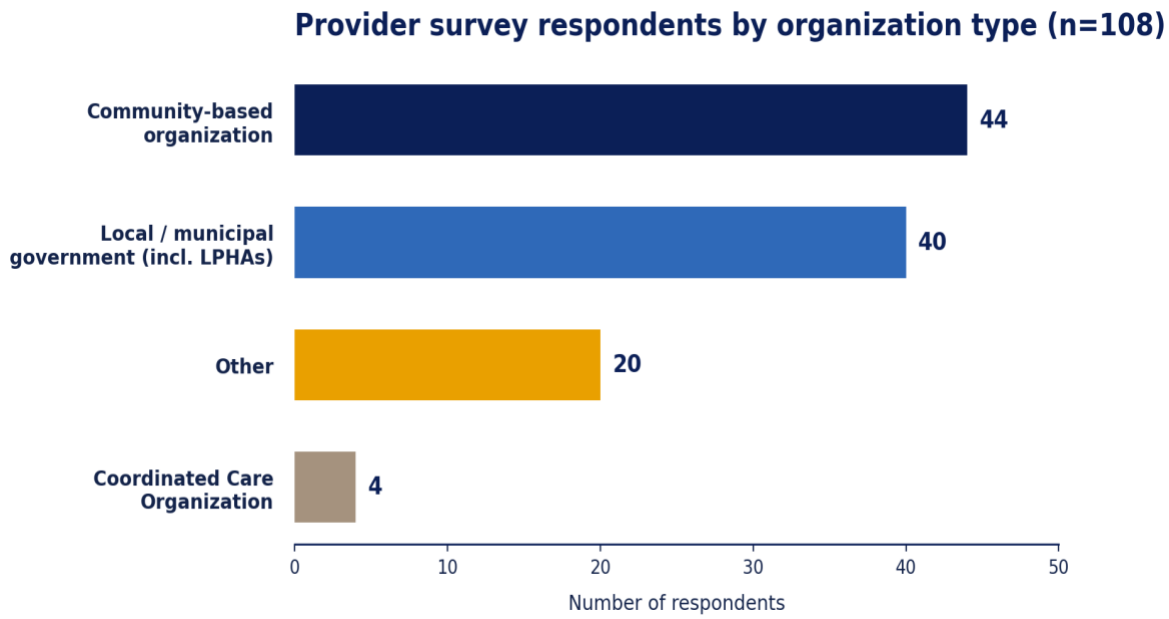


Figure xx. Provider survey respondents by organizations (n=108 of those who responded)

Note: Because twelve counties contract their ADPEP delivery to a community or behavioral health 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.

What kinds of prevention programs Oregon uses

How programs were matched to models and strategies

This section describes the kinds of prevention Oregon invests in: the recognized curricula and models 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 or prevention model. Conversely, many locally named programs may use similar strategies without identifying a formal branded model/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 models and strategies alongside a much larger amount of locally defined prevention activity. The inventory identified 29 distinct curricula and models.

The state's Rethink the Drink alcohol campaign is the most widely reported single intervention in the records reviewed, named in 63 county reports across 34 counties. 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 curricula such as, LifeSkills Training, QPR, Sources of Strength, Strengthening Families, Triple P, and Mental Health First Aid.

Named prevention models in the inventory

Models Identified in the Provider Survey

The following models represent the more formally established or researched prevention programs identified in the inventory. The evidence descriptions summarize the models' broader research records. Because respondents often described their work without naming a curriculum, all model counts here are minimums.

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.

Sources of Strength**.** A peer-leader evidence-based program for suicide prevention within schools, used in Oregon including with tribal partners. Trusted students, with adult mentors, spread messages of connection, help-seeking, and hope. Built as suicide prevention, it also protects against substance use.

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 models come from the school district and campus surveys, which were reviewed for named programs alongside the provider data. These are reported here because they are part of the same picture: recognized models in use in Oregon, each in a small number of places.

Models Identified in the School Survey

The school survey also identified SBIRT/Check Yourself, Sources of Strength, and LifeSkills Training as common models.

Teen Intervene is the most widely reported of these, named by five 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 models named anywhere in the inventory. Additionally, it is evidence-based as a gambling prevention strategy.

Other models named 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.

Models named 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 abuse 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.

ATLAS and 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.

Models Identified in the Intercollegiate Survey

Two further models come from the campus survey, both of which are established models 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.

BASICS: Brief Alcohol Screening and Intervention for College Students: 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.

Teen Intervene and Sources of Strength, the two most widely reported, appear at five and seven sites respectively in a state with 36 counties and 197 school districts.

Models 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 is a “control state”, and OLCC 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 their core functions contribute to primary prevention but reducing access and preventing sale to minors. With OLCC and other state agencies, Third Horizon reviewed through interviews and document review to capture these primary prevention services, their financing and the workforce that delivers them.

Here are the models identified through the state agency records:

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:
TMEC instructor training. CLEAR Alliance's substance use curriculum for use in Drivers' Education programs, with 179 trained instructors across 32 of Oregon's 36 counties

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 (DFC) 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.

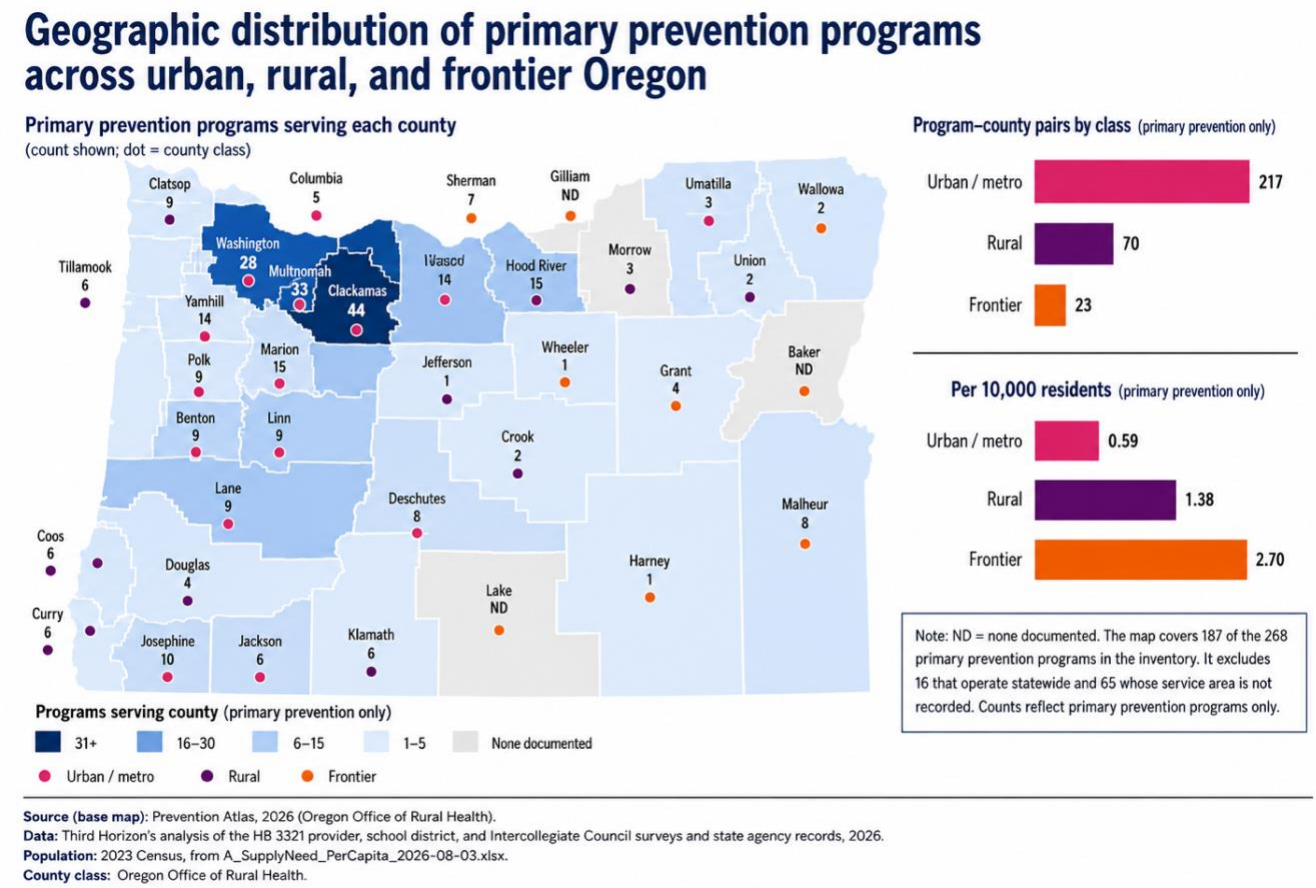
Where prevention is delivered

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 xx shows the geographic analysis where 15 counties are classified as urban or metropolitan, 12 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 side panels show the same data grouped by type of geography, both as raw counts and per 10,000 residents.



Note: provider survey based documented distinct prevention programs with a recorded county service area, counted once in each county served, so county counts and program–county connections exceed the number of unique programs. The map shows primary prevention programs only, consistent with the scope House Bill 3321 sets for this inventory. It covers 187 of the 268 primary prevention programs; 16 operate statewide and 65 have no service area recorded. Counties showing no programs are counties with none documented through these sources, not counties without prevention activity: Baker, Gilliam and Lake all receive prevention funding and file county activity reports

Programs serving more than one county are counted once in each county they report serving. County counts and program–county connections therefore exceed the number of unique programs. The map covers 187 of the 268 primary prevention programs. It excludes 16 that operate statewide and 81 whose service area is not recorded, including provider programs where the county question was left blank and campus programs recorded by institution rather than county. Because roughly a third of the inventory cannot be placed, the map should be read as showing where documented programs report serving, not as a complete picture of prevention activity.

In raw numbers, prevention activity concentrates where Oregon's population is largest. Urban and metropolitan counties account for 217 of the 310 mapped program–county relationships, just over two-thirds. Clackamas County alone has more documented programs serving it (44) than all nine frontier counties combined (23).

Per capita, however, the pattern reverses: frontier counties average 2.7 documented programs per 10,000 residents and rural counties 1.4, against 0.6 in urban counties. While frontier and rural communities have unique challenges around equitable access to services, this reverse pattern suggests that even in more urban and rural parts of Oregon, existing programs are unlikely to be able to capture and impact all of the individuals who could benefit from exposure to primary prevention services.

Prevention levels: who programs are designed to reach

Community programs by prevention level

Providers named 215 primary prevention programs, and not every program carries every classification: 167 report a prevention level and 147 report a CSAP strategy, with 140 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: 76 programs include selective or indicated work of any kind, while 60 operate at two or more levels. The difference is the 16 programs that work only at the selective or indicated level.

Among the 167 primary prevention programs that reported a prevention level:

- 91, or 54 percent, operate only at the universal level.
- 60, or 36 percent, span two or more prevention levels.
- 31 span all three levels.
- 74 include selective prevention.
- 43 include indicated prevention.
- Three are indicated-only programs.

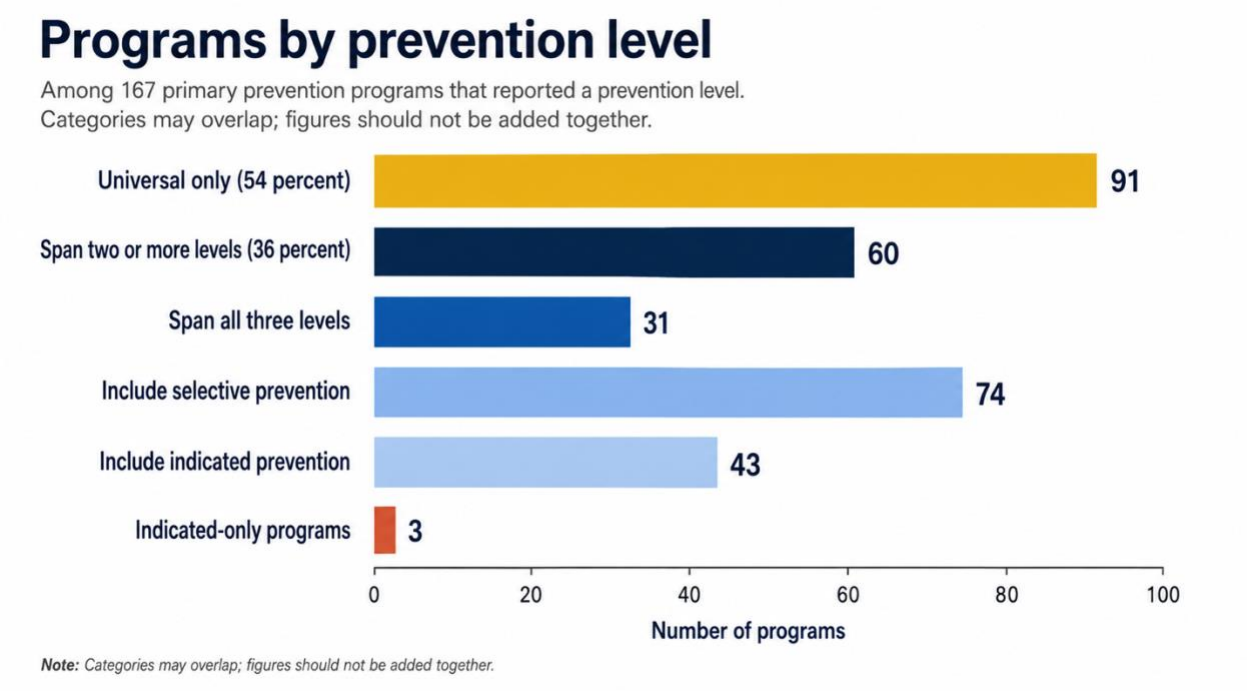


Figure xx Community programs by prevention level (provider survey; excludes programs that did not report a level).

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 exist 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. Fifty percent of local-government programs include selective or indicated work, compared with 39 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:

- 46 percent of county-level programs include selective or indicated work.
- 49 percent of programs serving a town or neighborhood include selective or indicated work.

- Too few programs report a statewide service area, five in the provider survey, to calculate a meaningful share for that category.

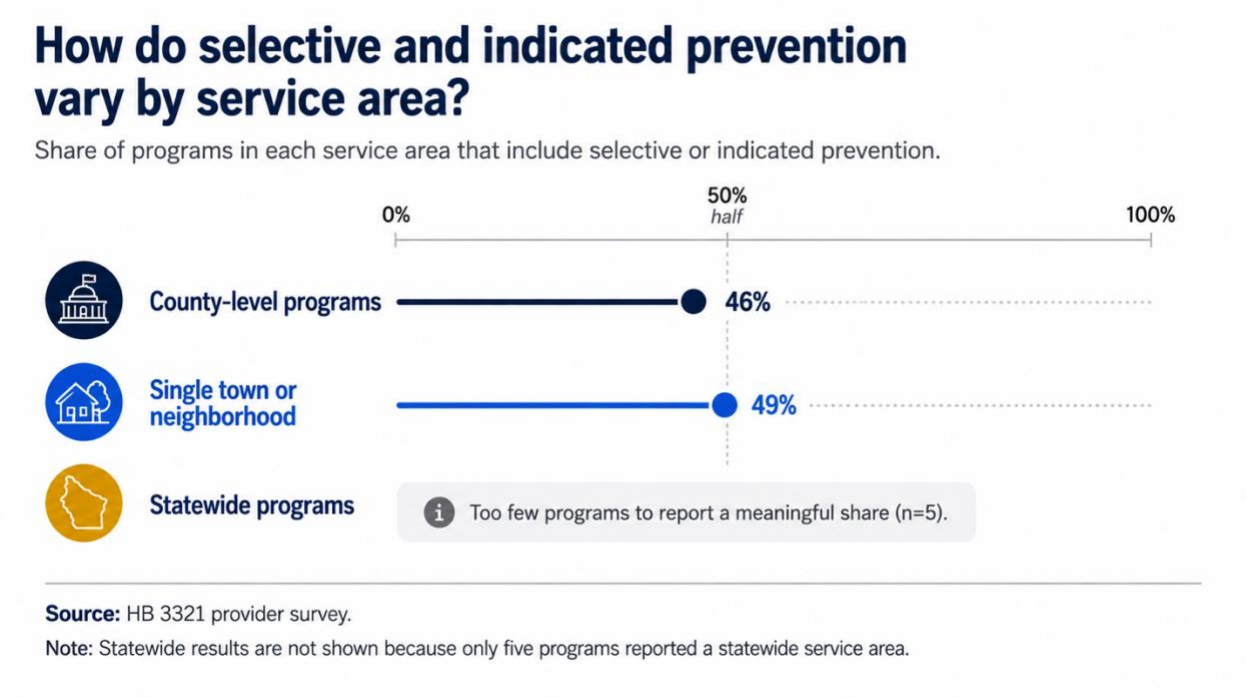


Figure xx. Share of programs that include selective or indicated work, by who runs them and by area served.

The survey reaches only the organizations that chose to answer; however, the agency data corroborate this finding as well. Across 722 activities that counties tagged in their mandatory ADPEP progress reports, 85% were universal, 12% selective, and 3% indicated, closely matching the surveys.

The differential in availability of universal versus selected and indicated strategies means that the people 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 xx provides an overview of reported primary prevention programs broken down by CSAP strategy, and is inclusive of programs that may deliver multiple strategies through a single program.

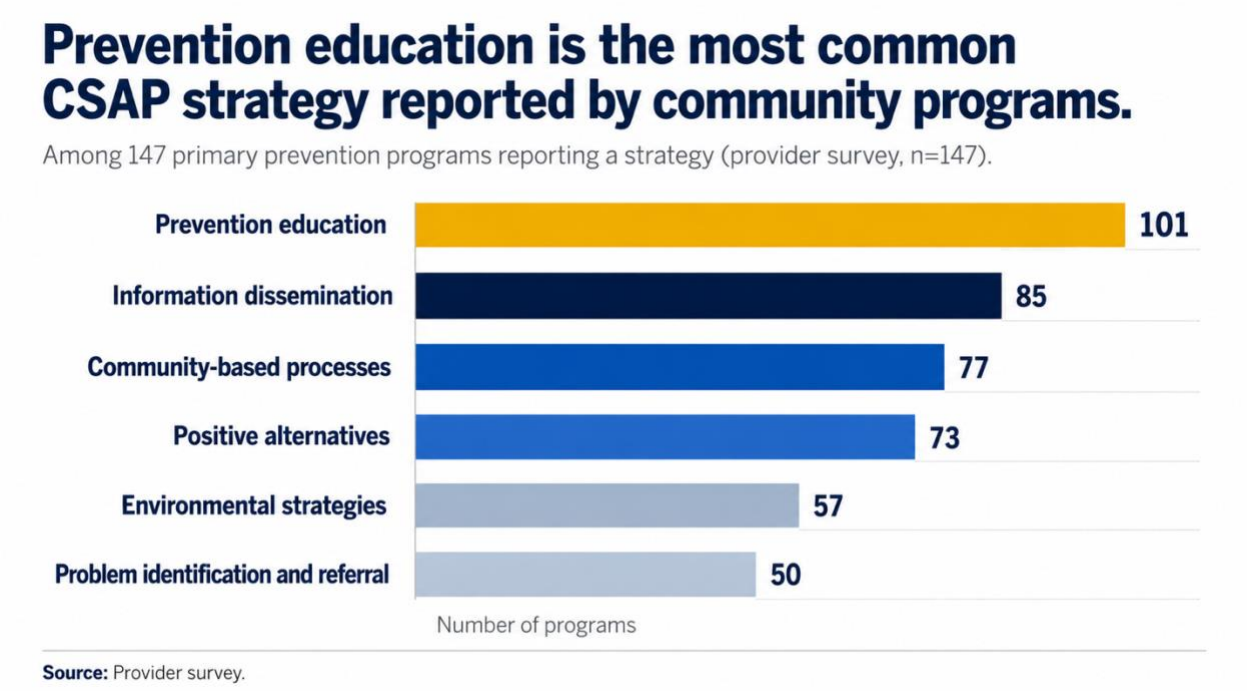


Figure xx. Community programs by CSAP strategy (provider survey, n=147).

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 many activities are embedded in the functionality of a school, most described their work by category rather than by program name. The named programs districts did report 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.

Oregon has required districts to plan for drug and alcohol prevention since 1989, but the requirement in its present form is new. In 2023, Senate Bill 238 required opioid prevention lessons in every district beginning with the 2024–25 school year and assigned the Oregon

Department of Education to oversee compliance with the rule. Districts were expected to update their plans to match, and the department published its planning template and example plan in August 2025. When this survey went out in spring 2026, districts had been working with those tools for less than a school year, and the results reflect that timeline.

Of the 65 districts that responded, 19 (29%) report a completed plan, 30 are developing one, 6 report no plan, and 10 are not sure (Figure 10). In all, 49 of the 65 responding districts (75%) have finished a plan or are actively building one.

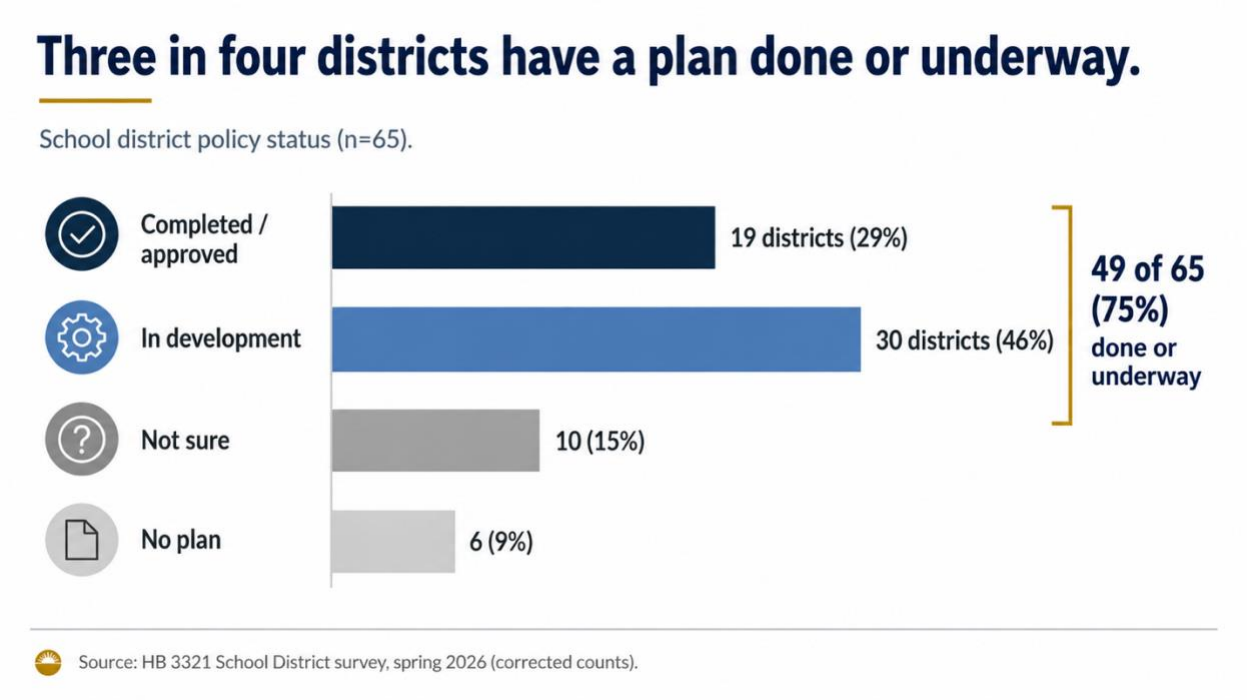
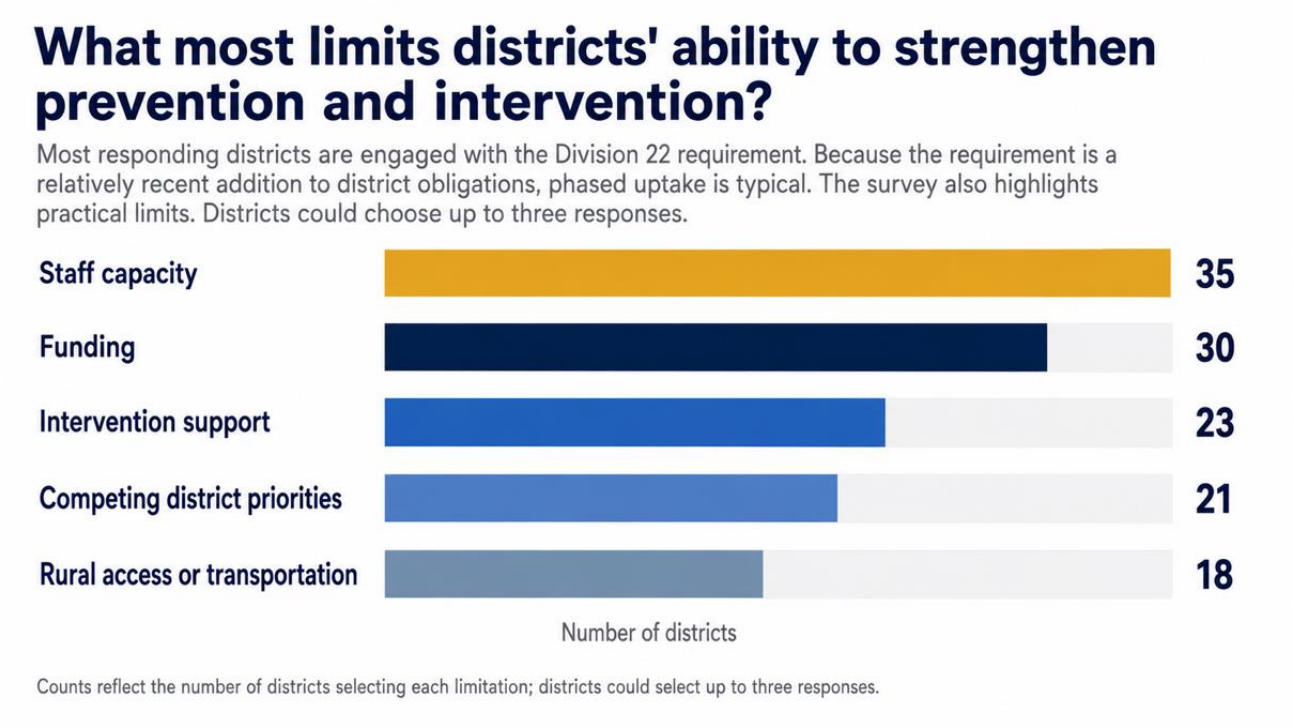


Figure xx School districts by Division 22 plan status (n=65)

Barriers to planning and implementation

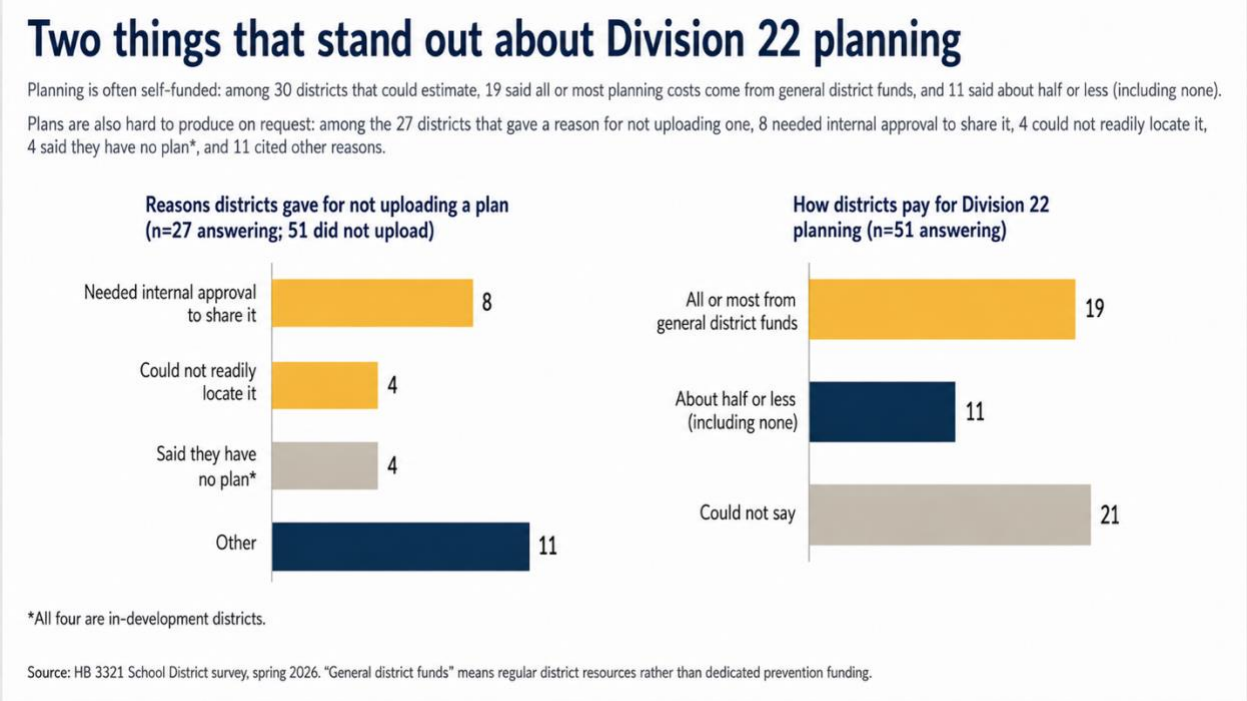
Most responding districts are engaged with the Division 22 requirement, and because the requirement is a comparatively recent addition to district obligations phased uptake is typical for new planning mandates. The survey also points to practical limits.

Figure xx illustrates how districts responded to what most limits their ability to strengthen substance use prevention and intervention (choosing up to three answers):



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. 19 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, ready access to the plan, or that did not have nothing in writing yet since their plan was in development. None of this signals non-compliance. It signals that a plan a district can approve, retrieve, and hand over 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.



- ~~Even the plans that exist are hard to produce when someone asks for them. Of the 16 districts that did not upload a plan, only 4 said they do not have one. The other 12 appear to have a plan but could not hand it over easily: 8 needed internal approval to share it, and 4 could not quickly find it.~~
- ~~Districts mostly pay for this work themselves. Of the 51 districts that answered, 30 were able to say how their planning is funded, and 20 of those pay for all or most of it out of regular district money rather than dedicated prevention funding. The other 21 could not say how it is paid for at all.~~

Who delivers school prevention

District staff deliver much of 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.

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.

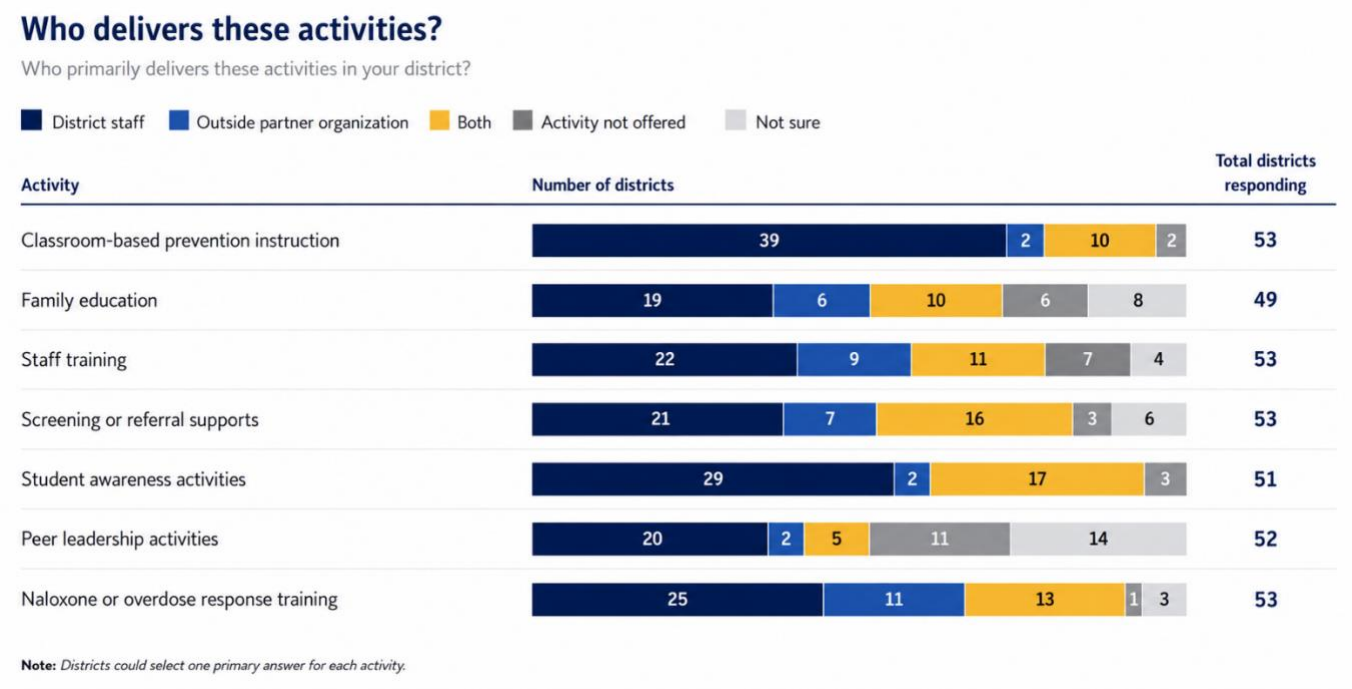


Figure xx. Who primarily delivers each prevention activity, as reported by school districts

School-community partnerships

School prevention depends on a broad local partner network, and prevention providers often will look to offering 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 and district staff, students, parents, and tribal partners when developing or updating prevention plans, although participation varies substantially by partner type.

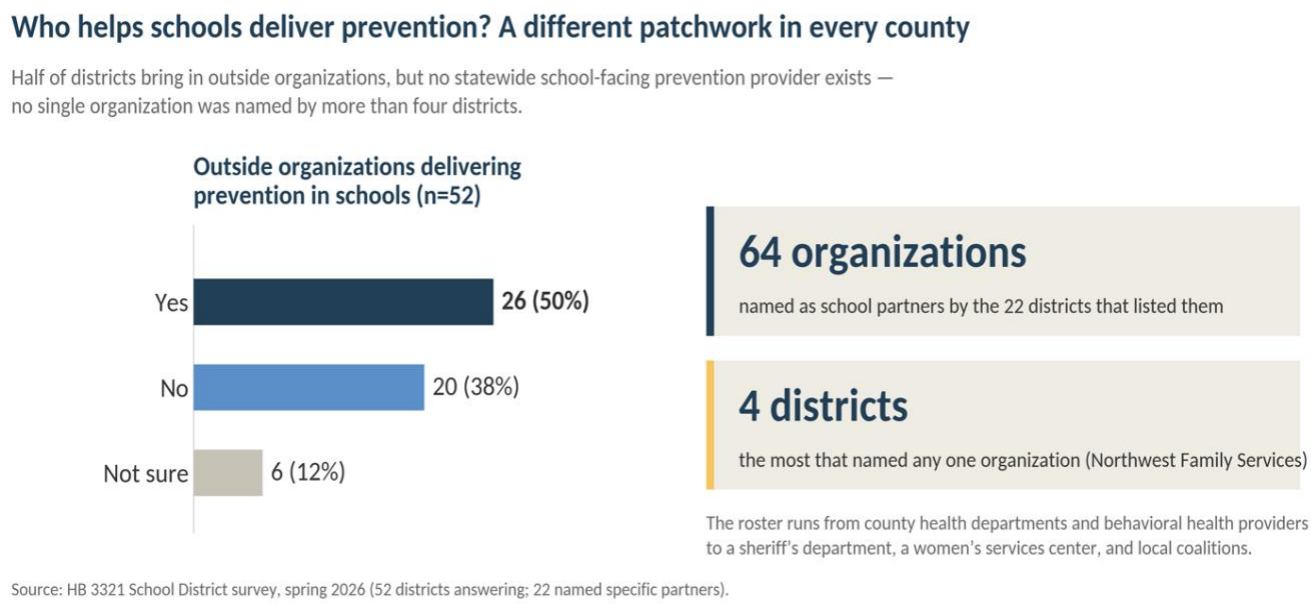


Figure xx who helps schools deliver prevention programming

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.

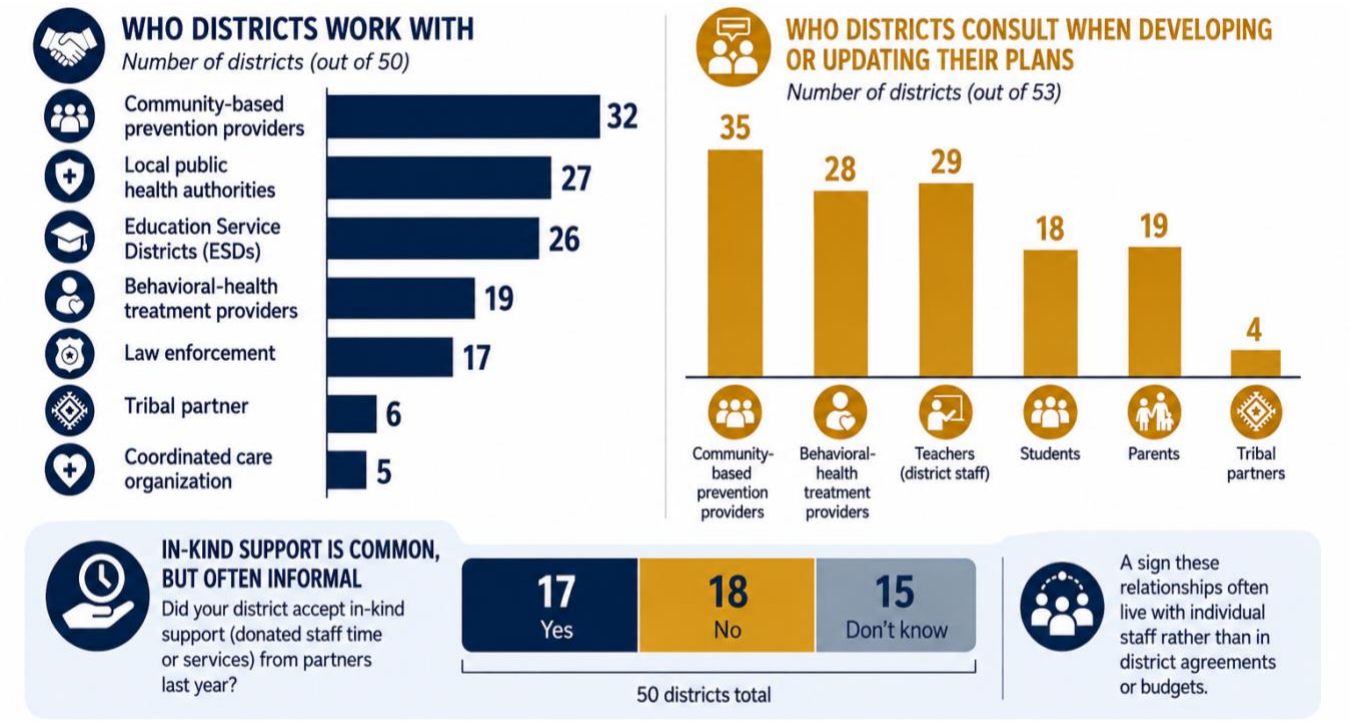


Figure xx illustrates how fifty districts described their local partnerships and networking landscape

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. Because the number of respondents is small, 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 models 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 and fraternity/sorority life, and underrepresented students.

Community and agency-based prevention: populations reached

Unless otherwise noted, the level, strategy and population analyses in this report describe the 268 primary prevention programs. The survey provider data identify 215 distinct primary prevention programs with self-reported information on levels, strategies, populations, and funding.

Figure xx illustrates how primary prevention programming as reported by providers reach by population type:

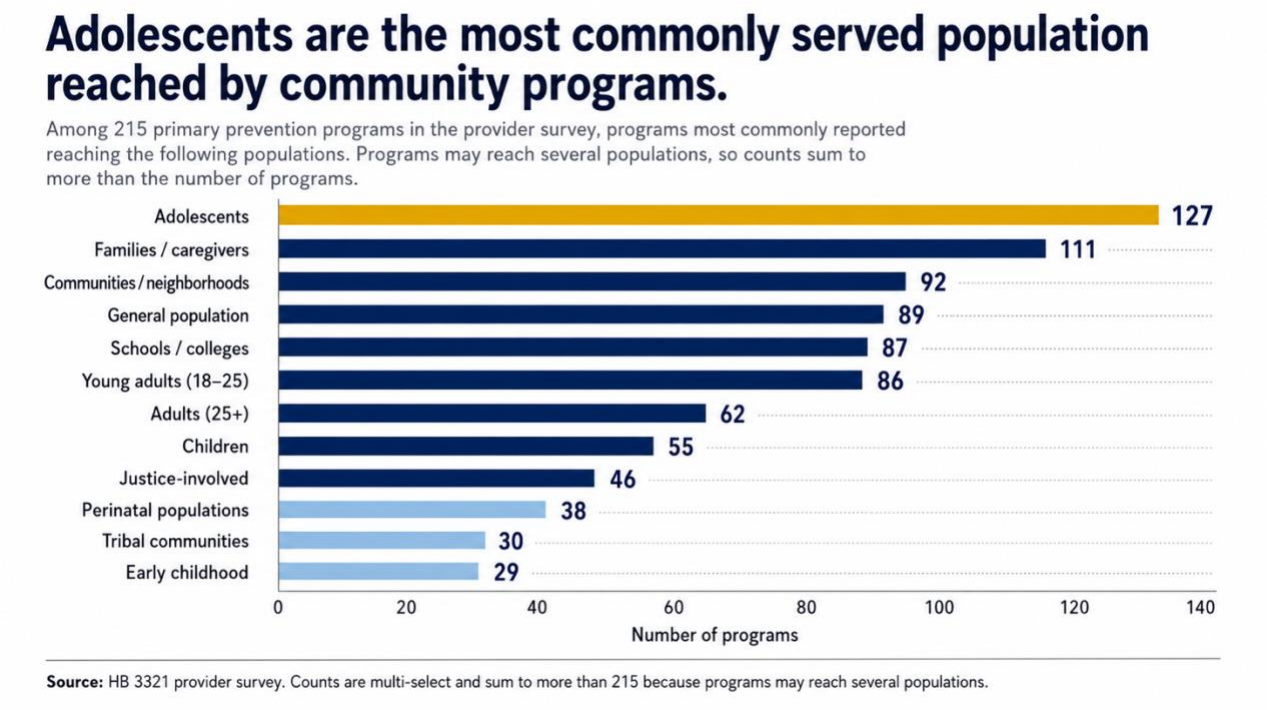


Figure xx. Populations reached by community programs (Programs can identify more than one population, so these counts are not mutually exclusive.

What state agency records add?

- Most state-funded prevention is written for all ages. Of the 42 entries that include primary prevention (16 squarely, 26 in part), and 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.
- County ADPEP workplans 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 child care subsidy, appear in agency records rather than in the provider survey. They are counted as prevention-adjacent and so fall outside the 268 primary prevention programs, but they represent the state's largest upstream investment in the conditions that shape later substance use.

- **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.

8.1 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.

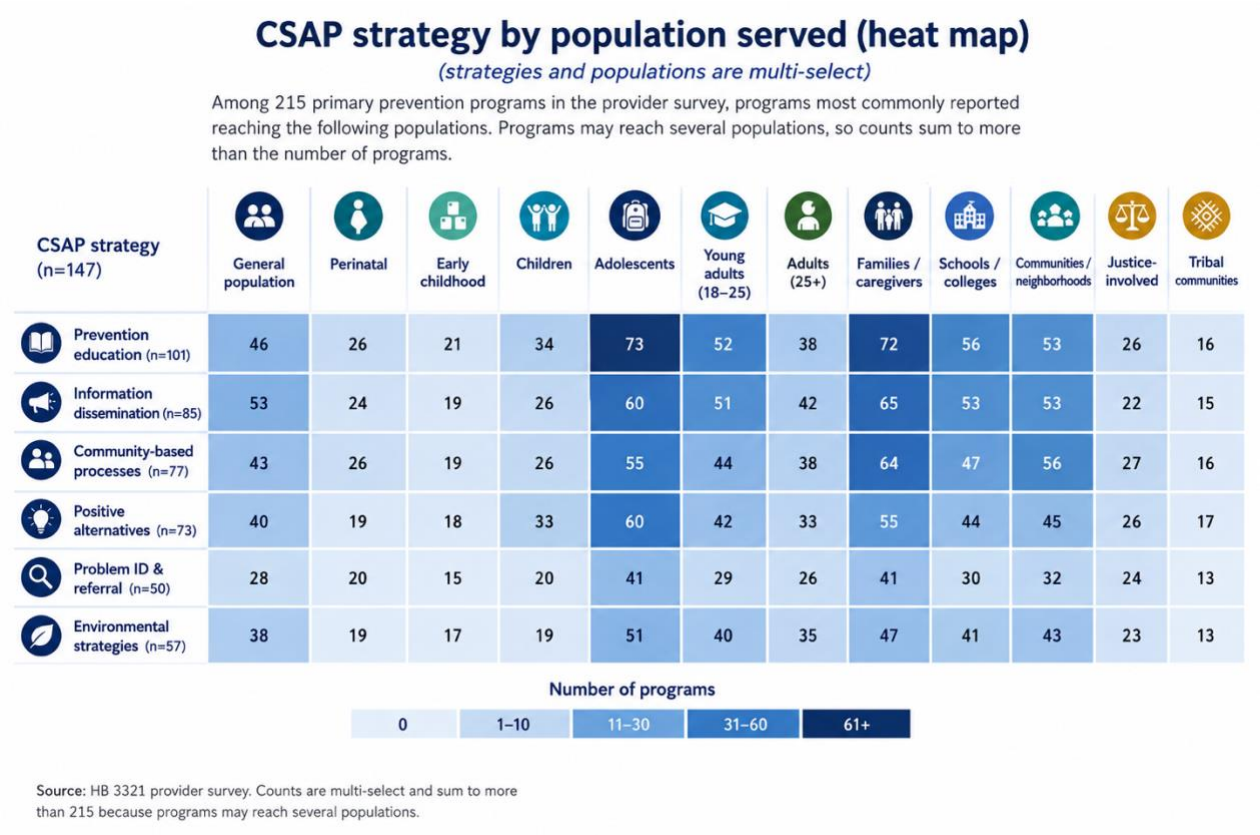


Figure xx. CSAP strategy by population served. Cell values are program counts (n=175 programs with a CSAP strategy; populations are multi-select).

Prevention education and community-based processes reach the widest range of populations. These strategies show comparatively high counts across most population groups, reinforcing their central role in the provider-reported prevention landscape.

The more intensive strategies attach to specific populations in telling ways:

• Adolescents are the most consistently served population across strategies. They appear most often in prevention education (73 programs), information dissemination (60), positive alternatives (60), and community-based processes (55).

• Families and communities also receive broad coverage. Community-based processes are particularly prominent for families (67 programs) and communities (65), while prevention education reaches 71 programs serving families.

•Perinatal, early childhood, and Tribal populations are reached by far fewer programs across every strategy. Tribal counts range from only 13 to 17 programs, although the provider survey should not be read as a complete account of Tribal prevention because agency records capture additional activity.

Culturally specific and tribal prevention

House Bill 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 district and Intercollegiate Council 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 the assessment applied, and no single definition of culturally responsive prevention was in use across the sources reviewed.

Respondents described three approaches to culturally responsive prevention. They differ in how far the culture of the receiving community shapes the program, and they place different demands on the organizations that deliver them.

Language access delivers an existing program in a community's language, with translated materials, and requires translation and interpretation capacity. Cultural adaptation revises the content, examples and delivery of an established model for a specific community, and requires both model expertise and time. Community-designed prevention is created and delivered by the community itself, and cultural practice is the prevention activity. It requires sustained funding to organizations rooted in the communities they serve. Exhibit XX gives examples of each as reported.

Exhibit XX. 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 model 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	Empoderando Familias, a family-centered prevention program for Latino and immigrant families, delivered by Clackamas County Children,

	practice is the prevention activity itself.	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, described in subsection 9.2.

Source: 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, 10 program entries reported by nine organizations describe work designed for, adapted for, or delivered in the language of a specific cultural community other than a Tribal community. Spanish-speaking and Latino families are the community named most often, followed by Slavic and Eastern European communities. Three organizations, Clackamas County Children, Family and Community Connections, Multnomah County Behavioral Health and Washington County Public Health, each reported Empoderando Familias, which the inventory counts once.

School districts report 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 survey worded it, 21 reported none, and 22 were unsure. Uncertainty on this scale is itself a finding: districts that cannot classify their own programming are unlikely to be planning it deliberately.

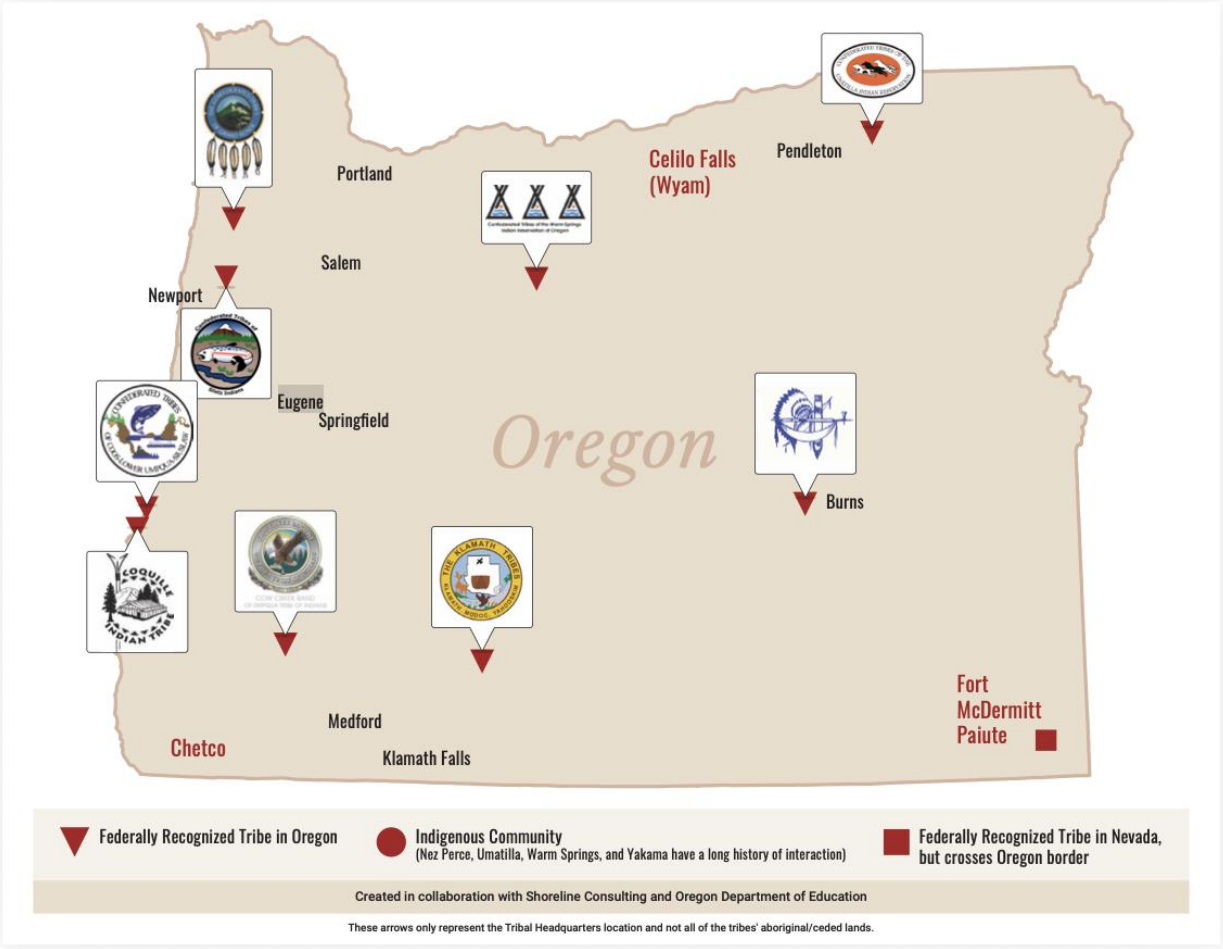
Campus respondents identify the populations they believe need more attention rather than the programming they deliver. Eight of the nine responding institutions named student populations that need more targeted prevention effort. Four named students of color, or students from underrepresented or marginalized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

Five of the 37 locally developed, innovative and grassroots primary prevention practices described in the next section are designed for a specific cultural community. They are Empoderando Familias; a bilingual integrated substance use and problem gambling prevention approach delivered in English and Spanish by Washington County Behavioral Health; arts-based family engagement delivered with culturally and linguistically specific arts organizations in

Gresham-Barlow School District; and culturally specific mentoring provided in schools and neighborhoods by Elevate Oregon and by the Portland Opportunities Industrialization Center.

9.2 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.



Source: https://www.oregon.gov/ode/students-and-family/equity/NativeAmericanEducation/Documents/Oregon%20map%20of%20tribes%20final%20version.pdf

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.[5] The addition is a defined set of 22 tribal-based practices. In this report, Tribal-Based Practices refers only to this 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 ceremony, and land-based and equine approaches.

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.[5] 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.[2],[3] 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.[4]

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, includes programs reported by community-based organizations and local governments providing Native-culture-grounded programming delivered by non-Tribal organizations. In the provider survey, 30 program entries report reaching Tribal communities among the populations they serve. 13 program entries were reported under a separate survey response option labeled "Tribal-based" when asked to categorize the type of program being reported. All 13 came from non-Tribal organizations: five 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 three fall within the definition of primary prevention used in this report: community building, referral to substance use services, and self-care activities delivered through Native cultural practice including sweat lodge, hiking, beading, hand drum making, basket weaving and traditional plant medicine. Its harm reduction and recovery entries 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 vote of the nine Tribes. The Native American Youth and Family Center is the state's largest Native-serving tobacco-prevention grantee.[5],[6]

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 29 recognized models described above, respondents described 37 locally developed, innovative or grassroots primary prevention practices: approaches that an organization, school district, 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 and school district surveys, the Intercollegiate Council survey, key-informant interviews and existing state records.

Locally developed prevention practice addresses needs 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 268 distinct prevention programs identified across this assessment, 29 use a recognized curriculum or named model. The remainder, including the 37 practices documented here, consists of work that a county, school district, 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 model 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 X gives the definition and count for each type.

Table X. 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 model 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

Source: HB 3321 provider survey (18 practices), school district survey (9), key-informant interviews (6), Intercollegiate Council survey (3), and existing state records (1). Practices that fit more than one type were assigned the closest match.

Locally developed, innovative and grassroots practice is 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.

Exhibit XX · 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 identifies young people who require support and connects 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, at two, which follows the pattern in county delivery; a result consistent with the funded system, in which counties planned environmental and policy work as 26 of their 183 objectives and delivered 6 percent of resources to it. 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.

Exhibit XX. 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 School District 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.
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 approach across eight to nine regions.

Source: HB 3321 provider, school district and Intercollegiate Council 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. Exhibit above is an illustrative list and the full breakdown of programs by strategy can be found in Appendix 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 its dissemination. No entity currently holds that responsibility.

Workforce Analysis

Credentialing and professional standards

Two national credentials anchor professional standards in prevention work in Oregon.

The Certified Prevention Specialist (CPS) is the prevention-specific credential. In Oregon, it is administered by MHACBO and is built on the International Certification and Reciprocity Consortium (IC&RC) Prevention Specialist standard, which Oregon adopted and which allows the credential to transfer between IC&RC member boards in other states. The pathway is practice-based. Candidates must complete 150 hours of prevention-specific education aligned with the IC&RC prevention domains, accrue 2,000 hours of supervised prevention work experience, and 120 hours of supervised experiential learning, sign an ethics agreement, pass a national criminal history check, and pass the IC&RC Prevention Specialist examination. The credential is renewed

every two years with 40 hours of continuing education, including six hours of ethics training and two hours of suicide prevention training.[1]

The Certified Health Education Specialist (CHES) is the credential most often held by public health staff. Given that prevention funding often moves through the state's Public Health Division, this credential appears in programs, contracts and public health organizations that also implement substance use prevention services. It is administered nationally by the National Commission for Health Education Credentialing (NCHEC), and its 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) of coursework aligned with the Eight Areas of Responsibility for health education specialists, and there is no work experience requirement. Candidates sit for a 165-item multiple-choice examination, of which 150 items are scored, and the credential is renewed on a five-year cycle with 75 continuing education contact hours. NCHEC has validated an updated nine-area framework that will serve as the basis for the examination beginning in 2027.[2]

Historical Background

In assessing the volume of credentialed professionals in Oregon, 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 covered 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

[1] Mental Health and Addiction Certification Board of Oregon. Certified Prevention Specialist (CPS): Testing and Recertification Requirements. https://www.mhacbo.org/en/cps/ and https://www.mhacbo.org/en/recertification/cps/ (accessed August 2026).
[2] National Commission for Health Education Credentialing. CHES Exam Eligibility, Certification Exams, CHES Recertification, and Responsibilities and Competencies. https://www.nchec.org/ (accessed August 2026).

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 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.

CPS and CHES Crosswalk

To understand the comparative utility of these credentials in the primary prevention workforce, Third Horizon conducted a crosswalk of the two credentials to ascertain their alignment.

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 waive any Mental Health and Addiction Certification Board of Oregon (MHACBO) requirement 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. This has material impact on the aligning program delivery strategies with the workforce; recognizing that there may be certain strategies and activities where individuals with the CHES may not have the appropriate training, technical skills or background to conduct the intervention in the same way a CPS might.

Shared competency base

- Community and population assessment
- Data-informed program planning
- Implementation of evidence-informed strategies
- Evaluation and continuous improvement

- Education, communication, and skill development
- Advocacy, policy, and systems-oriented work
- Ethical practice and continuing professional development

Material differences

- **Scope:** CHES is broad across health education and promotion; CPS is specialized in prevention practice, with particular relevance to substance use and behavioral health prevention.
- **Entry pathway:** CHES eligibility is based on academic preparation; CPS eligibility combines training, supervised work experience, experiential learning, ethics, background screening, and examination.
- **Community systems emphasis:** CPS more explicitly centers coalition development, community organization, and environmental prevention strategies.
- **Credential maintenance:** CHES uses a five-year recertification cycle with 75 CECH; MHACBO CPS uses a two-year cycle with 40 continuing education hours, including ethics training.

Credentialing Landscape

Across the four surveys, both credentials were asked about. The Workforce Survey asked in detail about CPS status and barriers, reported below, and included the CHES among other credentials, where 6 of 94 respondents reported holding it. The Provider Survey found 7 of 62 organizations with CHES-credentialed staff against 19 naming the CPS, and the School Survey found 4 of 34 districts with CHES-credentialed staff and none naming the CPS. The Intercollegiate Survey did not list CHES as an option, though 6 of 8 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 district, and campus settings.

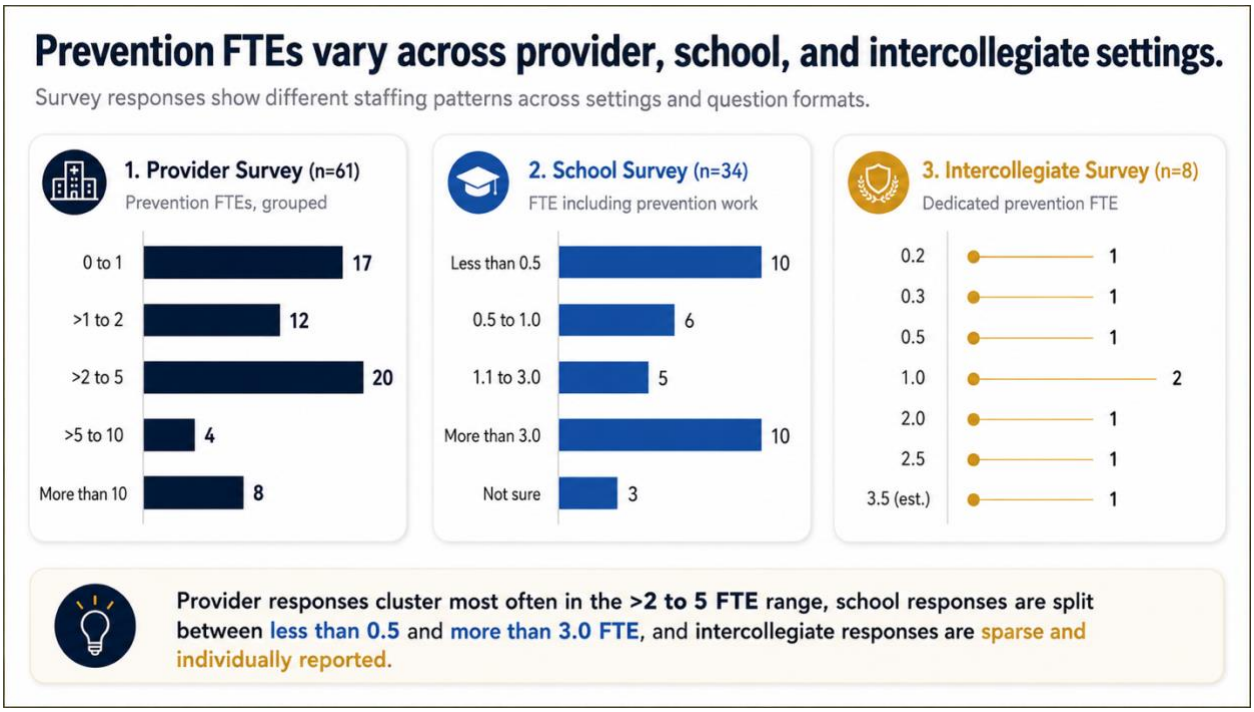
2. The CPS registry is maintained and shared with Third Horizon by the Mental Health and Addiction Certification Board of Oregon (MHACBO) and provides the total count of credentialed specialists to date.
3. Third Horizon conducted key informant interviews with MHACBO and other state agencies to learn 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.

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 4. 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 districts estimating staffing, 16 report one FTE or less, whose work even includes prevention, and the eight campuses reporting dedicated staffing range from a fifth of an FTE to about three and a half per campus.

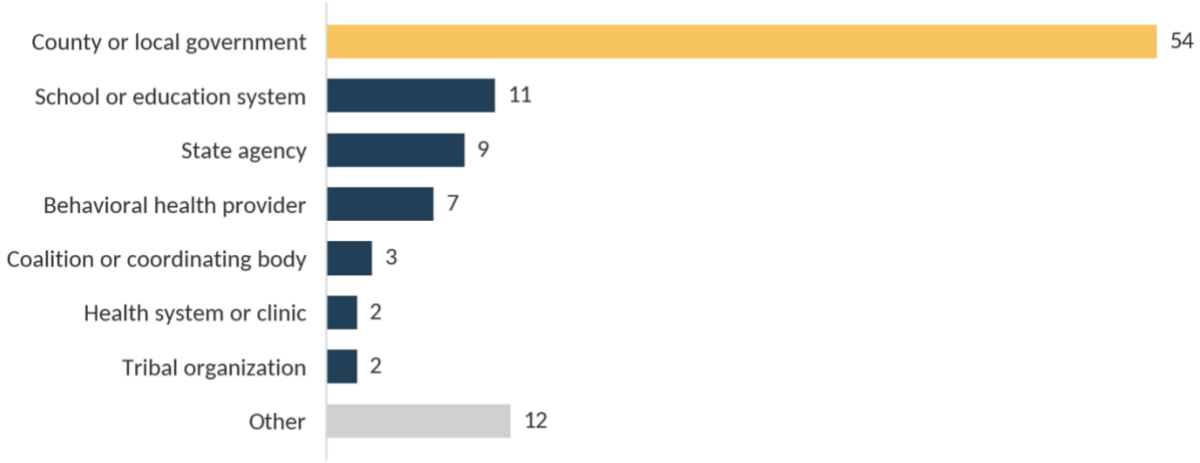
Figure X. Prevention staffing across provider, school, and campus settings



Source: 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.

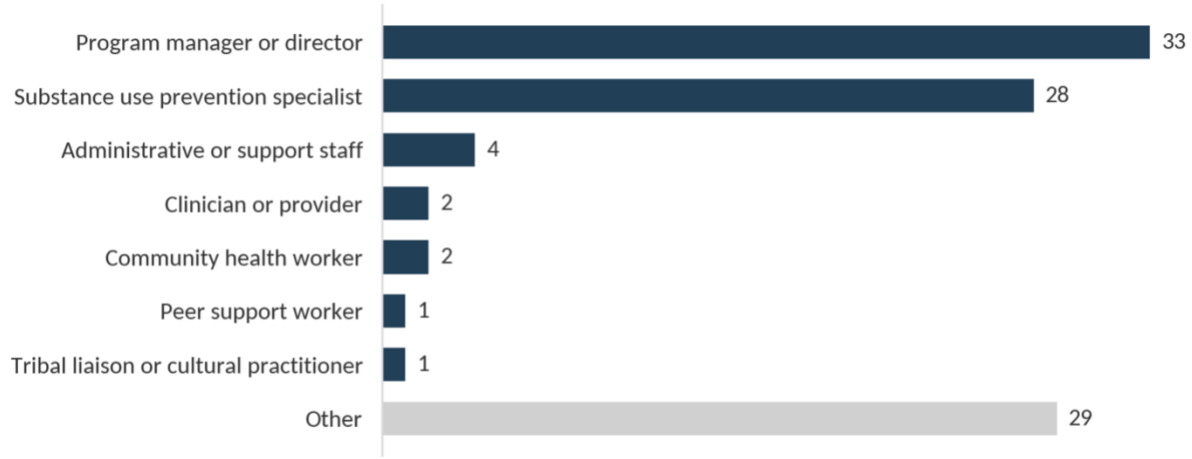
Figure X. Employer type among Workforce Survey respondents



Source: Workforce Survey, 2026 (n=100; one respondent did not identify an employer type).

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 X. Primary role among Workforce Survey respondents

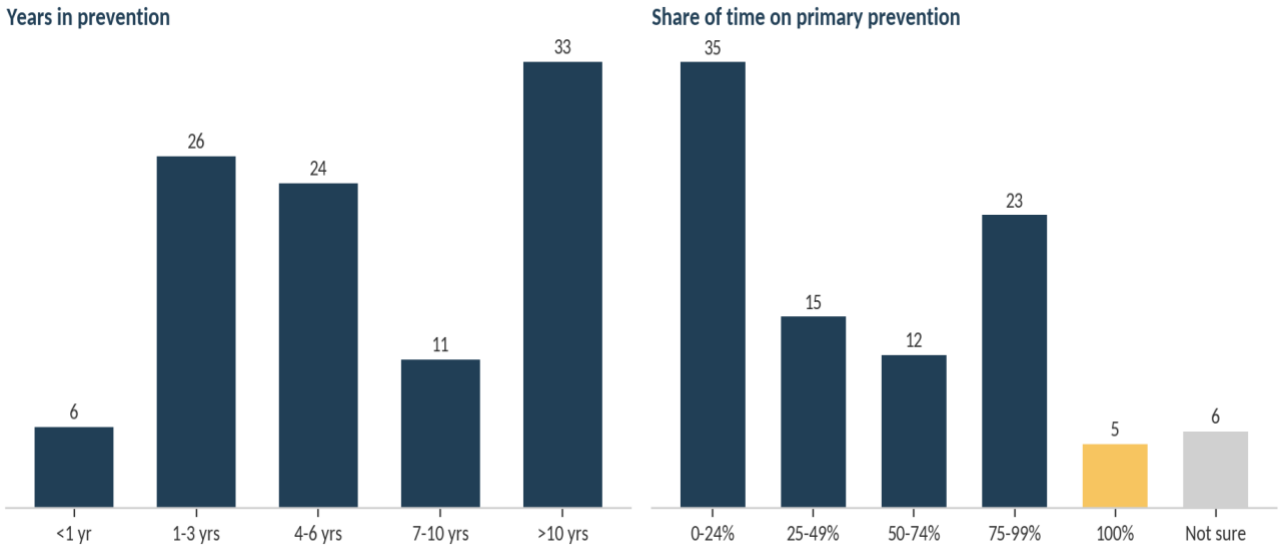


Source: Workforce Survey, 2026 (n=100; one respondent did not identify a role).

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 X. Workforce composition: years in prevention and share of time on primary prevention



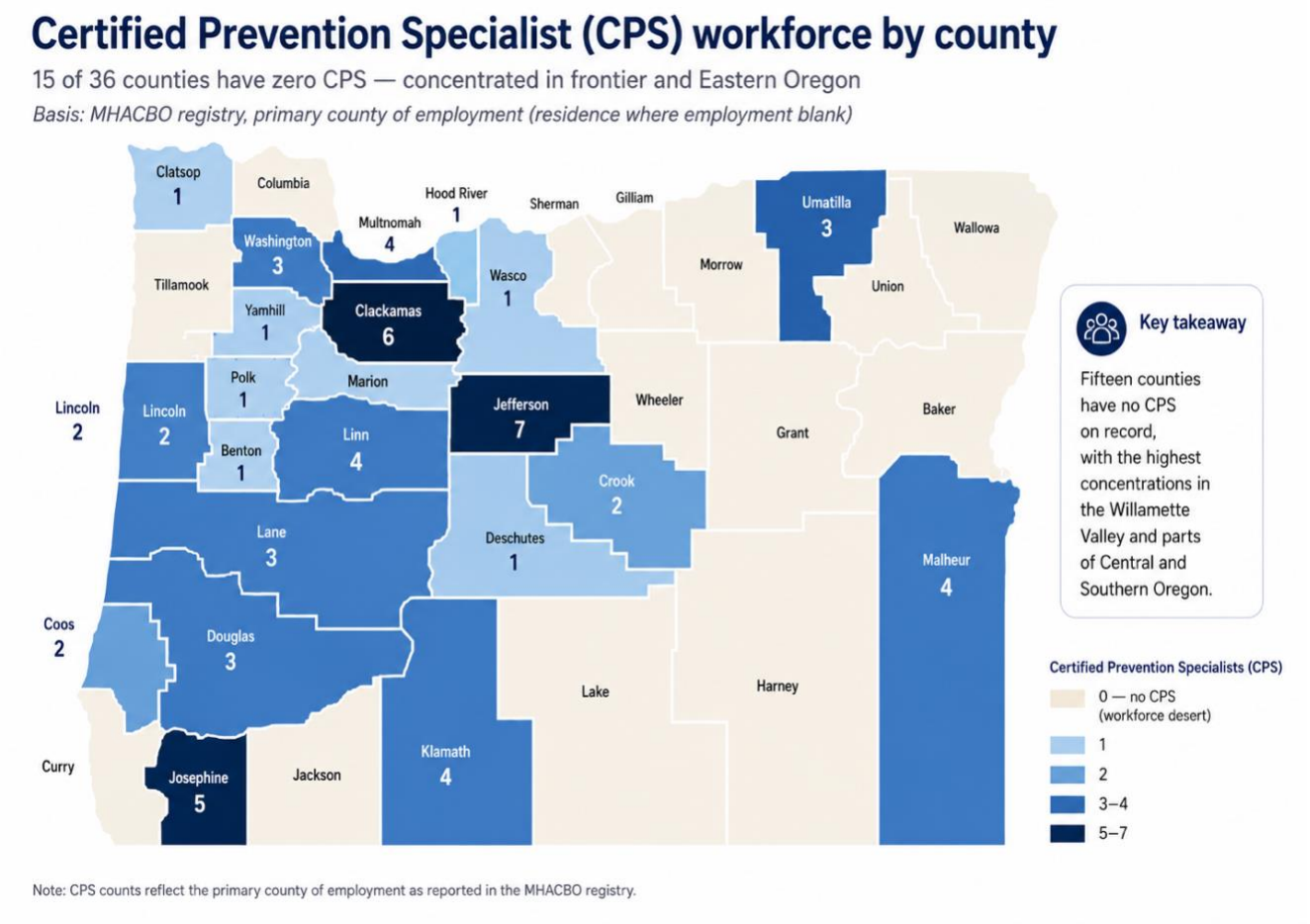
Source: Workforce Survey, 2026 (tenure n=100; time share n=96).

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 X. CPS credential holders by county of employment



Source: MHACBO CPS registry, 2026 (Oregon-based holders, n=57). Counties in gray have no CPS in the registry.

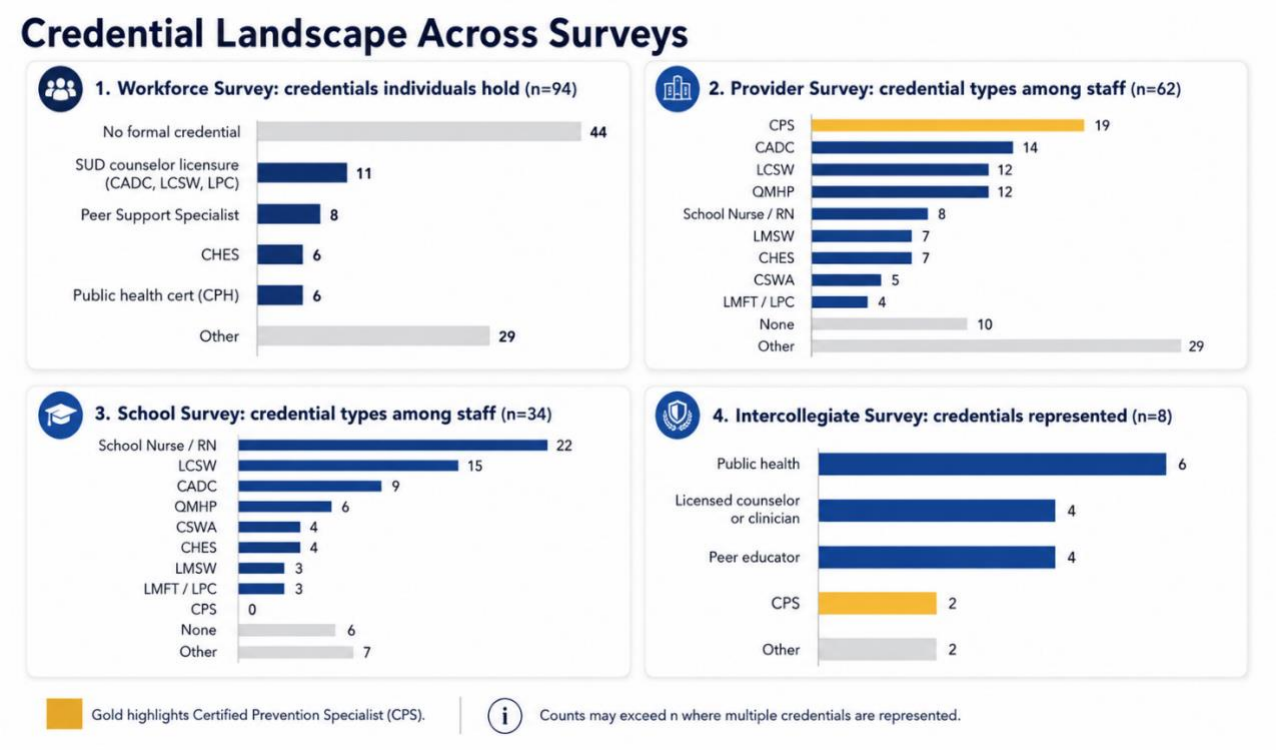
Credential status across the workforce

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 X. Credentials reported across the four surveys

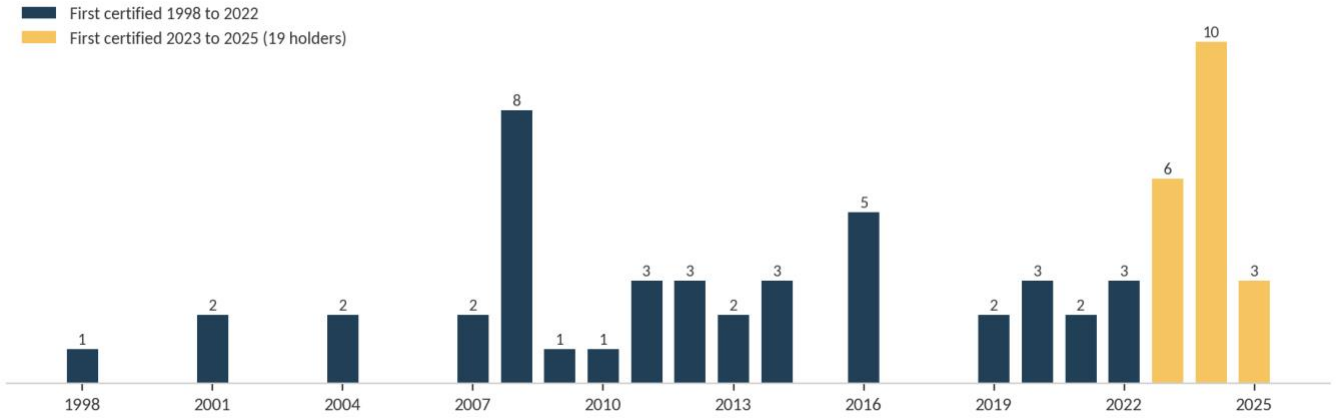


Source: Workforce, Provider, School, and Intercollegiate Surveys, 2026; select all that apply; n = respondents answering each item. CADC = Certified Alcohol and Drug Counselor; LCSW = Licensed Clinical Social Worker; QMHP = Qualified Mental Health Professional; RN = Registered Nurse; LMSW = Licensed 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 are age 55 or older, indicating meaningful succession risk. The credential is drawing new entrants, though not yet fast enough to replace those nearing retirement.

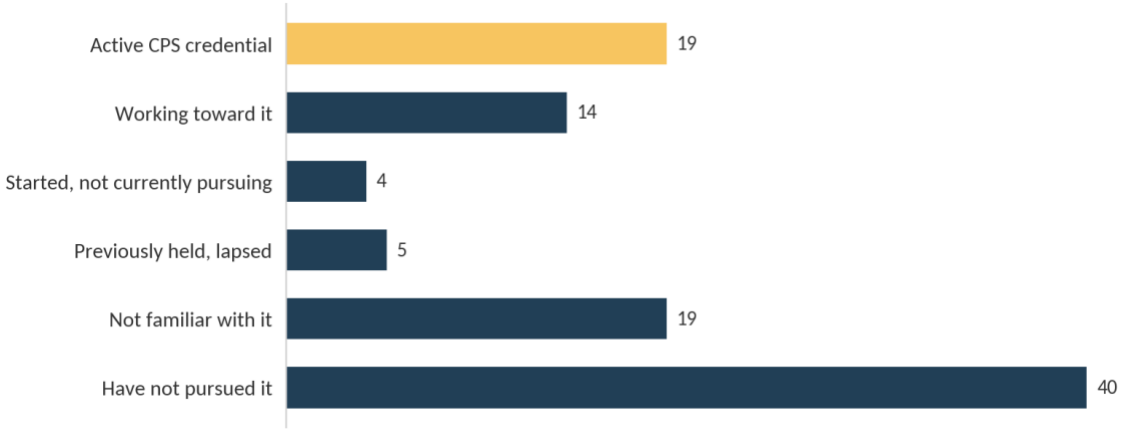
Figure X. First CPS certifications by year among current registry records



Source: MHACBO CPS registry, 2026 (n=62 current records; departures from the registry are not shown).

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 X. CPS credential status among the workforce

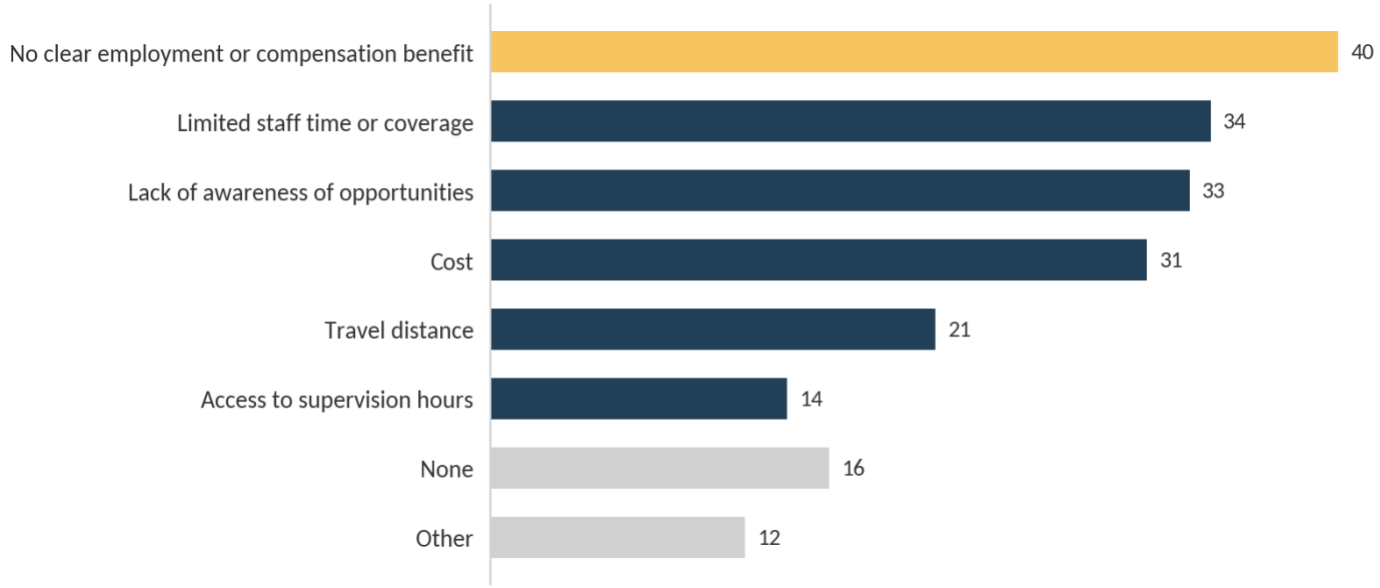


Source: Workforce Survey, 2026 (n=101).

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 X. Barriers to obtaining or maintaining CPS certification

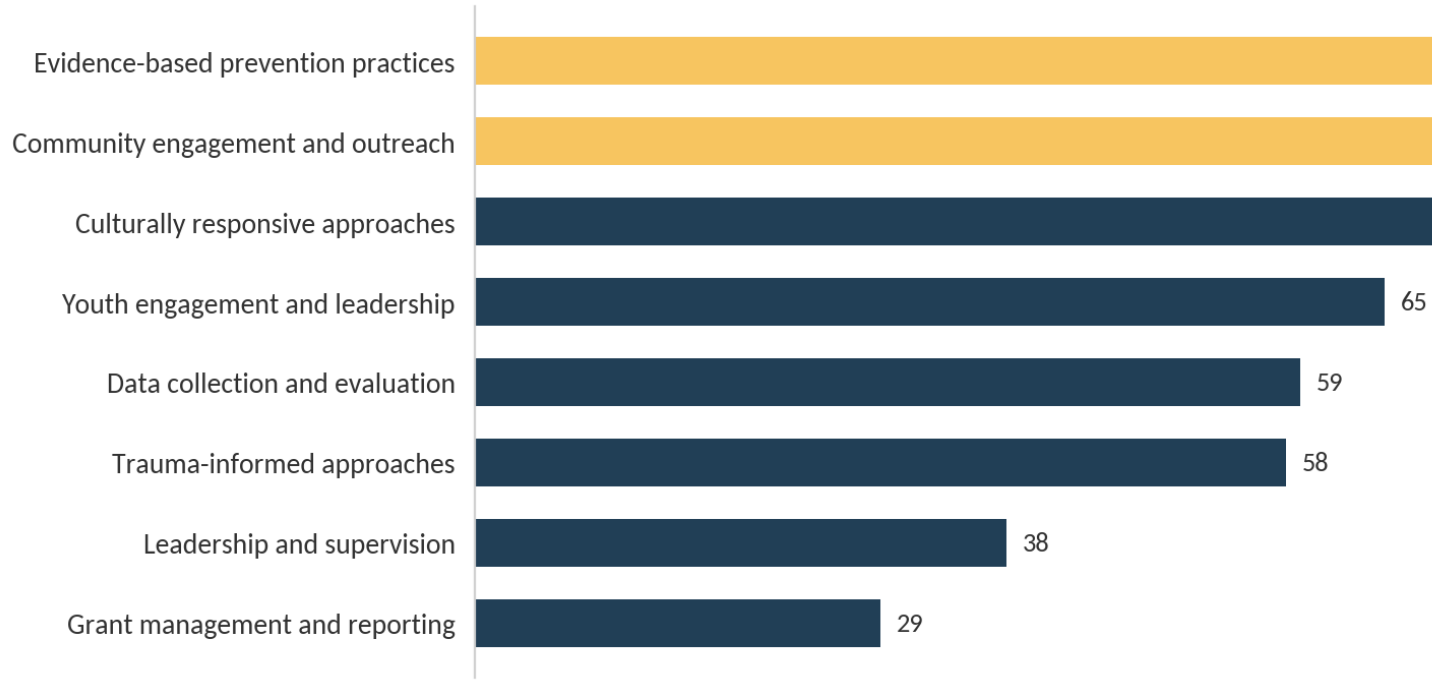


Source: Workforce Survey, 2026 (n=94; select all that apply).

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, the 95 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 X. Most requested training and capacity supports



Source: Workforce Survey, 2026 (n=95; select all that apply).

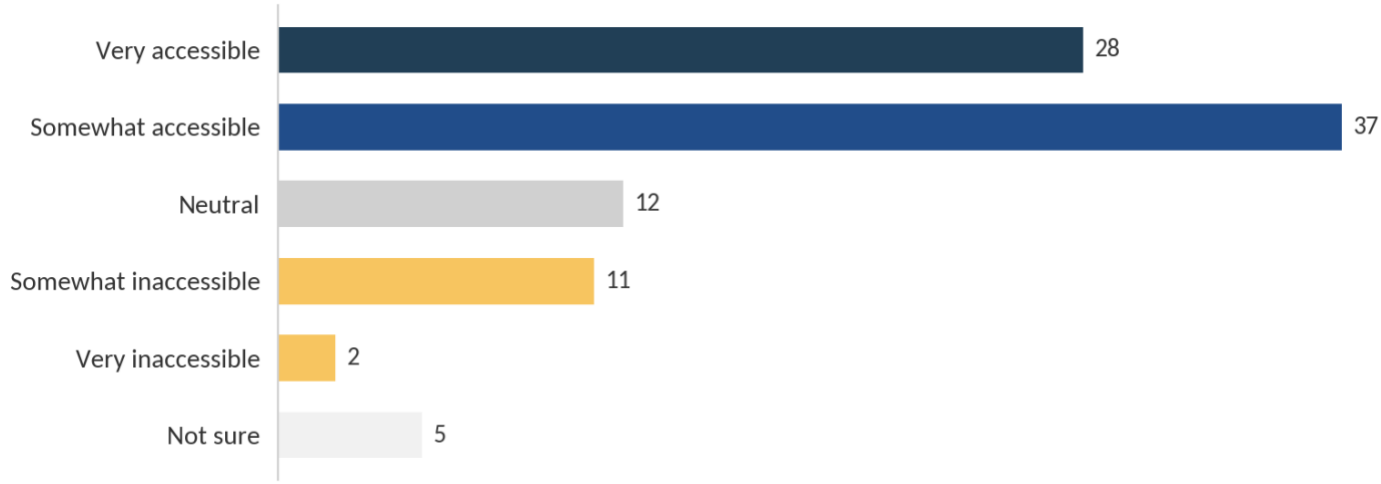
The Provider Survey shows that organizations are focused on ensuring their staff receive training when possible, with 53 of 68 organizations reporting that prevention staff receive regular training in prevention science and best practices. Of the 50 organizations that estimated annual hours, however, 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 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 X. Accessibility of prevention-related training opportunities



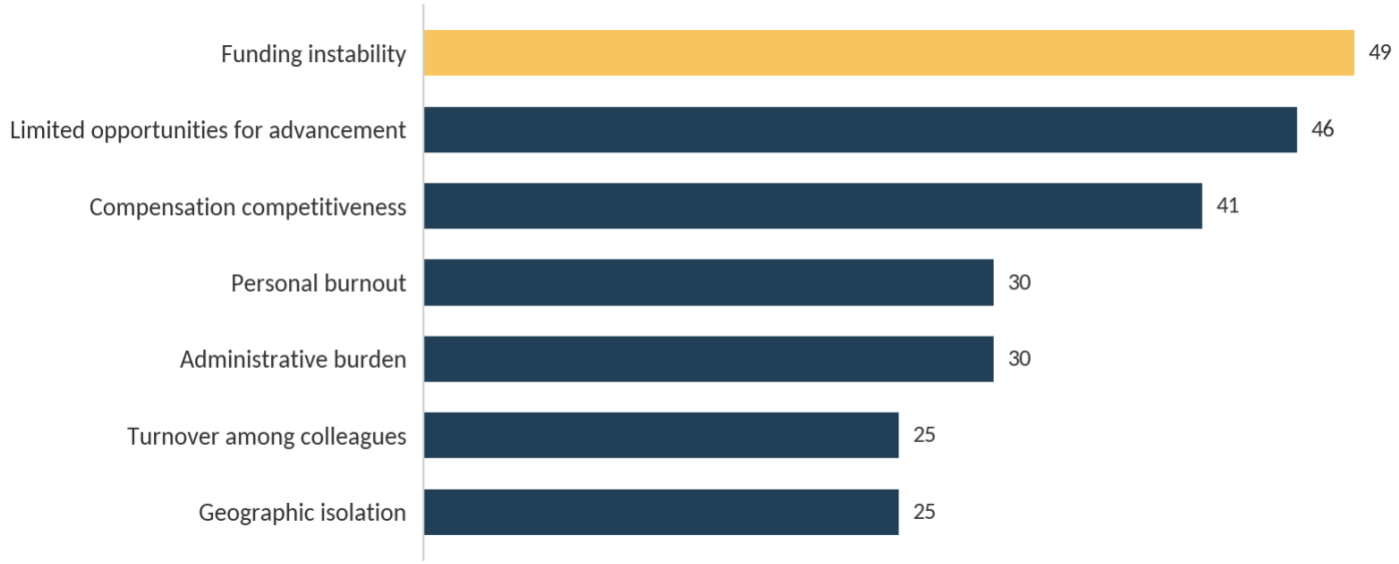
Source: Workforce Survey, 2026 (n=95).

Workforce sustainability

Workforce Survey respondents find both recruitment and retention difficult. Of 89 respondents rating recruitment, 61 (69 percent) described it as moderately, very, or extremely challenging. Of the 90 rating retention, 65 (72 percent) 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.

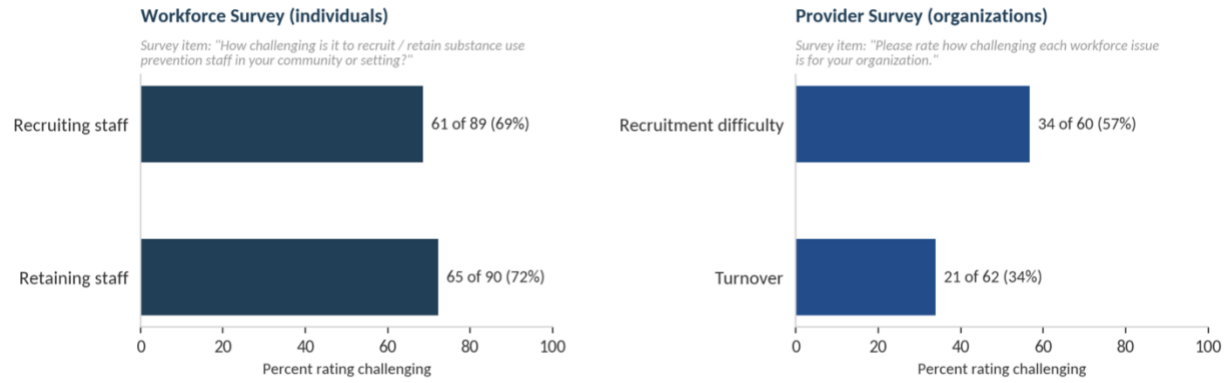
Figure X. Factors with high impact on sustaining prevention work



Source: Workforce Survey, 2026 (n=87 to 89 per item; combines a lot and a great deal).

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 counties' own 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 be reflecting 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.

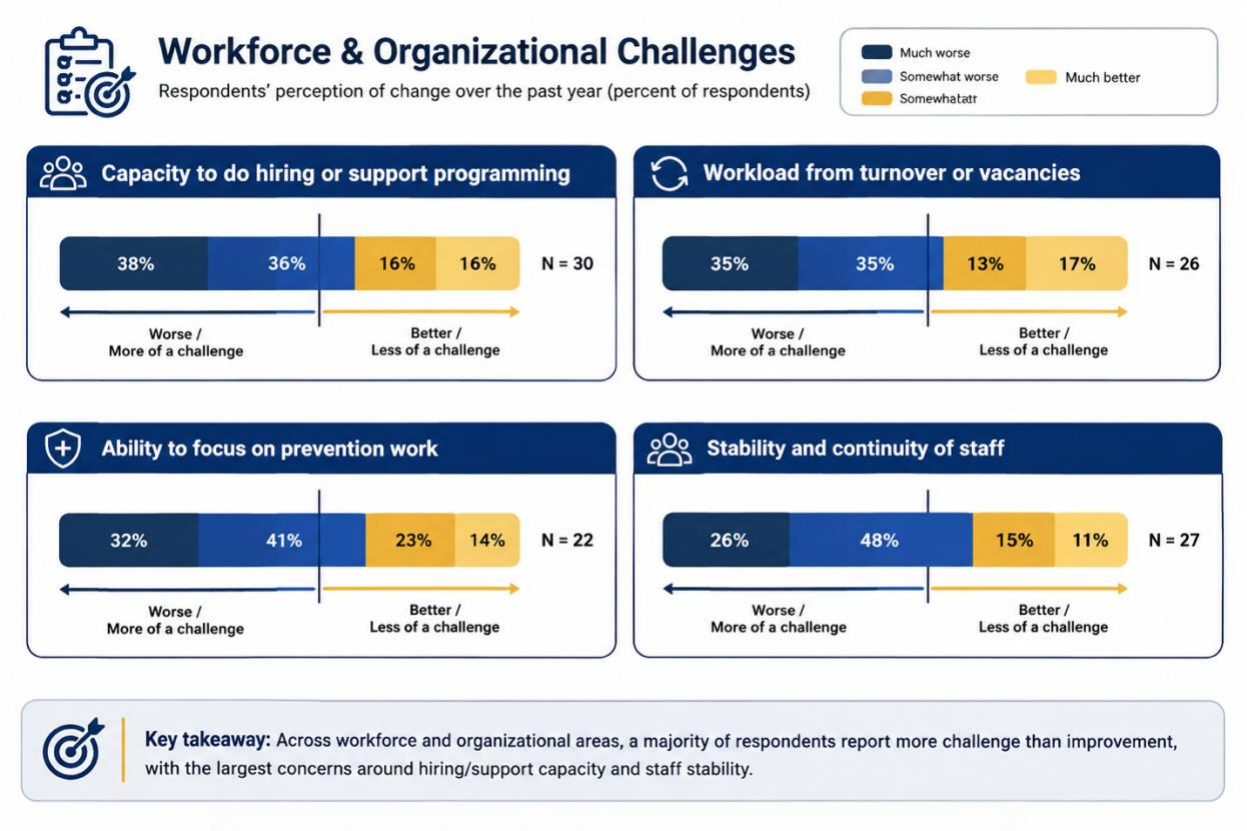
Figure X. Recruitment and retention, organizational and individual views



Source: Workforce Survey and Provider Survey, 2026. Challenging combines moderately, very, and extremely challenging.

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.

Figure X. Change over the past 12 months across four working conditions



Source: Workforce Survey, 2026 (n=88 to 89 per item).

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 answering 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.

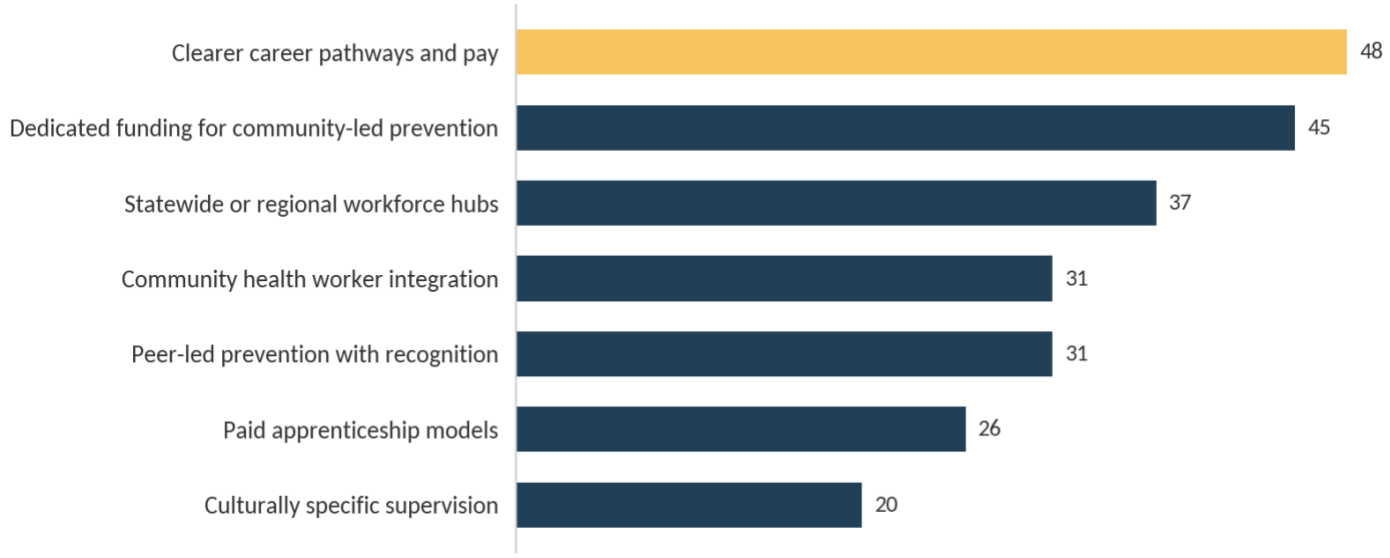
Placing a dollar figure on prevention work is difficult. The National Academies, in its 2025 report Blueprint for a National Prevention Infrastructure for Mental, Emotional, and Behavioral Disorders, reports that most prevention workforce roles are not listed in the federal Standard Occupational Classification system, which limits the ability to count these roles, track their pay,

and build formal career pathways.[3] 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 pay 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 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 X. Changes seen as most transformative for the workforce



Source: Workforce Survey, 2026 (n=93; select up to three).

[3] National Academies of Sciences, Engineering, and Medicine. 2025. Blueprint for a National Prevention Infrastructure for Mental, Emotional, and Behavioral Disorders. Washington, DC: The National Academies Press. https://doi.org/10.17226/28577

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.[4]

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 throughout 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 fund on primary prevention. This amount is referred to as the "prevention set-aside". 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 1 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 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, 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 explains 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. That work is authentic primary prevention, and Oregon does it well. As a control state, OLCC sets the wholesale price of distilled spirits, runs statewide retail compliance operations with paid minor decoys, and sets the server-education curriculum, strategies with a strong evidence base for reducing youth access. 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 1 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 alcohol revenue funds community prevention – which currently, it doesn't.

Table 1. 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.

Funding stream (normalized)	Administering agency	2023–25 mapped	Of which primary prevention (tagged or contract-verified)	Notes on flow, scope, and reliability
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.
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)	$3.5M	—	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.
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.

Funding stream (normalized)	Administering agency	2023–25 mapped	Of which primary prevention (tagged or contract-verified)	Notes on flow, scope, and reliability
				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.

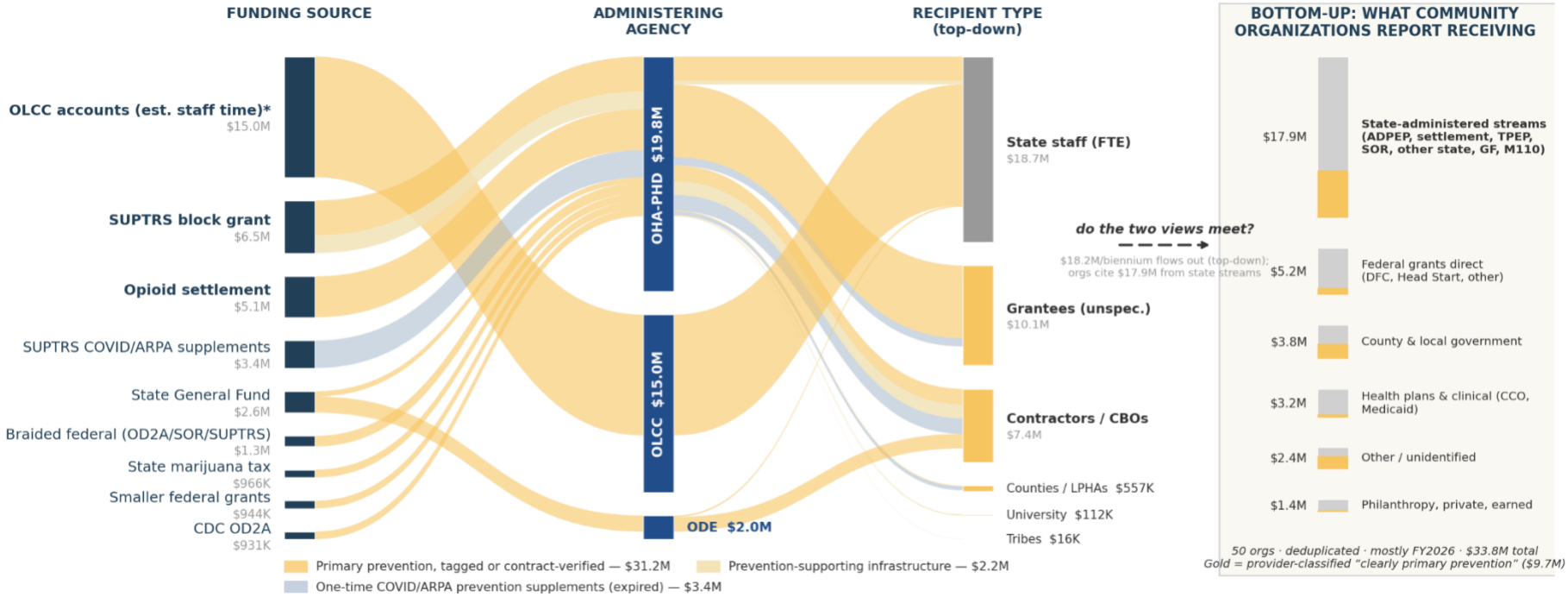
Where the prevention dollars sit

Prevention-tagged dollars exist in only three of the seven reporting agencies. They are OHA Public Health Division (PHD) ($6.0 million), Oregon Liquor and Cannabis Commission (OLCC) ($15.0 million, estimated staff time), and 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.

Two funds-flow maps follow on landscape pages. Figure 2 is the prevention-focused view. 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 3 shows the fully mapped universe ($66.6 million) for context. It depicts how prevention-relevant money moves through the same pipes as recovery, treatment, and surveillance dollars, and it should not be read as funding available for prevention.

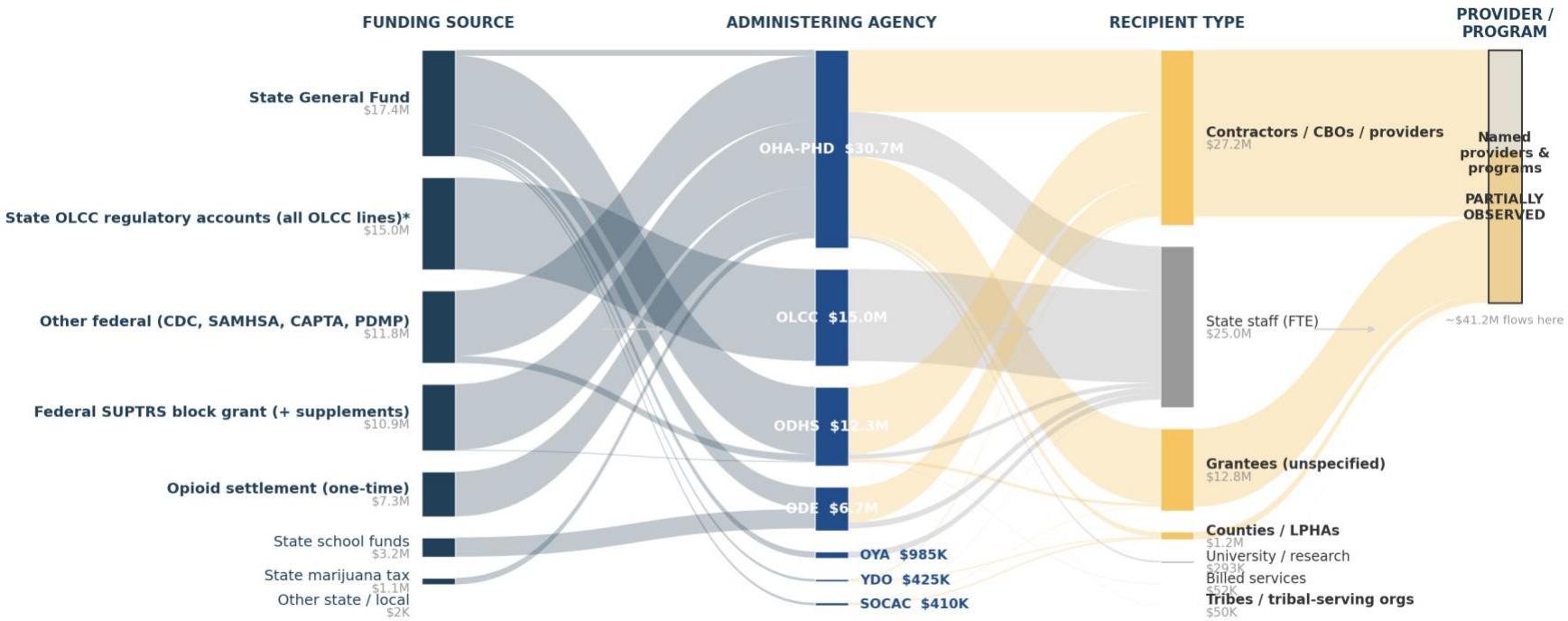
Figure 2. Two views of Oregon's prevention dollars: top-down funds-flow (2023–25) and what community organizations report receiving



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. Bottom-up detail: provider financial companion document.

In Figure 2, the SUPTRS block grant no longer arrives as unresolved cross-continuum. The contract-level review assigned it: $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, and counties. Communities cite $17.9M from the same state-administered streams, plus $15.9M from sources the state's financial reporting never sees. 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.

Figure 3. Context view of the full mapped universe of prevention-relevant dollars (NOT funding available for prevention)



The full $66.6M universe the project mapped (Title IV-B removed per the July 29 decision), shown to document how money moves, from sources into agencies, agencies out to recipient types, and a provider tier now partially observed through the provider survey (109 responses, 292 programs, self-reported, not summed). Most of this money funds recovery supports, treatment, and surveillance. Only the Figure 2 subset is tagged prevention. OLCC figures are estimated staff-time shares. Source: Oregon Prevention Funding Map v4, Layer A, and the HB 3321 provider survey.

Figure 3 documents the fragmentation finding, with State General Fund ($17.3M), smaller federal grants ($11.8M), the block grant ($10.9M), and OLCC accounts all moving through the same two or three agencies. It also locates the traceability gap. Roughly $41M leaves state agencies for contractors, counties, and grantees.

What stays in state government and what reaches communities

Within the $36.8 million prevention view, roughly half the money never leaves state government. Table 2a splits each band of the view by whether the recipient is state staff and operations or a community recipient (contractors, CBOs, grantees, counties and LPHAs, Tribes, universities).

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**

Table 2a. The 2023–25 prevention view split by recipient tier. Source: Oregon Prevention Funding Map v2 recipient types; HB 3321 cross-continuum contract review.

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 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, CAPTA child-abuse 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). The supplements carried the standard block-grant terms, including the 20 percent minimum primary-prevention set-aside and a 5 percent administrative allowance (OHA correspondence, June 16, 2026); 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 piece 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 1 ($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. 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 coordinate 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 1 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. The $7.3 million in settlement money that appears in Figure 3 is the portion that agencies booked as a biennium expenditure.

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 classed as primary prevention, $4.33 million is the ADPEP county and Tribal prevention pass-through, matching that federal itemization within one percent; $0.79 million is county lines listed a second time inside the ADPEP aggregate, removed as double-counts; $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 fews 20% as the floor (minimum) and not the ceiling. Third Horizon conducted a national scan of prevention set-aside allocations by states, and identified 9 states that are outlined in figure xx which have opted to go beyond the minimum in leveraging SUPTRS to support primary prevention services.

Figure xx: 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 CJC, mostly General Fund; $0.3 million by OHA-BHD, including about $138,000 of SUPTRS), and OHA-PHD reported essentially nothing under that designation. 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, so the top-down view in Figure 2 shows only about $17,000 reaching Tribal recipients. 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. An ongoing concern is that some of what is called braiding is 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."

This is why the funds-flow map is confident through Tier 3 and only partially observed at Tier 4. 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 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

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. OHA-PHD is the only agency that completed the next-tier recipient tab, OLCC's figures are estimates, and PHD's program budgets and actuals do not reconcile. 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 4 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.

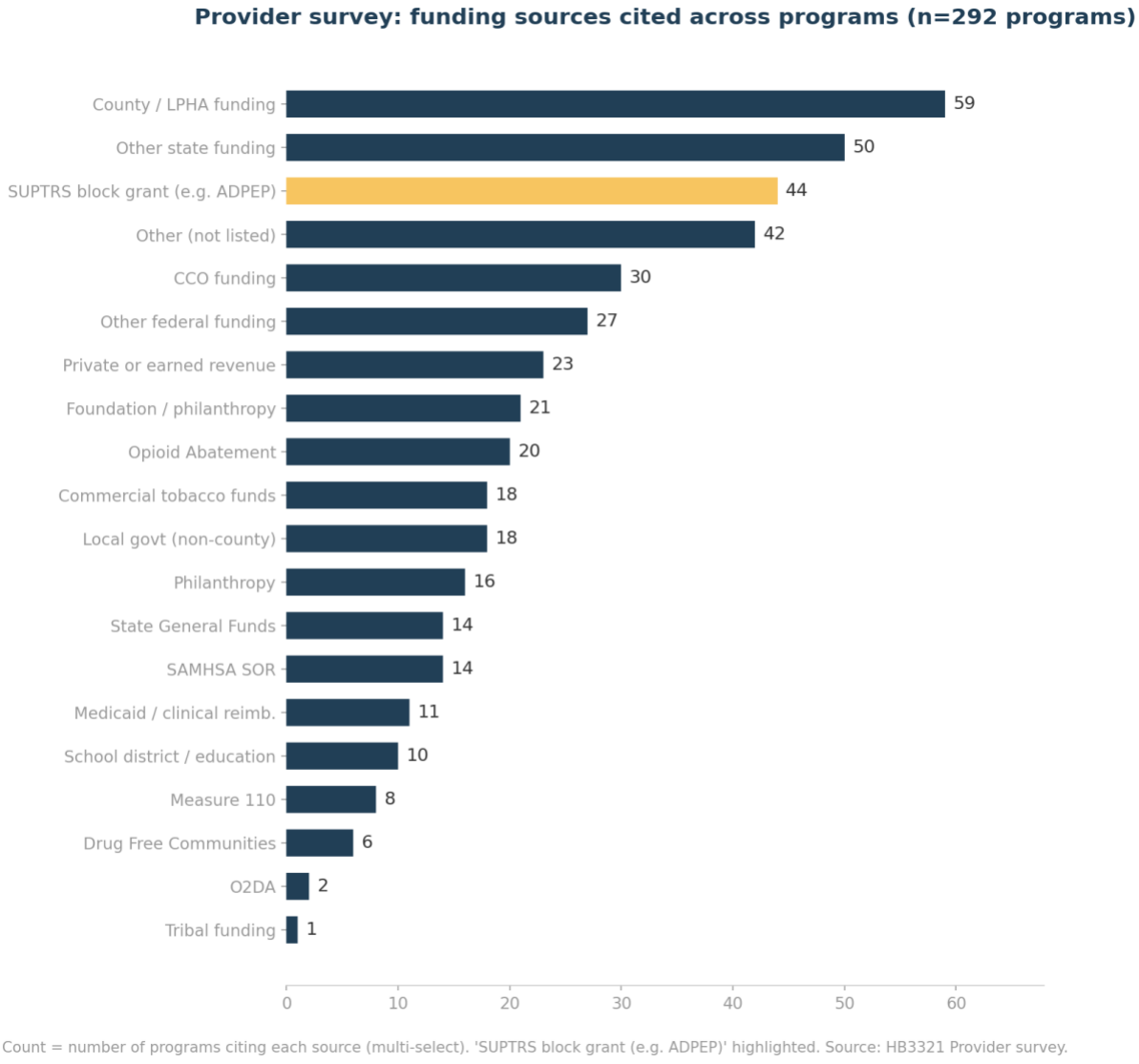


Figure 4. Funding sources cited across 292 provider programs (multi-select, a program may cite several). The SUPTRS block grant (ADPEP) is highlighted. Source: HB 3321 Provider survey.

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 6 program-funding lines) and mixed prevention-related support ($2.1M across 6 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.

The larger finding is on the other side of the ledger, in what the state's books never see. 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 unfunded or invisibly funded effort, which is the financial expression of the prevention-desert finding.

The 2025–27 biennium

Table 1 cannot yet be repeated 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 3 assembles what is already known.

Table 3. Known 2025–27 changes to the prevention funding picture

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	AY2027 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.
CDC OD2A-S and Alcohol Epi	Continuing, short cycles	Alcohol Epi year-5/6 workplan drafted through 2027. OD2A regional	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

Stream / change	Status for 2025–27	Known amount / detail	Bearing on this analysis's findings
		coordinators cover 23 of 36 counties	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.

> The temporary infusion is the strongest argument for the sustainability findings, and the report should be read against the 2027 cliff rather than the current high-water mark.

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. Of the $66.6 million in scope, $23.0 million, or 35 percent, is self-tagged as primary prevention, and a further $17.0 million (26 percent) 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 (47 percent) 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; $0.8 million is county lines duplicated inside the ADPEP aggregate; and the remainder is recovery supports, surveillance, treatment, and other work as agencies reported it. Figure 5 shows the distribution. Of the $31.2 million, $18.2 million sits with state staff and operations, dominated by the OLCC share, and $13.0 million goes out to community recipients. Two cautions apply. This dataset spans the whole continuum by design, so non-prevention categories are expected. And 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). Read carefully, the chart says that even after contract review, under half the money in a dataset assembled for a prevention analysis is primary prevention, leaving significant resources 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.

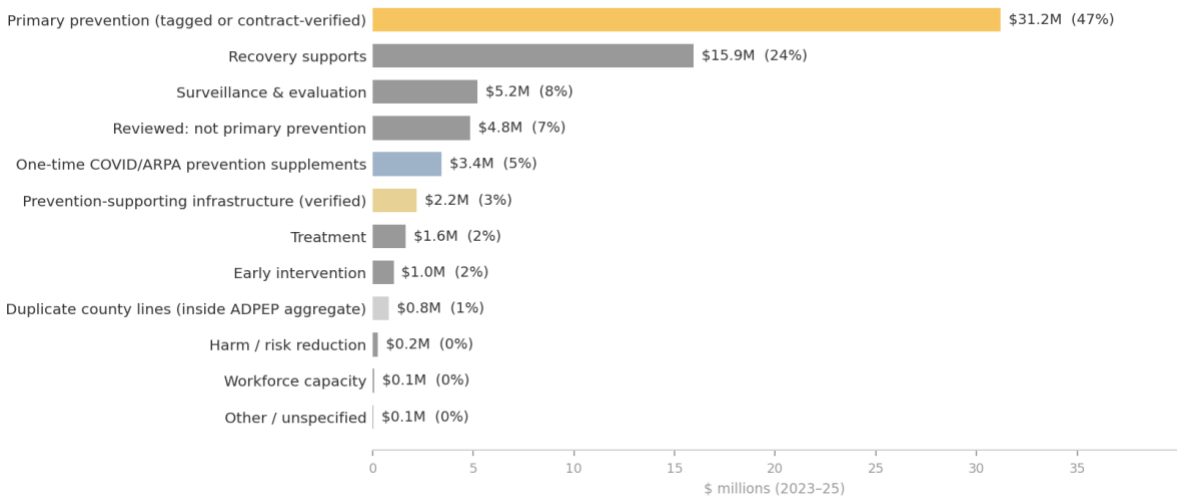


Figure 5. 2023–25 spending by continuum category after the August 2026 contract-level review. Primary prevention (tagged or contract-verified) in gold; prevention-supporting in pale gold; one-time COVID/ARPA in blue-gray; duplicate county lines shown separately.

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.

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 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 having 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.

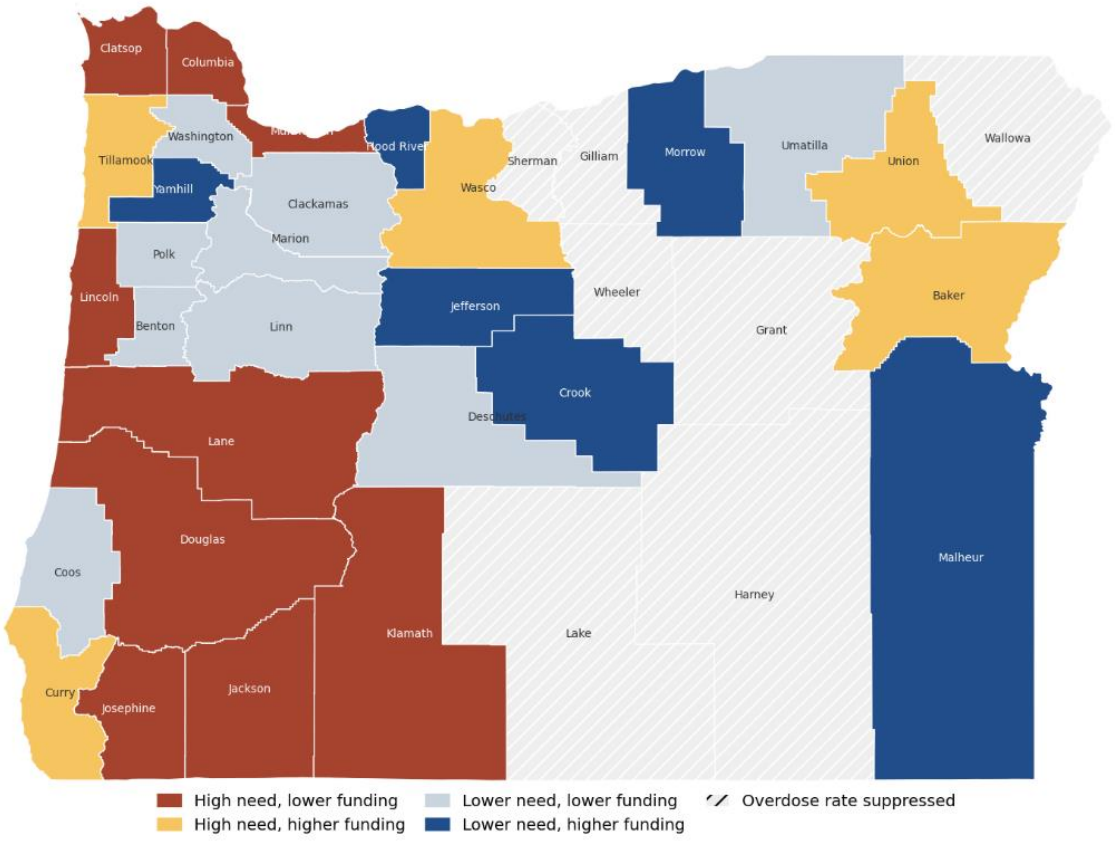
- Workforce. Fourteen to fifteen of Oregon's 36 counties have no Certified Prevention Specialist (CPS) in the workforce registry, and five certified prevention specialists serve all of Eastern Oregon. Frontier counties rely on professionals covering large multicounty areas, so a single departure can 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 — amounts too small to fund a position. The provider survey identifies ten counties with a prevention provider but no reported prevention money.
- 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.

Additionally – financing and program implementation are not necessarily targeting communities with disproportionate consequence burden.

To the extent financing is traceable from the federal government or state agencies, decisions around where to place resources and investments in prevention do not seem to align in some instances with areas of the state with disproportionate consequence burden.

To assess this, 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. Figure xx maps the relationship between these three elements.

Table xx: Need versus Primary Prevention Funding



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The map sorts counties two ways: the overdose burden they carry, and the ADPEP funding they receive for each resident.

Nine counties sit in the high-need, lower-funding group: Clatsop, Columbia, Multnomah, Lincoln, Lane, Douglas, Klamath, Jackson and Josephine. Multnomah is the clearest case of the disconnect between available prevention resources and need - It has the highest overdose rate in the state and receives about $2 per resident.

Limited Prevention Services for Youth at Risk

The most primary prevention strategy implementation is Universal. Oregon communities lack access to appropriate and needed levels of Selected and Indicated prevention strategies,

[5] Drug overdose mortality and population are 2020–2024 five-year estimates. Mortality reflects drug poisoning deaths, whether accidental or intentional, per 100,000 residents (NVSS-M, CDC WONDER); population reflects average resident population (ACS)

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 percent) include universal work aimed at a whole community or population, and 91 (54 percent) work only at that level. Seventy-six (46 percent) include selective or indicated work: 74 (44 percent) selective prevention for groups at higher risk, and 43 (26 percent) 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 works exclusively at the selective or indicated level. Only 3 percent of 722 activities in the county ADPEP progress reports were indicated. Tabe xx visualizes this disconnect.

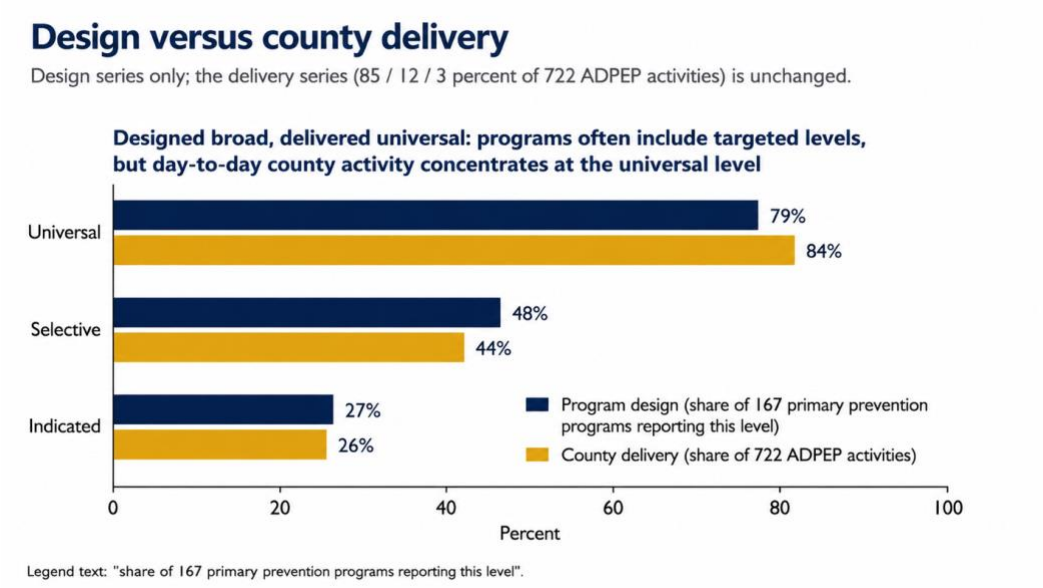

Figure 1. *Prevention levels in program design compared with county delivery. Design: primary prevention programs reporting a level in the provider survey. Delivery: activities recorded in county ADPEP progress reports. Sources: HB 3321 provider survey; county ADPEP progress reports.*

What Selected or Indicated prevention efforts are in place, they are 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 sustainability of services is a generally sound approach, it reinforces the conclusion that the state of Oregon is not making adequate, equitable investment in Selected and Indicated strategies, which inhibit capacity development and increase 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 models, it relies heavily on locally defined activity, operates no program at statewide scale beyond public awareness campaigns and state operated retail compliance. State agency reporting infrastructure lacks mechanisms to capture effectiveness of funded programs.

Only 29 of the 375 distinct programs identified are a recognized curriculum or named model. The remainder is locally defined activity, including 37 locally developed, innovative, or grassroots practices respondents described in their own terms. No curriculum operates at 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 models 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 about 5 percent of delivered resources going to it. OHA assigned a single theme per objective, so referral work embedded in a broader objective would not appear in the theme counts; the planning gap is real, but its size cannot be determined from the current coding.

There is not a unified, single definition of prevention that is utilized across the system; and providers reflect mixed understanding of Primary Substance Use Prevention.

While the National Academy of Medicine framework of Universal, Selected and Indicated prevention is in use by the ADPC, HB3321 and OHA, stakeholders within the ecosystem have inconsistent definitions of what constitutes substance use prevention services. While ADPEP guidance includes the 6 CSAP strategies and requirements for them to engage in one or more strategy, most recent analysis took an indirect route to aligning ADPEP work to CSAP strategies, creating inconsistent representation of CSAP strategy work and scale within the ADPEP ecosystem.

Additionally – though surveys administered by Third Horizon provided explicit definitions for respondents to use in determining if a program or funding source qualified for inclusion in their response, a sizeable number of respondents included programs that are not considered primary prevention. This inconsistent framing and lack of understanding of primary prevention definitions risk limiting 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

Oregon has the parts of a prevention system, but it remains disjointed and inconsistent. A funding backbone reaches every county, counties 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 no shared definition of prevention and no body assigned to coordinate them.

However, there is 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 BHRN audit, against roughly $800 million in behavioral health network awards. By the state's own 2023–25 analysis, primary prevention is 1.7 percent 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 delivery 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 audits from the Substance Abuse and Mental Health Administration has repeated every year since 2022. No standing structure champions 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.

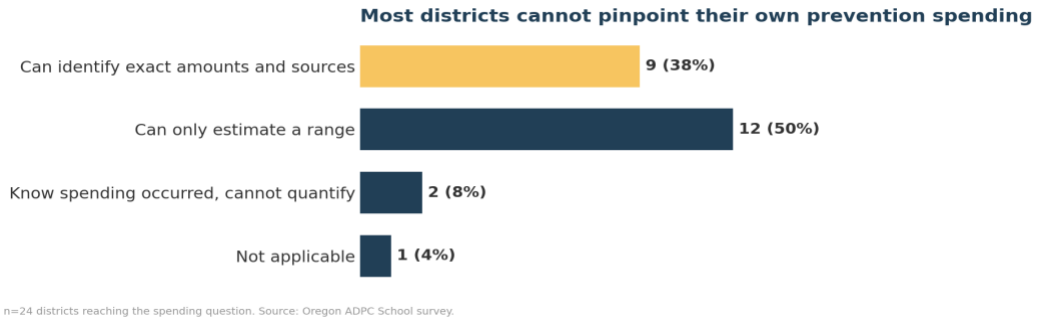

Figure 2. Whether districts can identify their own prevention spending (n=24 districts reaching the spending item). Source: Oregon ADPC school survey. Note: the narrative reports 8 districts able to identify exact amounts; this exhibit shows 9. See reconciliation notes.

The significance of Figure 2 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 PHOCUS and RHEC grants that must be spent by mid-2027 — although 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.

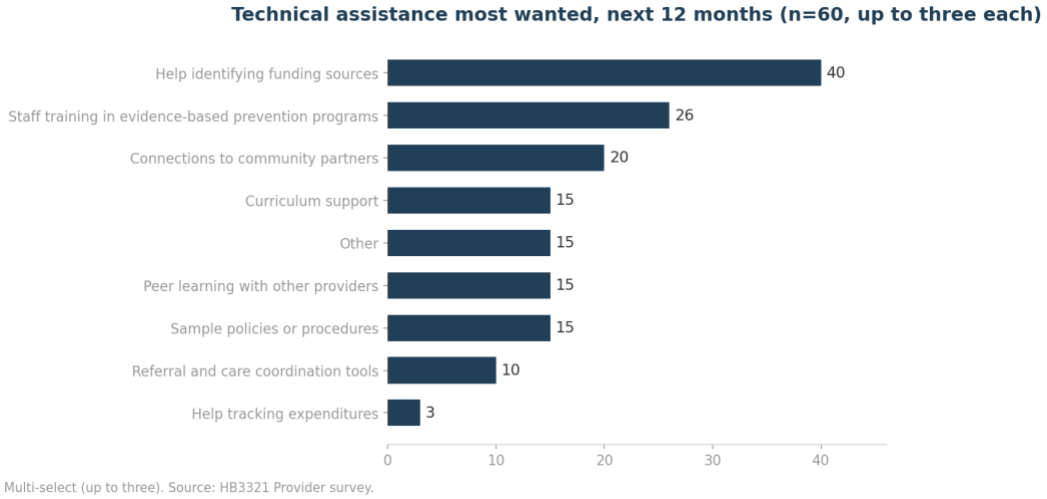

Figure 3. *Technical assistance providers most want over the next 12 months (n=60, up to three choices each). Help identifying funding sources leads every other request. Source: HB 3321 provider survey.*

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 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 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, it's pathways and support mechanisms. With the exception of tribal related 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.

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 states across the US have considered. 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.

Oregon should adopt a single definition of Primary Substance Use Disorders Prevention, grounded in the definitions set forth in HB3321.

Funding sources, state procurement, contracting, reporting and school-based Division 22 guidance should utilize the exact same definitional framework, and tether financing and reporting to it. Training and technical assistance, and credential regulations, should mirror these definitions as well, to ensure the current and future workforce can more clearly articulate what constitutes primary prevention programs, practices and strategies. In addition to system and state-wide adoption of the HB3321 definition, the CSAP 6 Strategies overlaid with National Academy of Medicine Framework (Universal, Selected and Indicated) should be the basis for a single, statewide taxonomy.

In lieu of a dedicated fund exclusively for primary prevention, Oregon should consider developing a consistent framework permanently dedicating a portion of broad funding pools to prevention, similar to the SUPTRS set aside – and moving 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. This will

enhance the ability of local communities to grow and expand prevention services, knowing that there is reliable, consistent funding available to support such efforts.

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 explore the potential benefits of furthering integration of prevention services by easing restrictions on tobacco and other opioid or drug-specific funding, to encourage better integration at the community level.

Regulators should consider fiscal policy and brings additional revenue through OLCC that could be used to invest in community-based primary prevention.

Oregon's status as a control state represents a substantive input to advance substance use prevention efforts by engaging in oversight and enforcement that can protect and reduce access to the controlled substances by youth – in Oregon's case, marijuana and alcohol. Nationally, many states with a control environment apportion some of the revenue to funding community services that reduce the burden caused by the substances they regulate. Given the focus on Alcohol as a substance of concern by state officials, the lack of funding appropriated to community services to address that trend is notable, and could be solved by a review of alcohol pricing and taxation policy to foster opportunities to align with other control states' strategy of using alcohol revenue, in part, to support primary prevention services.

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 then Oregon state budget, through to state agencies and the contracts delivered to community-based organizations.

Third Horizon does not suggest in this report that funds are 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.

Oregon should consider appropriating resources balancing statewide coverage with resources that better match need.

While states often struggle to balance fairness, fund 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. In building out a comprehensive prevention system, moving away from a straight population-based funding methodology towards something that provides additional resources in higher need communities, may be warranted.

Financial investment should be prioritized to develop a centralized technical assistance and data monitoring resource for the primary prevention system in Oregon.

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, 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.

As Medicaid and commercial insurance increasingly fund treatment and recovery services, Oregon should explore related finance reform efforts, alternative payment models, and coverage innovations that could reduce reliance on SUPTRS for billable services, allowing the state to exceed the SUPTRS 20% set aside.

As noted in the report, many states have made strategic decisions to leverage more SUPTRS dollars into primary prevention than is required. Despite volatility at the federal level, to date the block grant remains a consistent funding source for SUD services, and thus may be worth reviewing to explore whether it could play more of a role in the delivery of primary prevention programs and services. Efforts to maximize the SUPTRS capacity to finance primary prevention may become a more critical strategy to deploy even while payment reform efforts maximize reimbursement for clinical services, given increasing health care cost pressures that may reduce upstream, preventative investment capacity by CCOs and health systems.

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

Oregon should adopt a methodology to workforce development that codifies what functions, service delivery and programs in primary prevention are best served by someone with a CPS, and then require the credential in the funding of those specific activities. While the CHES may be an appropriate credential within services delivered in a broad public health context, it is not an equivalent credential to the CPS, which exclusively focuses on professional training in primary substance use prevention.

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 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 was clear. Moving forward, Oregon has an opportunity to make a clear, robust and long-term commitment to expand the reach and impact of primary prevention services and the local, regional and state level, 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 benefit, alleviating the burden caused by substance use while supporting youth towards healthy, vibrant lives.

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19. National Institute on Drug Abuse. “Investing in Prevention Makes Good Financial Sense” (2022). nida.nih.gov
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21. Oregon Alcohol and Drug Policy Commission. 2023–25 Substance Use Disorder Financial Assessment (draft report). Oregon.gov/adpc

22. Oregon-Idaho HIDTA. 2027 Threat Assessment (June 2026), Information Sharing and Analytical Coordination Center. Figures reflect 2025 calendar-year data.

Figures and findings above are drawn from the project's consolidated working materials and the underlying source documents they cite. Principal sources:

- HB 3321 surveys (provider, school, workforce, intercollegiate)
- ADPC 23–25 SUD Financial Analysis
- HB 3321 cross-continuum contract review: methodology memo and line-item reclassification workbook (August 2026)
- PCG SUD Financial Analysis Report (April 2024)
- OHA SUPTRS block-grant reports FY2025 and FY2026, and the 2026 Combined MHBG-SUPTRS block-grant application.
- OHA ADPEP funding and program guidance (2023–25 and 2025–27) with grantee and budget lists, and TPEP grantee and budget lists
- Statewide Single Audit Report, Secretary of State, March 2026 (Report 2026-10, year ended June 30, 2025), which repeats SUPTRS subrecipient-monitoring findings from 2024, 2023 and 2022
- OSPTR Board implementation plan and PHOCUS/RHEC grant guidance. 2023–24
- SOCAC '25–'27 regional grant summary and tribal grant summary (OHA, December 2025), with per-grantee scopes of work. SPF-PFS FY26 continuation application. Alcohol Epi year-5/6 workplan. OD2A and HIDTA award materials. MHACBO SB 1547 materials. Basis for the 2025–27 outlook (Table 3).
- Secretary of State Measure 110 audit (2025-29). Governor's Office overdose and illicit-drug-demand-reduction briefs.
- Agency financial templates, contracts, and workplans (OHA, SOCAC, OYA, ODHS, ODE, OLCC, YDO).
- Agency interview transcripts.