OREGON HEALTH AUTHORITY

Behavioral Health Division

March 2026

Substance Use Disorder Integration Report

Acknowledgments

The Oregon Health Authority prepared this publication in collaboration with members of OHA's cross-divisional SUD Alignment & Governance teams, spanning Behavioral Health, Public Health, Medicaid, and Tribal Affairs.

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Executive Summary

Oregon has made substantial progress in strengthening its substance use disorder (SUD) system, building on historic investments in behavioral health treatment capacity, overdose prevention, Tribal partnerships, workforce expansion, and the creation of statewide Behavioral Health Resource Networks (BHRNs). OHA has expanded residential and withdrawal management beds, broadened access to medication-assisted treatment across rural and Tribal communities, increased naloxone distribution, and supported the growth of peer services and recovery housing. These successes reflect meaningful systemwide momentum, contributing to Oregon's first decline in overdose deaths since 2016 and offering a strong foundation on which to advance broader integration efforts.

Despite this progress, Oregon continues to experience some of the highest substance use disorder (SUD) rates in the nation, with deep and persistent inequities affecting Tribal communities, communities of color, rural areas, and people experiencing poverty, housing instability, and co-occurring behavioral health conditions. The state's prevention, harm reduction, treatment, and recovery systems work together but continue to face challenges due to increased need and limited resources. Funding stream siloes, workforce capacity limitations, and lags in data system modernization contribute to a statewide 49% gap in SUD services.

In January 2023, the Secretary of State completed a performance audit of Measure 110. The audit underscored the challenges described above and directed OHA to develop a plan to integrate Behavioral Health Resource Networks (BHRNs) into the broader behavioral health – SUD system. This report meets the audit requirement. In addition, the December 2025 Secretary of State performance audit recommends development of a comprehensive SUD integration roadmap. This report will inform that roadmap, which is due in December 2026.

The **SUD Strategic Integration Plan** outlines OHA's framework for building a coordinated, equitable, person-centered SUD system aligned with Oregon's goal of eliminating health inequities by 2030. The plan strengthens integration across funding, policy, programs, and data systems; expands the SUD continuum of care; supports a diverse, culturally responsive workforce; and aligns with the Alcohol and Drug Policy Commission's 2026–2030 Comprehensive Plan. It also leverages major

investments—including BHRN funding, Medicaid's 1115 waiver, the Rural Health Transformation Grant, and opioid settlement resources—to expand prevention, treatment, harm reduction, and recovery capacity statewide. As OHA develops the required 2026 roadmap, this plan provides the strategic foundation for sequencing integration milestones, strengthening accountability, and ensuring that every Oregon community has access to consistent, high-quality SUD services.

Introduction and Background

Contextualizing Substance Use Disorder and the Continuum of Care in Oregon

Substance use and substance use disorders (SUD) are a major population health problem, impacting the health of individuals, families, workplaces, schools, healthcare, and social service systems. The substance use disorder rate in Oregon (21.6%) is significantly higher than the national rate (16.5%) with 12.7% of Oregon's total population having a substance use disorder (2022-23 National Survey on Drug Use and Health/NSDUH).

Alcohol, stimulants, and opioids represent the most critical substances to address based on prevalence of use and incidence of fatality. Alcohol Use Disorder affects more than one in ten residents, and overdose deaths from stimulants and/or opioids, while declining 22% between 2023 and 2024, remain a major public health crisis in Oregon, with disproportionate impacts among Black/African American and American Indian/Alaskan Native populations (Opioids and the Ongoing Drug Overdose Crisis in Oregon: 2025 Report to the Legislature, 2026). Despite broad awareness of the severity of these substance use challenges in Oregon, there remain significant cultural barriers to providing access to effective prevention and treatment, including stigma, discrimination and criminalization (OHSU-PSU 2022 SUD Gaps Analyses).

People with SUD experience intense stigma and discrimination in public life and across systems, including within the behavioral health system. Addiction stigma involves the negative prejudice against people who use substances and results in discrimination or unjust treatment. Among the most pervasive addiction stigmas is the belief that substance use disorders are a matter of personal failing or criminality, rather than an addressable chronic disease related health concern, and thus rendering treatment and recovery impossible. This systemic bias means that people

who use alcohol and other drugs are often excluded from mental health treatment and primary care services.

Due in part to addiction stigma and bias, primary prevention has been inadequately funded and often not well understood as a critical part of the SUD continuum of care. A lack of upstream resources at the prevention level has exacerbated the need for SUD treatment services, also mired by bias and dislocated from more resourced forms of care. SUD treatment has historically been siloed from physical and mental health care as a result of separate, categorical funding streams, regulations, and service benefit designs. Recovery supports and harm reduction services are also frequently separated from treatment services by oversight and funding mechanisms. This fragmentation creates barriers to prevention, treatment, and recovery, resulting in avoidable harm, higher costs, and widening health inequities.

In parallel with the division of the broader care delivery system, issues of decentralization within the SUD system itself have limited the efficacy of SUD prevention, treatment, and recovery in Oregon. The implementation of Ballot Measure 110, the 2021 measure decriminalizing or reducing penalties for most cases of possession of a controlled substance and instead emphasizing treatment, is a prominent example. It is through the process of integrating the Behavioral Health Resource Networks which emerged from the implementation of Measure 110 into the overall behavioral health system, that the opportunity for SUD system integration can be realized.

Measure 110/Behavioral Health Resource Networks: A Catalyst for Integration

Ballot Measure 110 (M110) was a model to be implemented outside of the traditional behavioral health system. This model launched the Behavioral Health Resource Network (BHRN) Program. Through this program, every county in Oregon established a BHRN - a network of SUD providers funded to provide screening, assessment, low barrier SUD treatment, housing, peer support, and harm reduction. Some BHRN services are reimbursable by Medicaid or other insurance. BHRN services are also provided to individuals who are un/under insured. For these reasons, BHRN providers and their services fill an important gap in Oregon’s SUD system of care. The supportive, low barrier elements of BHRN services augment traditional and clinical care.

The independence of the program elevated the program's visibility, but simultaneously isolated it from the broader system, limiting its integration and clear role within the behavioral health continuum of care. Moreover, programming outside of M110 continued as usual, without direction on how to incorporate the new philosophies of M110 or awareness of funding provided to shared community providers. This contributed to a disjointed substance use disorder (SUD) system where providers have multiple funding streams, multiple contract and grant managers, multiple reporting requirements, and multiple Oregon Administrative Rules, without uniform oversight and accountability.

In response to the aforementioned problems created by this disjointed system, a January 2023 Secretary of State audit of Measure 110 recommended that OHA publish a plan for integrating Measure 110/Behavioral Health Resource Networks (BHRNs) into the overall behavioral health system in Oregon. This report of the OHA SUD Strategic Integration Plan details an overall approach for BHRN integration and improved access to SUD services in fulfillment of the 2023 recommendation. Simultaneously, the enclosed report lays the groundwork for development of the integration roadmap requested in the December 2025 audit and due by December 2026.

OHA SUD Strategic Integration Plan Summary

The OHA SUD Strategic Integration Plan outlines a framework to build a coordinated, person-centered system that supports integration, improves outcomes, and advances Oregon's vision of eliminating health inequities by 2030. This plan is informed by previous community engagement, needs assessment, and public input during the state Opioid/Polysubstance Use Rapid Response project in years 2021-2025. It aligns and complements the Alcohol and Drug Commission (ADPC) Comprehensive Plan for Oregon, OHA-Public Health Division's Healthier Together Oregon, OHA's Tribal Behavioral Health Plan and OHA Strategic Plan, and other key state plans. Overarching core values include:

- **System Integration:** Align funding, policies, and data systems; streamline administration; and modernize infrastructure.
- **Continuum of Care:** Expand access to prevention, harm reduction, treatment, and recovery supports, including culturally specific and youth-focused services.

- **Workforce Development:** Strengthen and diversify the behavioral health workforce through training, incentives, and culturally responsive practices.
- **Policy and Sustainability:** Inform the 2029 BHRN funding allocation process, secure long-term funding, leverage Medicaid waivers to sustain evidence-based interventions.

Through these efforts, Oregon aims to strengthen primary prevention, improve treatment access, expand recovery efforts, reduce substance-related mortality, and create a comprehensive, equity centered behavioral health system that meets the needs of individuals, families, and communities across the state. In the sections that follow, this report will expound on the topics addressed in the introduction: additional detail on substance use and overdose prevalence in Oregon, behavioral health system fragmentation, the integration of the SUD continuum of care, OHA Behavioral Health System investments, the administration of funding, the 2026-2030 integration goals and roadmap, and policy opportunities.

Substance Use and Overdose Prevalence in Oregon

Overall Substance Use Prevalence in Oregon

Substance use disorder refers to the pattern of use of an intoxicating substance leading to clinically significant impairment or distress. Substances commonly classified in instances of substance use disorder include, but are not limited to, commercial tobacco, alcohol, cannabis, cocaine (powder and crack forms), methamphetamine, heroin, hallucinogens, inhalants, and the misuse of prescription pain relievers.

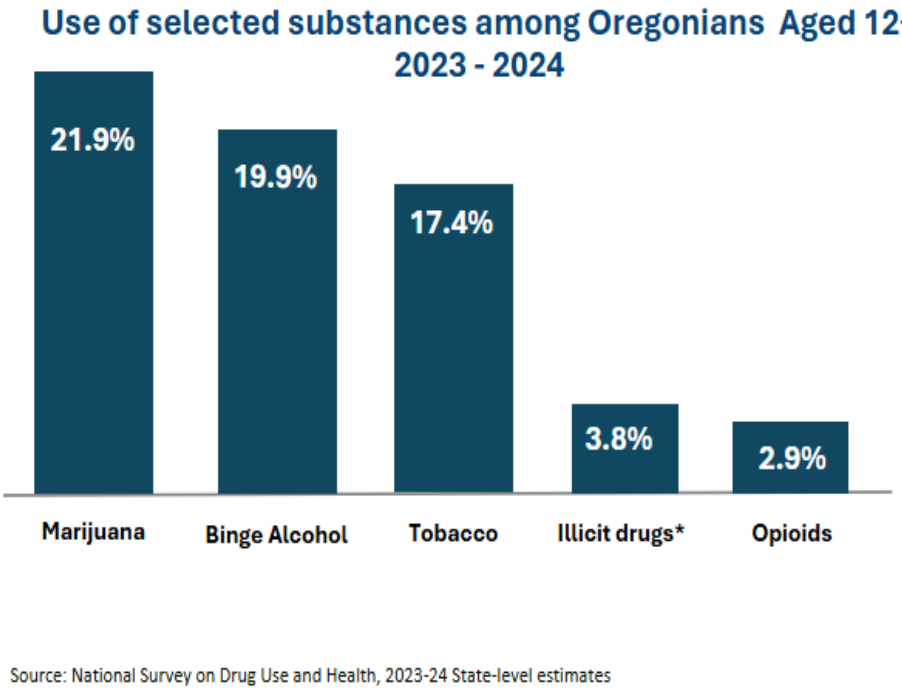

Table 1: Selected Substances Among Oregonians Aged 12+ (2023-24)

Substance use and substance use disorders (SUD) are a major population health problem, impacting the health of individuals, families, workplaces, schools, healthcare, and social service systems. Oregon's overall substance use disorder rate (21.6%) is significantly higher than the national rate (16.5%) with 12.7% of Oregon's population having a substance use disorder (2022-23 National Survey on Drug Use and Health/NSDUH) (see Table 1).

Alcohol Use Disorder (AUD) affects more than one in ten residents, and overdose deaths from stimulants and/or opioids, while declining, disproportionately impact communities of color, tribal communities, rural areas, and individuals experiencing poverty, housing instability, and co-occurring mental health conditions. Given current barriers in accessing screening and treatment services, this rate may be even higher. Stigma and discrimination, criminalization, and treatment siloes foster additional barriers to accessing prevention and effective treatment in Oregon (OHSU-PSU 2022 SUD Gaps Analyses).

Approximately 2.0% of Oregon's population has an Opioid Use Disorder (OUD) (2023-2024 NSDUH). An estimated 54,000 Oregonians ages 12 and older have used methamphetamine within the last year. People who use drugs may use a combination of multiple substances (polysubstance use), including opioids and methamphetamine,

to blunt the effects of one drug with another. Polysubstance use is one of the greatest risk factors for fatal overdose in Oregon, accounting for more than half (62.2%) of overdose deaths in 2024 (Oregon State Unintentional Drug Overdose Reporting System). See Table 2.

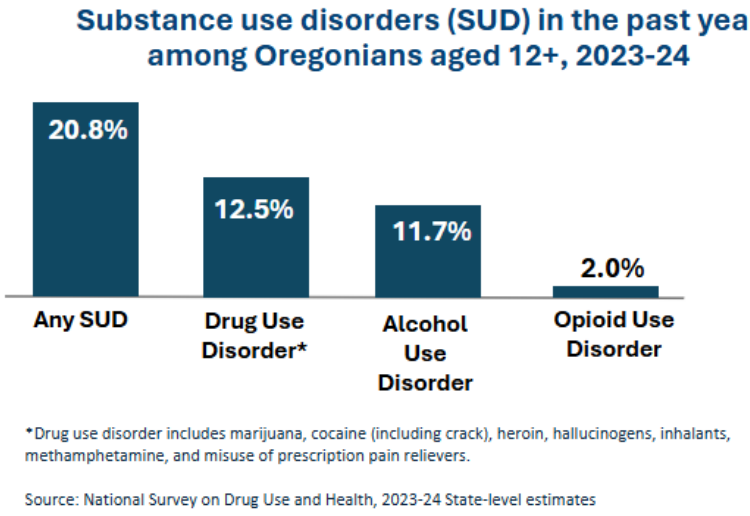

Table 2: Substance Use Disorders in the past year among Oregonians aged 12+ (2023-24)

Commercial Tobacco Use

Commercial tobacco consumption in Oregon is at an all-time low, mirroring national trends; however, tobacco use is still the #1 leading cause of preventable death in Oregon. Among 11th graders in Oregon, current tobacco use is nearly 10%. E-cigarettes are the most popular among 11th graders (decreasing from 23% in 2019 to 9% in 2024) (Behavioral Risk Factor Surveillance System-(BRFSS).

Excessive Alcohol Use/Alcohol Use Disorder (AUD)

Alcohol Use Disorder (AUD) makes up a large portion of overall substance use disorders, with over 1 in 10 Oregonians having an AUD. Oregon has the 8th-highest alcohol use disorder rate in the nation at 11.7% and 19.9% of Oregonians over the age of 12 engaged in binge drinking in the past month (NSDUH State Estimates, 2023-24).

Oregon's alcohol-related death rate has increased by 44% since 2011 and is now the third leading preventable cause of death in Oregon. Alcohol kills more people than all other drugs combined in Oregon (not including tobacco) (Oregon Vital Records,

2011-2023). Alcohol consumption among adults has increased nationally and in Oregon See Table 3); however, binge drinking among Oregon 8th and 11th graders has decreased by over 50% since 2001 (Oregon Healthy Teens & Student Health Surveys).

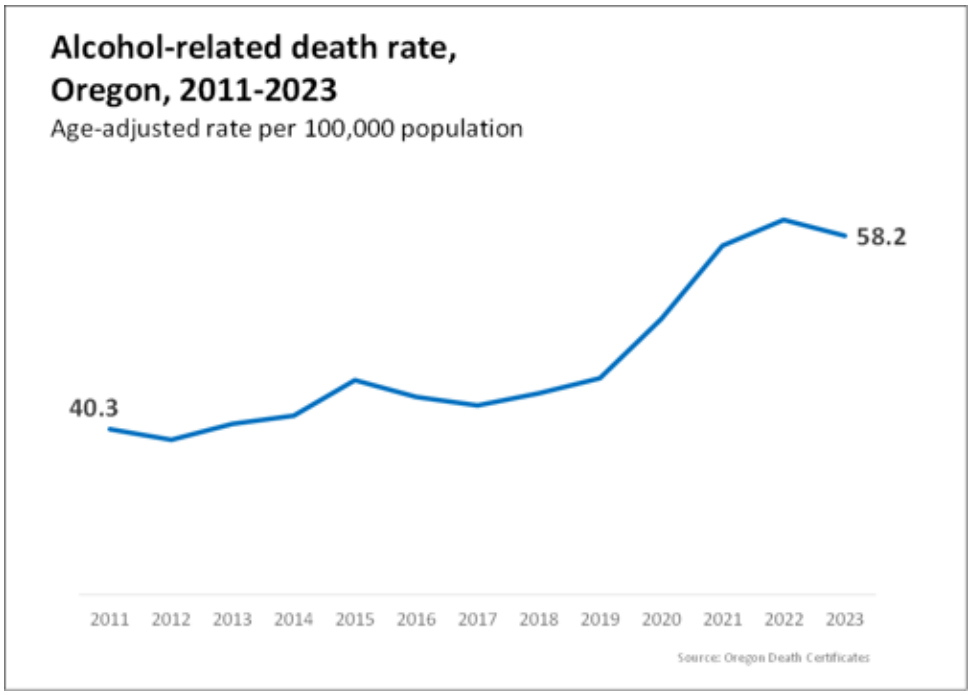

Table 3: Alcohol Related Death Rate, Oregon, 2011-2023

In Oregon, 10.2% of youth ages 12-17 met the criteria for SUD in the last year and 4.0% percent met the criteria for AUD, and 77.0% of those ages 12-17 needing treatment for substance use (alcohol or other drug) received treatment in the last year. For young adults (18-25), 32.0% met the criteria for substance use disorder in the last year and 17.2% met the criteria for alcohol use disorder. Among those in this age group in Oregon classified as needing treatment, 90.5% received substance or alcohol use treatment in the last year (2023-2024 NSDUH).

In 2024, overdose deaths decreased for the first time in Oregon since 2016, with 1,544 Oregonians dying of a drug overdose (a 16% decrease compared to 1,833 deaths in 2023) (See Table 4). Sixty-two percent of Oregon overdose deaths involved multiple substances (polysubstance). Fentanyl and methamphetamine are the most common substances identified in drug overdose deaths, with over 90% of fatal overdoses involving fentanyl, methamphetamine, or a combination of both substances. Alcohol was associated with 10% of all overdose deaths in 2024.

This 2024 decrease in overdose deaths was primarily influenced by a reduction in the number of fentanyl-related deaths. Overdoses involving only stimulants remained stable throughout 2024. While the 2024 decrease in overdose deaths is heartening, Oregon health care systems remain heavily burdened by overdose-related encounters. In 2024, there were 4,193 inpatient hospitalizations associated with a drug overdose and 10,365 overdose-related emergency department visits.

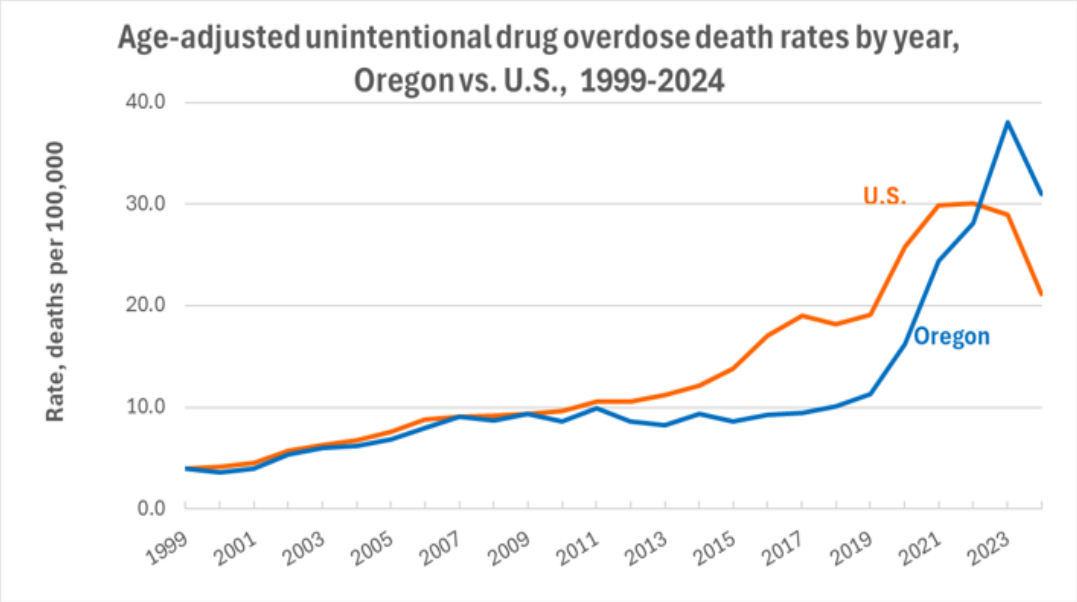

Table 4: Age Adjusted unintentional drug overdose death rates by Year, Oregon vs. US, 1999-2024

At this time, it is unknown if the decreasing overdose trend will continue. The volatility of the illicit drug supply, changes in drug use behaviors, and social, political, and economic factors may all impact substance use trends and overdose rates. In 2025, the federal administration enacted sweeping cuts to national support for harm reduction, substance use disorder treatment, and overdose prevention. It is possible that these cuts will have an impact on overdose rates in Oregon (Opioids and the Ongoing Drug Overdose Crisis in Oregon: 2025 Report to the Legislature, 2026).

Disproportionate Substance Use Related Impacts

Populations disproportionately impacted by illicit drug overdose, excessive alcohol use, and commercial tobacco use in Oregon include young adults (18-34) and adults (35-55) from:

- Non-Hispanic Black/African American populations
- American Indian/Alaska Native (AI/AN) populations

- Communities with high rates of poverty and economic disinvestment, including persons experiencing housing instability and homelessness

Youth and Young Adults

Cannabis is the most commonly used substance among adolescents in the United States. The 2023-2024 National Survey on Drug Use and Health (NSDUH) found that on average across the country, 11.2% of adolescents age 12 – 17 reported cannabis use in the last year, while in Oregon, that number was higher than average at 14.7%. 2024 Student Health Survey data shows that 31.4% of students reported that using cannabis regularly (once or twice per week) was slight or no risk, and 30.6% of students reported that cannabis would be “easy to get” if wanted. As cannabis use becomes increasingly normalized and accessible to Oregon’s youth, there is increasing evidence that cannabis use in adolescents increases the risk of psychiatric disorders, including specifically psychotic and bipolar disorders, and that while these were once thought to be transient and related only to the substance use, the disorders may continue into adulthood (Young-Wolff KC, Cortez CA, Alexeeff SE, et al. Adolescent Cannabis Use and Risk of Psychotic, Bipolar, Depressive, and Anxiety Disorders. JAMA Health Forum. 2026).

The 2023-2024 National Survey on Drug Use and Health (NSDUH) also found that young adults use illicit substances such as cocaine, methamphetamines, or opioids at a significantly higher rate than youth age 12 – 17 (See Table 5). The 2024 Student Health Survey results found that only 7.1% of students reported that these types of illicit substances were reported to be “easy to get.” Oregon’s health data shows that young adults age 18 – 25 are less likely to seek mental health treatment, are more likely to report suicidal ideation and intent, and are more likely to present to a hospital emergency room following an overdose than other age groups (System of Care data dashboard).

Metric	Youth (12-17)	Young adult (18-25)
In the last year:		
Reported using cannabis	14.7%	43.3%
Reported using cocaine	0.3%	5.7%
Reported using hallucinogens	2.5%	12.3%
Reported using methamphetamine	0.2%	0.5%
Reported misusing prescription opioids	1.7%	2.2%
Reported misusing opioids	1.8%	1.8%

Table 5: Proportion of youth (ages 12-17) and young adult (ages 18-25) populations by selected substance use indicators, Oregon 2023-2024 NSDUH survey

Equity Impacts (Overdose)

Black/African American communities and American Indian/Alaska Native (AI/AN) communities continue to have the highest rates of fatal and nonfatal overdoses in Oregon. People identifying as male were more likely to experience a fatal or nonfatal overdose compared to those identifying as female in 2024. Adults 25–34 and 45–54 years old experienced the highest number of fatal and nonfatal overdoses in 2024 (See Table 6).

While opioid deaths decreased for all age groups younger than age 65 in 2023-2024, they increased for older adults (age 65+) by 9% during this time frame. In 2024, 25.6% of older adults who experienced a fatal overdose were houseless and 3% had been recently incarcerated. Stigma, decreased social support, lack of transportation, and limited SUD treatment designed for older adults may also be contributing factors. Older adults have higher rates of opioid prescriptions and co-prescribing of overdose reversal medication is low.

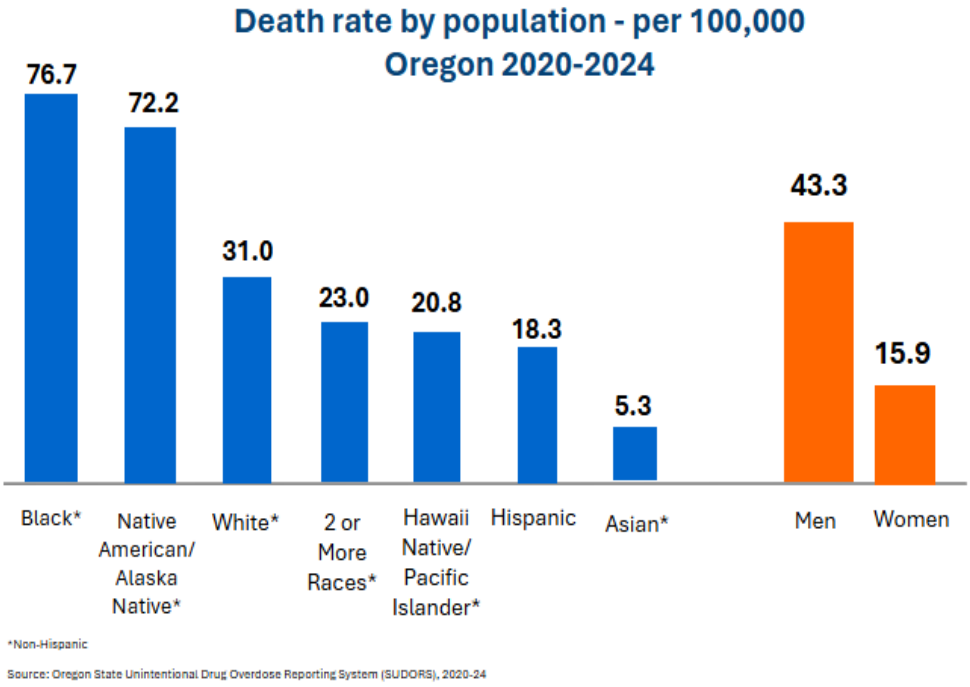

Table 6: Death rate by population – per 100,000, Oregon, 2020-2024

Equity Impacts (Alcohol)

Non-Hispanic Black/African American populations in Oregon have an alcohol-related death rate of 71.7 per 100,000, which is higher than non-Hispanic whites (58.7 per 100,000) (Oregon Vital Records, 2020-2023). The rate of alcohol-related deaths among AI/AN groups (120.2 per 100,000) is also higher than whites. These groups are disproportionately impacted by negative harms from excessive alcohol, despite consumption rates that are lower than whites. Alcohol is disproportionately available for sale in lower-income neighborhoods and systemic racism, discrimination, oppression, toxic stress, and trauma continue to perpetuate health inequities.

Equity Impacts (Tobacco)

American Indian/Alaska Native (AI/AN), Black, Lesbian, Gay, Bisexual (LGB), rural (2020-23 Combined Oregon Behavioral Risk Factor Surveillance System) and lower income (2023 BRFSS) populations have higher rates of tobacco use. Forty percent of all commercial tobacco products are purchased by people with behavioral health conditions (JAMA, 284. 2606-10, 2000) and 27.2% of people with serious mental illness (SMI) use commercial tobacco products (Prevent Chronic Disease, 9:220184, 2022). This use contributes to people with BH conditions who use tobacco producing dying on average 10 years earlier than the general population (Centers for Disease Control and Prevention, 2024).

System Division

Oregon's behavioral health/SUD system is composed of multiple interconnected but often siloed sectors, including:

- Public health and other primary prevention partners
- Culturally specific community-based organizations and Regional Health Coalitions
- School-based programs and interventions
- Substance use disorder treatment providers
- Community Mental Health Programs (CMHPs)
- Coordinated Care Organizations (CCOs)
- Housing and social service systems
- Behavioral Health Resource Networks

- Oregon Tribes and Tribal Programs
- Recovery Support Programs

Likewise, funding for substance use disorder (SUD) treatment is often separated from primary or physical health care because of historical policy and financing structures that treat behavioral health as separate from medical care, and approach substance use and misuse as a moral failing rather than a treatable chronic health condition. This stems from diverse categorical funding streams, regulatory requirements, and benefit designs within Medicaid, Medicare, and private insurance.

System fragmentation across behavioral health, public health, and other regulatory, health and social service sectors creates barriers for people and communities experiencing substance use related harms and limits timely access to and continue across prevention, harm reduction, treatment, and recovery services.

People rarely present with a single need. A well-functioning, integrated system must respond to the full range of supports individuals require, including housing, peer services, and relapse and recovery supports.

This also results in increased reliance on crisis response and emergency departments, increased encounters with the legal system, increased housing instability and homelessness, and lost opportunities for early intervention and prevention.

In 2022, OHA contracted with Oregon Health Sciences University's School of Public Health to complete a SUD Service Inventory and Gap Analysis. Takeaways include:

- *Oregon faces a large system shortfall*. There is an estimated 49% gap in SUD services across the continuum of care (prevention, harm reduction, treatment, and recovery).
- *Capacity is strained.* Most providers cannot meet current demand, with staffing and funding identified as persistent constraints.
- *Oregon has a lack of data about youth services:* Many data sources do not differentiate between the youth and adult systems or collect the age of participants, making it difficult to determine type and level of services provided to youth.
- *There is limited understanding of primary prevention practices and investments* beyond school-based interventions.

Oregon can address this crisis through coordinated implementation of the Alcohol and Drug Policy Commission (ADPC) Comprehensive Plan and the Oregon Health Authority (OHA) Strategic Plan. Without intentional system integration, Oregon will continue to see preventable harms related to substance use and overdose deaths, escalating healthcare costs, and widening health inequities (2023 OSHU SUD Gaps Analysis, 2024 SUD Fiscal Analysis, and ADPC 26-30 Plan).

Based on the findings in this gap analysis, OHA has prioritized funding from federal grants to increase access to treatment, workforce capacity, as well as implementing investment from the legislature to develop provider capacity. This work will be expanded upon as part of the SUD integration strategy: Improving Population Health through an Integrated SUD Continuum of Care.

Improving Population Health through an Integrated SUD Continuum of Care

The OHA Substance Use Disorder (SUD) Integration Report describes a pathway for intentional alignment of programs, funding, data, and workforce to ensure coordinated and accessible services grounded in values of preventing substance use harms, centering people with lived and living experience, harm reduction as a strategy, and local community governance.

To achieve these goals, OHA will broaden the focus from individual providers and services to a comprehensive, well-coordinated, accountable SUD continuum of care. OHA will evaluate the strength of this integrated system through established standards of care across the SUD continuum, which includes tracking of referrals and shared clients but also reviewing overall improvements in population health.

System integration improves outcomes by jointly advancing population-level prevention goals with individual-level engagement, stabilization and linkage to systems of care so that individuals, families and communities experience:

- Universal benefits of primary prevention of substance use
- Faster access to treatment
- Reduced overdose and infectious disease risk
- Improved recovery outcomes

- Reduced healthcare and public safety costs
- Greater equity in service access and outcomes

Alcohol and Drug Policy Commission (ADPC) Comprehensive Plan (2026-2030)

Under the leadership of the Governor appointed Alcohol Drug Policy Commission (ADPC), Oregon's comprehensive 2026-2030 Comprehensive Plan outlines a vision, goals, and strategies for modernizing Oregon's substance use prevention, risk reduction, treatment, and recovery system. This plan is informed by evidence- and tribal-based best practices, with significant input from community partners and the public, including people with lived and living experience and expertise. Behavioral Health has successfully implemented numerous initiatives under its previous strategic direction, achieving measurable progress in system integration and service delivery. Building on this foundation, OHA will now align its work with the Alcohol and Drug Policy Commission's 2026–2030 Comprehensive Plan, ensuring statewide consistency and advancing shared objectives to reduce substance use, improve outcomes, and eliminate disparities.

State Strategic Impact Goals

Impact 1 — Reduce Substance Use Disorders: Reduce the percentage of Oregonians with SUD through prevention, early intervention, treatment access, and recovery support expansion.

Impact 2 — Reduce Substance-Related Mortality: Reduce deaths related to alcohol, tobacco, opioids, and other drugs through prevention, harm reduction, and treatment access expansion.

Impact 3 — Reduce Health Inequities: Address disparities driven by structural inequities, stigma, discrimination, and unequal access to resources.

Impact 4 — Reduce Economic Burden: Reduce the overall cost of substance use to the state through prevention, early treatment, and integrated system design.

ADPC strategies specific to youth are closely coordinated with the Oregon System of Care Advisory Council (SOCAC). SOCAC priorities include Improving access to coordinated, integrated, and community-based systems of care; Promoting the co-creation of equitable policy and systems by providers and the youth and families they

serve; Creating sustainable infrastructure that increases the System of Care's capacity and credibility; and transforming the systems that serve children, youth, and families.

The BHRN Program regularly collaborates with ADPC staff and will use the ADPC comprehensive plan to inform and drive the next funding cycle in 2029. In addition, the ADPC's Executive Director is a member of the Oversight and Accountability Council, the advisory group to BHRN funding and funding priorities. BHRN services align well with the priorities of ADPCs plan by funding statutorily required services: screening, comprehensive behavioral health needs assessment, SUD treatment, peer support, housing, and harm reduction.

OHA's SUD teams regularly collaborate with the ADPC staff, including acting as subject matter experts on various subcommittees. This partnership ensures statewide consistency and focuses on shared priorities — implementing primary prevention initiatives, expanding access to care, reducing fragmentation, improving outcomes, and addressing health inequities. BHD has already begun to integrate ADPC strategies into its funding models, county Local Plans, and program operations, while collaborating through ADPC committees, aligning metrics, and jointly reporting progress. Together, these efforts will create a coordinated, person-centered system that advances Oregon's vision for a recovery-oriented continuum of care.

Oregon Health Authority's (OHAs) Role and Investments in the System

Behavioral Health Division

OHA's Behavioral Health Division (BHD) provides statewide leadership through:

- Policy and regulatory standards
- System oversight and accountability
- Funding for evidence-based harm reduction, treatment and recovery programs, stabilization and housing supports, ensuring a continuum of care across the state.
- Equity and culturally responsive system transformation
- Data and performance monitoring
- Cross-agency and cross-sector coordination

Behavioral Health Resource Networks (BHRN)

Measure 110 (M110) is a first-in-the nation program that dramatically expands access to substance use recovery and harm reduction services through flexible funding and Behavioral Health Resource Networks (BHRNs). Forty-two BHRNs, one in each Oregon county and Tribe, provide free comprehensive low barrier SUD treatment and supports, like housing and peer services. Oregon Cannabis Tax revenue covers services not paid by Medicaid or costs of care for un/under-insured individuals. BHRNs provide services covering screening and assessments, SUD Treatment, peer support services, harm reduction, and housing.

OHA's BHRN Program allocates grant funds to BHRNs and is responsible for reporting on BHRNs activities and outcomes. In total, OHA funds 234 grantees and 11 Oregon Tribal grants. The BHRN Oversight and Accountability Council (OAC) advises OHA on funding allocations and priorities. The BHRNs provide a single point of access to six core service areas, expanding access to treatment and support across the state. BHRNs elevate the voices of people with lived experience to guide program design. The BHRN program also prioritizes treatment and services for communities most impacted by the war on drugs and culturally specific programming.

Some BHRNs are small; several have 3-4 providers, and one county has just one provider. Other BHRNs are large; a few counties have multiple providers. OHA's BHRN program has been working with the providers in the new grant cycle (which began on July 1, 2025) to ensure the providers in each county are collaborating, coordinating, and creating a true network of SUD services for Oregonians who need them.

When a network is stable and sturdy, it will expand to include all SUD providers. The BHRNs are creating a foundation of a well-networked system of care, into which other providers should integrate. This process will allow for more seamless care across Oregon.

The integration goals and process will:

- Align with the priorities of the Alcohol and Drug Policy comprehensive plan,
- Inform the 2029 BHRN funding process, and

- Help build the SUD integration roadmap (required by the most recent M110 Secretary of State performance audit), which will include timelines, assigned accountability, and key integration deliverables.

Adult Behavioral Health (ABH)

OHA's Adult Behavioral Health (ABH) Unit focuses on promotion, treatment, and recovery for adults impacted by substance use and mental health disorders. The ABH includes multiple specialized units, including residential, outpatient, addictive disorders, and forensic behavioral health services. SUD subject matter experts are integrated into each of these units to ensure internal integration and coordination.

ABH is responsible for four main areas of strategic planning:

- Continuum of care- maintain and expand statewide SUD treatment capacity to increase treatment access for individuals.
- Harm Reduction – Expand, strengthen, and increase access to lifesaving evidence-based resources and services in Oregon.
- Decrease alcohol and other drug-related morbidity and mortality
- Workforce capacity building (in partnership with the Behavioral Health Incentives Workforce team)

ABH also develops policy, rules, and process to support implementation of these strategies for civil commitments, under the Psychiatric Security Review Board and under Aid and Assist orders.

Child, Family, and Lifespan Behavioral Health (CFLBH)

The CFLBH unit champions effective and efficient statewide behavioral health services, supports and safety for Oregon's children, young adults, and their families, incorporating System of Care principles, developmental science, and trauma informed approaches. CFLBH strives to increase resources and services for youth and young adults, ensuring that every youth gets high quality services, regardless of location, race, ethnicity, disability, or socio-economic status.

CFLBH prioritizes efforts and investments across the following five programs areas:

- Continuum of care: Maintain and expand SUD residential capacity

- Partnerships: Increase SUD services to schools and youth helping agencies with prevention, early intervention and treatment and recovery supports
- Workforce: Increase supports for the youth SUD workforce
- Data modernization: Centralize youth SUD data and referral information
- Policy/ Youth & Family voice: Continue collaboration with youth, young adults and family members to center community voice

Behavioral Health Investments (BHI)

The Behavioral Health Investments (BHI) team administers legislatively appropriated funding for the development, or expansion of behavioral health capacity in Oregon. Since 2021, BHI has received roughly $415M in funding to support these investments, including two Senate Bills totaling $32M specifically earmarked to increase SUD residential treatment facilities, withdrawal management facilities, and recovery housing capacity throughout the state.

As of February 2026, these Legislative investments have supported the development of hundreds of new beds, including:

- SUD Residential Treatment: 213 new beds, with 380 additional beds in development.
- Withdrawal Management: 50 new beds, with 103 additional beds in development.
- Recovery Housing: 260 new beds.

Behavioral Health Workforce Incentives Team

The Behavioral Health Workforce Incentives (BHWI) Team oversees the distribution of Legislative funding to increase capacity of the behavioral health workforce, including the mental health and SUD workforce. Overall goals include:

- Increase behavioral health system capacity embeds practices and promotes principles of health equity, cultural responsiveness, de-stigmatization of services, restorative healing. and community empowerment.
- Develop and invest in a culturally specific workforce and increase access to culturally responsive services and interventions.

- Engage communities through shared decision-making to build structures, processes, resources and supports for increasing recruitment and retention of a culturally specific behavioral health workforce.

988 and Behavioral Health Crisis

The 988 & Behavioral Health Crisis System (988 BHCS) offers a no-barrier, statewide continuum of care for individuals experiencing behavioral health crises, including those related to substance use. Three pillars inform the system: someone to call (988), someone to respond (mobile crisis teams), and a safe place for help (crisis stabilization centers). Oregon's approach aligns with the Crisis Now and Mobile Response and Stabilization Services (MRSS) models, emphasizing equity, interoperability, and workforce readiness. Since 2022, monthly counts of SUD-related calls to 988 have seen steadily increased (*Oregon Health Authority (OHA); preliminary population estimates from U.S. Census Bureau).*

Integrating substance use prevention and response in 988 BHCS is a core priority, including developing protocols and referral resources for 988 contacts involving substance use crises in collaboration with the Behavioral Health Resource Networks (BHRNs) and 988 Lifeline centers. Mobile Crisis Intervention Services (MCIS) and MRSS teams receive training on substance use disorder (SUD) response, including self-paced modules to improve de-escalation and linkage to treatment. The Behavioral Health Crisis System Advisory Committee (BHCSAC) provides input to improve SUD crisis response. These efforts ensure that individuals in SUD crisis are connected to appropriate treatment and recovery supports through warm handoffs and post-response follow up.

Public Health Division

OHA's Public Health Division (PHD) administers OHA's Alcohol and Other Drugs (AOD) Prevention/Shared Risk and Protective Factors Alignment Initiative, which coordinates programs across tobacco, alcohol, overdose, and opioid and other drug prevention; adolescent and school health, family and child health; and Women Infant and Children's (WIC) Program.

PHD-Health Promotion and Chronic Disease Prevention (HPCDP)'s Tobacco and Alcohol and Other Drug Prevention and Education Programs (TPEP and ADPEP) work to reduce tobacco use, excessive alcohol use, and associated chronic disease

in Oregon through 36 counties, eight Regional Health Equity Coalitions, and over 150 community based and non-profit agencies and state-wide associations.

PHD-Injury and Violence Prevention (IVP) address a wide range of injury and violence prevention issues including prescription and illicit opioids and other drugs, suicide prevention, and community violence initiatives. IVP funds 11 regional overdose coordinators to implement evidence-based overdose prevention strategies at the local level, administers the State Unintentional Drug Overdose Reporting System (SUDORS) and Oregon's Prescription Drug Monitoring Program (PDMP), and coordinates cross-agency operational and planning for the Oregon Overdose Settlement Prevention, Treatment and Recovery (OSPTR) Board and related funding investments.

Medicaid Division

The Medicaid Division administers the Oregon Health Plan (OHP), Oregon's medical assistance program. OHP provides comprehensive health coverage, including mental health and substance use disorder (SUD) services and supports. Nearly 90% of individuals served through OHP are enrolled in one of Oregon's 15 managed care plans, or a Coordinated Care Organization (CCO). The remainder are enrolled in fee-for-service, or the open card program.

Covered SUD services include crisis intervention, outreach and engagement, case management and care coordination, outpatient and intensive outpatient treatment, medication-assisted treatment (MAT), residential treatment, withdrawal management, and Community Integration Services (CIS).

Tribal Affairs Division

The Tribal Affairs Division works with Oregon's nine federally recognized Tribes and the Urban Indian Health Program to fund and strengthen mental health and substance use services that meet each community's cultural needs. They provide dedicated funding for tribal mental health programs, supporting initiatives like early intervention, mental health promotion, school-based counseling, crisis services, jail diversion, supportive housing, peer-delivered care, and wraparound services for children and youth with behavioral challenges. These efforts aim to increase access and reduce stigma by offering services rooted in tribal cultural values and traditions.

They also manage funds specifically allocated to tribal services from various sources including Oregon's Opioid Settlement. This funding supports culturally appropriate prevention, treatment, and recovery services, including training Tribal Certified Alcohol and Drug Counselors and Prevention Specialists, developing sober living housing, mobile crisis units, peer support, and youth suicide prevention programs. Through this sustained investment and workforce development, the division ensures that tribal communities can deliver effective, culturally aligned behavioral health care on their term.

Streamlining Siloed Administration of Funding

OHA manages a wide portfolio of SUD revenue sources, each with unique reporting, cadence, staffing, and fiscal and administrative guidelines. Many include state statutory or federal requirements that conflict with OHA's goal of reducing administrative burden. These categorically funded programs make collaboration and partnership across OHA challenging. It also creates challenges for clients, who may experience bifurcated care; providers, who manage multiple contracts, administrators, requirements, and reporting; and staff, who lack connection and understanding of SUD systems and OHA's larger role in promoting health and wellness and reducing health inequities.

This also makes it more difficult for OHA to effectively monitor funding as the same provider may receive multiple OHA grants or contracts. The lack of a predictable and streamlined mechanism to distribute funds also negatively impacts local providers who must manage multiple contract/grant administrators and a variety of reporting requirements that can be duplicative.

One clear action by OHA is the streamlining of processes to reduce provider burden through a County Financial Assistance Agreement (CFAA) modernization process.

The following highlights: BHRN Program Integration, Rural Health Transformation, SUD 1115 Waiver, and Certified Community Behavioral Health Clinics, represent immediate efforts to align funding decisions and improve the administrative functions of managing those funds.

BHRN Program Integration

Currently, the BHRN Program operates separately from other BHD SUD units, in part informed by the 2020 Ballot Measure that elevated the need for independent oversight by the M110 Oversight and Accountability Council. While BHRN and other BHD SUD managers collaborate regularly, the BHRN Program staff historically work in isolation to facilitate funding decisions, conduct program administration, and provide technical assistance and training. To integrate the BHRN with other BHD programs, leadership of the various BHD SUD programs, including Child and Family, have:

- Completed an inventory/crosswalk of providers and funding streams to decrease duplication and increase opportunities for collaboration.
- Held two all-day SUD staff retreats to create new ways of integrating and working together, including cross training and building relationships across teams.
- Conducted a survey to identify learning needs. Proposed, planned, and launched topical and regional OHA SUD teams that will meet regularly and collaborate. Topical teams include residential treatment, opioid treatment programs, youth, peers, harm reduction, transitions between levels of care, veterans, and older adults. These teams will:
    - Identify challenges and opportunities in each County
    - Ensure on-the-ground provider collaboration
    - Work collaboratively on specific projects, like legislative asks, policy option packages, program and policy decisions, development of new programs, etc.
    - Troubleshoot administrative and programmatic barriers to integration

Rural Health Transformation Grant

In December 2025, the federal government awarded the State of Oregon a 1-year, $197.3M Rural Health Transformation Grant (RHTG) to strengthen rural health care. RHTG will increase healthcare access, advance chronic disease management and prevention, expand and sustain the healthcare workforce, and expand the use of health technology and data in Oregon's rural and remote communities. Direct allocation to Oregon's Nine Federally Recognized Tribes is also included.

Through the RHTG, OHA will amplify existing OHA SUD initiatives by:

- Integrating standardized screening tools and early intervention practices into schools
- Increasing access to community naloxone
- Implementing telehealth-based ambulatory detox programs
- Increasing availability of remote medication assisted treatment
- Partnering with EMS providers to initiate buprenorphine after individuals experience overdose reversals

By mid-2026, OHA will rapidly distribute the funding via two sets of awards. Additional federal funding may be secured in future years through a competitive process.

SUD 1115 Waiver

The Medicaid Division works with BHD to administer Oregon's current SUD 1115 Medicaid Demonstration Wavier (covering the time frame of April 8, 2021-March 31, 2026). In 2025, the State applied to renew waiver authority for an additional five years and is completing the application review and negotiation process with the Centers for Medicare & Medicaid Services (CMS). The waiver is projected to bring in over $87M of federally matched funds to Oregon over the course of the initial five-year waiver.

This renewal will sustain and build upon Oregon's progress in developing a comprehensive, statewide continuum of care for individuals with SUD by:

- Authorizing federal Medicaid reimbursement for services provided in residential treatment facilities with more than 16 beds, including Institutions for Mental Disease (IMDs), expanding access to clinically appropriate levels of care for individuals with SUD.
- Expanding access to Community Integration Services (CIS) by Oregon Health Plan (OHP) members with SUD, include housing and employment supports for individuals transitioning from institutional and residential treatment settings into stable, community-based living environments.
- Operationalize the $5,000 lifetime Community Transition Services (CTS) benefit. This benefit supports individuals as they transition from residential settings to independent housing in their communities.
- Provide Contingency Management (CM) services to individuals diagnosed with SUD, an evidence-based intervention to improve treatment

engagement and retention and complementing existing SUD treatment modalities.

OHA has made additional system-level investments to strengthen the SUD provider delivery system by codifying waiver flexibilities in OARs, adopting a consistent statewide ASAM (American Society of Addiction Medicine) framework, and improving provider licensing, certification, and staffing standards to support a person-centered, recovery-oriented model of care. Additionally, the OARs now outline the qualifications for providers offering integrated co-occurring disorder services.

An October 2022 assessment conducted by Oregon Health & Science University and Portland State University identified opportunities to further enhance SUD service delivery statewide. In response, Oregon increased provider reimbursement rates, established ASAM 3.7 residential treatment capacity, and expanded services beyond integration supports to include crisis intervention and early recovery pathways. Collectively, these efforts have strengthened Oregon's continuum of care and contributed to measurable reductions in emergency department utilization statewide.

Certified Community Behavioral Health Clinics (CCBHC)

In 2017, Oregon participated along with seven other states in the first Certified Community Behavioral Health Clinic (CCBHC) Medicaid demonstration program. CCBHCs offer integrated, holistic mental health and substance use treatment, along with crisis services, case management, habilitative services, physical health screening, peer-delivered services, and care coordination.

SUD-specific service requirements include: co-occurring disorder staff training requirements, prescribing of buprenorphine and other FDA-approved medications used to treat opioid, alcohol, and tobacco use disorders (directly or through close coordination with providers in the community), employed or contracted staff who are licensed or certified substance use treatment counselors or specialists, and written protocols establishing care coordination expectations with community substance use providers, inpatient and residential providers and other community partners and walk-in substance use crisis stabilization services.

CCBHCs must offer services to all, regardless of ability to pay. CCBHC's provide care to people in the community, "meeting people where they are," including homes, hospitals and EDs, jails, shelters, schools, among others. CCBHCs are required to

collect and use data to inform services and to conduct continuous quality improvement. CCBHCs must also work with a variety of community partners—including housing services, health centers, hospitals, inpatient psychiatric facilities, jails, courts and juvenile justice systems, local health department, local System of Care bodies, schools, Veterans Affairs facilities—to develop a Community Needs Assessment that informs staffing and service delivery.

CCBHCs utilize an innovative payment model—known as the Prospective Payment System (PPS) —to support this robust model of care, in addition to ensuring clinics have sufficient administrative resources to oversee quality and data collection. The PPS provides a daily payment to clinics, based on their actual costs, regardless of the number or type of services they provide—incentivizing the provision of services that clients need, where they need them.

Presently, Oregonians have access to 12 CCBHCs across 14 counties. With the passage of HB 4002 in 2024, OHA is now able to expand the program statewide, through an update to the Medicaid State Plan. OHA is currently securing final approval for the State Plan Amendment (SPA) for CCBHCs.

2026-30 SUD Integration Goals and Roadmap

OHA is working to better connect the Behavioral Health Resource Network (BHRN) with the larger behavioral health system by aligning with the ADPC strategic plan, SOCAC guidance, and OHA's priorities. This includes improving data sharing, strengthening the workforce, and bolstering treatment and recovery supports so the system functions more consistently and effectively for communities across Oregon.

To meet the requirements outlined in the December 2025 Measure 110 Secretary of State's performance audit, OHA is developing a roadmap for BHRN and SUD program integration. The roadmap will include timelines, assigned accountability, and key deliverables. The roadmap is due by December 31, 2026. The work is being led by an assigned project manager who is responsible for aligning timelines, leading and facilitating workgroups, and ensuring deadlines are met.

An implementation roadmap will provide a framework that guides how OHA will integrate the BHRNs into Oregon's broader SUD continuum of care. It will outline high level timelines for major integration milestones, delineate agency and program level

accountability, and identify key deliverables across data and information sharing, workforce development, funding alignment, and continuum of care strengthening. This roadmap will serve as OHA's operational blueprint by coordinating workgroups and establishing decision making structures, sequencing activities, and ensuring transparent progress tracking. By defining who is responsible for what, when each component will be completed, and how outcomes will be measured, the roadmap will ensure an organized, consistent, and transparent approach to system integration that supports OHA's goals for a coordinated, equitable, and effective SUD system of care.

Data and Information Sharing

Overall Goal

Integrate data systems supporting care coordination and population health monitoring and improvement efforts.

Background

OHA's Resilience Outcomes and Data Submission (ROADS) system standardizes behavioral health data collection, replaces outdated platforms, and eliminates duplicative reporting, enabling agencies statewide to track and report on mental health, addiction, crisis, and involuntary services. ROADS focuses on tracking outcomes rather than aggregated service counts, helping to evaluate client demographics, monitor treatment effectiveness, support quality improvement, and meet federal and state funding requirements. The State Opioid Response (SOR) Grant, Overdose 2 Action Grant, and SUPTRS Block Grant, among other major funding sources, also collect federally required data, and population level prevalence data is collected and analyzed through public health surveillance and epidemiologic activities.

Workforce Development

Overall Goal

Strengthen and expand a cross-trained workforce supporting co-occurring care and culturally responsive services.

Background

Over the last decade, Oregon has made historical investments to develop and retain a skilled and diverse SUD workforce to meet statewide primary and overdose prevention, harm reduction, treatment, and recovery support needs. HB 2235 produced two key legislative reports (published in 2025) focusing on 1) recommendations for incentivizing the workforce and 2) recommendations for legislative actions and policy change. These reports continue to inform agency program and policy decisions that will improve recruitment and retention of the publicly financed behavioral health workforce. Key Strategies:

- Expand workforce capacity to better serve older adults and veterans and their families.
- Partner with ODHS to sponsor trainings and workforce development activities.
- Participate in development of the Be Sensitive, Brave SUD curriculum.

Strengthening SUD Continuum of Care and Supports

Overall Goal

Standardize expectations for prevention, harm reduction, treatment, recovery, and withdrawal management services statewide**.** Expand and sustain network of available services and supports.

Background

To improve access to care and outcomes, OHA has strategically invested in expanding harm reduction, treatment, and workforce capacity. Primary investments to address stimulant and opioid use, misuse, and disorders have come from Federally funded grants. This expansion has included increasing capacity for treatment, harm reduction, and recovery supports.

Recent efforts have focused on reducing overdose deaths and expanding treatment access. Oregon opened two new Opioid Treatment Programs in rural areas (Springfield and Pendleton) and trained over 200 providers through Project ECHO to improve buprenorphine prescribing and care for high-risk patients. Housing-linked treatment programs were funded in rural communities, and naloxone distribution expanded statewide—eight counties received funding for law enforcement training, Lane County distributed 1,700 doses reversing 121 overdoses, and five counties

trained 927 individuals, resulting in 331 treatment referrals. All nine Federally recognized Tribes and Oregon's Urban Indian Program are implementing Medication-Assisted Treatment (MAT) models. Additionally, partnerships with corrections introduced peer mentor training and connected incarcerated individuals to treatment and MAT upon release.

Oregon expanded treatment access and workforce capacity through several initiatives. Twenty-three new rural SUD providers now qualify for the National Health Service Corps loan repayment program, supporting recruitment and retention; seven also received federal opioid grants to implement and expand Medication-Assisted Treatment (MAT) and wraparound services. A new Opioid Treatment Program opened in Seaside, addressing high overdose rates on the North Coast. MAT access was expanded across non-OTP providers in Southern, South Central, and Eastern Oregon, and two tribes now offer MAT directly through tribal behavioral health programs. Oregon also sustained jail-based buprenorphine programs in Yamhill County, improving treatment engagement after release.

Fostering Integration Across the SUD Continuum of Care

Prevention

Overall Goal

To prevent substance use disorders before they start by strengthening community supports, reducing harm, and promoting health and well-being across Oregon.

Background

Oregon has taken a public health approach to substance use disorders, seeing them not as criminal issues, but as preventable health challenges that affect whole communities. Prevention services are primarily administered through the Oregon Health Authority's Public Health Division, which uses education, data, and community-based strategies—like school programs, public awareness campaigns, and harm reduction services.

Expanding Harm Reduction

Overall Goal

By 2030, strengthen and expand lifesaving, evidence-based resources, and services to reduce overdose deaths and prevent infectious disease.

Background

Save Lives Oregon (SLO) was formed in 2020, as a response to the historical flooding of fentanyl in the illicit markets at the height of Oregon's overdose crisis. Led by the Oregon Health Authority and a coalition of diverse community organizations, SLO provides education, training, and lifesaving supplies to organizations and Tribal communities. SLO conducts an annual survey of participating organizations and hosts a monthly Learning Collaborative covering a wide range of topics and are offered in both Spanish and English.

Expand Treatment

Overall Goal

Expand the statewide SUD treatment system to increase treatment access for individuals with substance use disorder.

Background

Oregon includes comprehensive coverage for substance use disorder (SUD) treatment—including alcohol, opioid, and stimulant misuse—without requiring prior authorization or referrals under the Oregon Health Plan. Covered services encompass screening, assessment, medically monitored withdrawal management, outpatient and residential treatment, individual/group/family counseling, and medication-assisted treatment. Beneficiaries can access care through Coordinated Care Organizations (CCOs) and community mental health programs, with coverage extending to peer-delivered supports, home- and community-based services.

All SUD treatment programs in Oregon offer services and supports for alcohol use disorder in addition to treatment for other drugs. Some offer specialty services for OUD (such as methadone treatment) or stimulant use disorder (such as contingency management) or treatment for gambling disorders. Problem gambling and stimulant use—including cocaine, methamphetamines, and non-prescribed ADHD

medications—are strongly correlated. Research indicates stimulant users experience problem gambling at rates up to three times higher than non-users (Journal of Gambling Studies, 32(3)2016). Addressing stimulant use and gambling together can significantly improve recovery outcomes and reduce relapse risk.

In 2025-2026, Oregon Opioid Settlement Prevention, Treatment, and Recovery Board (OSPTR) allocations increased access to opioid use disorder (OUD) treatment by establishing medication units in The Dalles, Redmond and Klamath Falls. This expansion brings crucial access to methadone and other FDA approved OUD medication to Oregonians along US Highway 97, Central Oregon, and populations from the Washington border to the California state line. OHA and OSPTR continue to collaborate in opening eight more OTP medication units on the Oregon Coast, the Willamette Valley, Northeastern Oregon, and the Portland metropolitan area in 2026.

OHA also has plans to increase access to Contingency Management for Substance Use Disorders across the state (by June 2020).

Sustain and Expand Recovery Support Services

Overall Goal

Sustain & expand the statewide recovery support services framework for individuals with substance use disorder.

Background

In June 2024, the Oregon Opioid Settlement Prevention, Treatment & Recovery (OSPTR) Board approved a $13.08 million allocation to expand access to six Recovery Community Centers (RCCs) and recovery housing in high-need, rural and remote areas across the states. In February 2026, OSPTR provided an additional $13 million to address a funding gap for Behavioral Health Resource Networks resulting from cannabis revenue shortfalls from July 2026 – June 2027. Oregon’s State Opioid Response Grant-4 increases access to culturally specific services and recovery wellness programs, and OHA also funds a SAMHSA recognized Recovery Café model in Medford.

Policy Opportunities to Address System Gaps

OHA recommends the following policy, program, and regulatory strategies to address current and anticipated gaps in Oregon's SUD Continuum of care:

- Ensure critical, life-saving evidence-based interventions are supported through on-going operational funding, not limited one-time, pilot, or discretionary grant funding.
- Pursue Medicaid reimbursement, Medicaid Waiver, and state plan options to support complementary interventions such as peer assisted telemedicine services for HIV/STI, Hepatitis C, mental health and MOUD, and peer-delivered contingency management.
- Maximize the Substance Use Prevention Treatment and Recovery Services (SUPTRS) Block Grant to support integration, innovation and direct prevention and treatment services and supports to individuals across the lifespan.
- Secure long term, sustainable funding for Save Lives Oregon.
- Secure long term, sustainable funding for Oregon's Behavioral Health Resource Networks.
- Stabilize investments in Nurture Oregon, to ensure SUD treatment and recovery supports are available to pregnant and parenting people with SUD in Oregon.
- Increase investments in primary and school base prevention of substance use, currently 6.9% of the total behavioral health investments in Oregon.
- In coordination with the Oregon Liquor and Cannabis Commission (OLCC), maintain Oregon's state control of distilled spirits, aligned with national best practices and policies to prevent excessive alcohol use at the population level.
- Reduce exposure to alcohol and tobacco marketing and availability through retail outlet density and hours of sale, aligned with national best practices and policies to reduce access to youth.
- Maintain Nurture Oregon, to ensure SUD screening, treatment, care coordination, and recovery supports are available to pregnant and parenting people with SUD in Oregon.

- Ensure compliance with federal CARA/CAPTA requirements by fully implementing a SUD Safe Plans of Care referral system in Oregon.
- Stabilize the Electronic Surveillance System for Early Notification of Community-Based Epidemics (ESSENCE) to ensure continued availability of timely ER data.
- Review current restrictions on Veteran Services Funds and conduct a study assessing the current service landscape with recommendations for improvement.
- Repeal ORS 430.590 to remove barriers that limit infrastructure for treatment of severe OUD given lack of empirical evidence that placement of OTP near schools, or any other business entities, increases crime or other type of anti-social activity.
- Mitigate barriers for people with a DUII charge who also possess an Oregon Medical Marijuana Program (OMMP) card, along with court approval, to regain driving privileges.
- Modernize the financing mechanism for the Ignition Interlock Device (IID) program jointly administered by OHA and the Oregon State Police (OSP) to address ongoing funding gaps and ensure compliance with statutory and administrative requirements.
- Continue to innovate in braiding and coordinating funding across behavioral health, Medicaid, public health, and housing.

OHA is committed to respond to legislative requests, reporting to the legislature as statutorily required, providing objective bill analysis using subject matter expertise to assess community and equity impacts, submit LCs and POPs to address high priority needs, align investment with Oregon's SUD integration efforts, and increase the overall health outcomes of the individuals, families, and community.

Conclusion

OHA's efforts to strengthen the Behavioral Health Resource Networks and align them with broader system priorities reflect a comprehensive approach to improving behavioral health outcomes for all Oregonians. By advancing integrated data systems, expanding and supporting a diverse and culturally responsive workforce, and reinforcing a full continuum of prevention, treatment, harm reduction, and

recovery services, OHA is building a more coordinated, equitable, and effective behavioral health system. These ongoing investments—grounded in community partnership, federal and state funding alignment, and evidence-based strategies—are designed to ensure that every Oregon community has access to consistent, high-quality care. As OHA deepens collaboration across programs and partners, it continues to move the state toward a more resilient, person-centered system where individuals and families can access the support they need to thrive.

Resources

Resources Consulted and Key Reports

2026-2030 Alcohol & Drug Policy Commission (ADPC) Comprehensive Plan

Oregon Substance Use Disorder Services Inventory and Gaps Analysis. OHSU-PSU School of Public Health, Alcohol and Drug Policy Commission, and OHA (2022)

Oregon State Unintentional Drug Overdose Reporting System, 2023-2025

Oregon Vital Records, 2011-2023

Oregon Health Authority, Public Health Division. Opioids and the Ongoing Drug Overdose Crisis in Oregon: 2025 Report to the Legislature. Portland, OR. January 2026.

2023-24 National Survey on Drug Use and Health (NSDUH)

Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention

Oregon Health Authority, Public Health Division. Opioids and the Ongoing Drug Overdose Crisis in Oregon: 2025 Report to the Legislature (January 2026)

2023 Summary Report, Overdose/Polysubstance Use Regional Listening Sessions, Oregon Health Authority, Behavioral Health Division and Public Health Division

2024 Overdose/Polysubstance Use Culturally Specific Listening Sessions Summary Report, Oregon Health Authority, Behavioral Health Division and Public Health Divisions

Young-Wolff KC, Cortez CA, Alexeeff SE, et al. Adolescent Cannabis Use and Risk of Psychotic, Bipolar, Depressive, and Anxiety Disorders. JAMA Health Forum. 2026).

Loretan CG, Wang TW, Watson CV, Jamal A. Disparities in Current Cigarette Smoking Among US Adults with Mental Health Conditions. Prev Chronic Dis 2022;19:220184

"People with Behavioral Health Conditions Experience a Health Burden From Commercial Tobacco," Centers for Disease Control and Prevention, May 2024

Karen Lasser, MD; J. Wesley Boyd, MD, PhD; Steffie Woolhandler, MD, MPH, Smoking and Mental Illness: A Population-Based Prevalence Study, Journal of the American Medical Association, 284. 2606-10, 2000

Other Resources

https://www.oregon.gov/ode/learning-options/schooltypes/RecoverySchools/Pages/default.aspx

https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/Intensive In-Home Behavioral Health Treatment Fact Sheet.pdf

https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/Early Assessment and Support Alliance Fact Sheet.pdf

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