Planning Steps:

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question

Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

Provide an overview of the state's prevention system (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application.

PREVENTION AND HEALTH PROMOTION

Oregon Health Authority (OHA)'s Alcohol and Other Drugs (AOD) Prevention – Substance Use Alignment Initiative serves as an umbrella framework which is building infrastructure to better coordinate staff, funding, programs, policy, and data and evaluation systems across Oregon's SUD Continuum of Care. This includes engagement of other sectors in the Public Health Division (PHD) of OHA addressing injury and violence, sexual and domestic violence, maternal, child and adolescent health, nutrition and food security, HIV/STI/HCV, and carceral health, in addition to behavioral health, given shared risk and protective factors across populations.

Primary prevention and population-based substance use prevention initiatives are coordinated through the Oregon Health Authority (OHA) - PHD. Tribal Behavioral Health substance use prevention initiatives are coordinated through OHA – Behavioral Health Division (BHD). Tribal substance use prevention program elements are consolidated into one comprehensive behavioral health contract, through OHA-BHD. The Nine Federally Recognized Tribes and Oregon's designated Urban American Indian Health Program (UAIHP) all develop their plans under this contract, supported by OHA subject matter experts.

a. Public Health Prevention

PUBLIC HEALTH PREVENTION INITIATIVES

OHA-PHD works with internal and external partners across the state to prevent and reduce substance use and overdose across the lifespan. These efforts advance primary prevention, population health strategies outlined in the **State Health Improvement Plan, Healthier Together Oregon, and the 2020-2025 Oregon Statewide Strategic Plan** developed by the **Alcohol Drug Policy Commission** and aligns with OHA's Strategic goal of eliminating health harms.

TOBACCO, ALCOHOL AND OVERDOSE PREVENTION

OHA funds every Oregon county and tribal health department to plan, implement and evaluate prevention strategies to reduce and prevent tobacco, alcohol, and other drug use. OHA-PHD is working towards building comprehensive prevention infrastructure across all three prevention areas, ensuring effective administration and management, data and evaluation, strategic health communications, state-level training and technical assistance, and funding for communities to plan and implement strategies that prevent tobacco, alcohol, and other drug use at the population level.

Tobacco Control and Prevention
In 1996, Oregon voters passed Measure 44 which raised the price of tobacco and dedicated funding to OHA PHD's comprehensive **Tobacco Prevention and Education Program (TPEP).** In 2020, Oregon voters passed Ballot Measure 108 which again raised the price of tobacco products, including cigarettes, by $2.00 per pack ($1.33 to $3.33). Increasing the price of tobacco is a proven strategy shown to be highly effective in reducing consumption of tobacco products, particularly for youth. Per capita cigarette pack sales have decreased by 31% since 2020, when Oregon's tobacco tax increased.

Tobacco Prevention and Education Program (TPEP) implements community- and state-level interventions, surveillance and evaluation, communications, screening interventions, and state administration and management to prevent tobacco use and associated effects across the lifespan. Currently, OHA-PHD directly funds Oregon's 36 counties, 94 geographic and local organizations, and eight Regional Health Coalitions to advance a comprehensive tobacco prevention system in Oregon. In Oregon, adult tobacco use continues to drop each year, reaching a low of 10.2% in 2023.

During the 2021 Legislative Session, Senate Bill 587 created a **Tobacco Retail License (TRL) Program** to increase retailer knowledge and compliance of federal and state laws regulating the retail sale of tobacco and vaping products. As of January 1, 2022, any business selling tobacco, nicotine or vaping products in Oregon is required to get a license from the Department of Revenue. OHA-PHD conducts minimum legal sales age inspections and tobacco retail sales law compliance inspections for all retailers. In other states and internationally, TRL has reduced youth access to tobacco products in their communities. OHA-PHD inspected 99.6% and 99.3% of tobacco retailers licensed by the state in 2023 and 2024, respectively. Rates of illegal sales of tobacco and inhalant delivery systems to people under 21 have dropped, moving from 25.6% in 2022 to 21.4% in 2023 to 14.1% in 2024.

Alcohol Policy & Prevention
OHA-PHD's **Alcohol and Drug Prevention and Education Program (ADPEP)** directly funds 36 counties to plan and implement community-driven solutions to address excessive alcohol use and prevent substance misuse. ADPEP prioritizes interventions and locally based strategies to address shared risk and protective factors that foster social and physical environments that discourage excessive alcohol consumption and substance misuse, thereby reducing alcohol-related fatalities, preventing substance use disorders and related costs, and other harms.

Over the last decade, OHA-PHD has worked towards the goal of building a comprehensive prevention program addressing alcohol and other drug use that parallels the more robust infrastructure of tobacco prevention and cessation. This work occurs in collaboration with Oregon's local public health authorities (LPHAs), locally based organizations, nine federally recognized Tribes, eight regional health coalitions and non-profits. OHA-PHD also coordinates closely with OHA-BHD's Child and Family Behavioral Health Program; Addiction Treatment, Recovery and Prevention Unit; Medicaid Policy and Partnerships Team; Health

Policy & Analytics and Medicaid Programs to align efforts across the substance use continuum of prevention, tertiary care, treatment, and recovery.

Population-level primary prevention strategies include raising the price of alcohol, increasing access to comprehensive alcohol screening, referral, and treatment, maintaining state control for distilled spirits, increasing regulation of alcohol outlet density and retail environments, and limiting exposure to and access to alcohol. Community ADPEP prevention strategies include coalition building, school-based prevention programs and supports or environmental prevention and mobilization through consistently effective practices.

In 2021, CDC awarded Oregon a competitive five-year **Alcohol Epidemiology Grant** to increase capacity in alcohol epidemiology and excessive alcohol use prevention. Funding supports a 1.0 FTE epidemiologist dedicated to strengthening alcohol related data systems that inform and expand alcohol prevention program, systems, and policy in Oregon. New **Oregon Alcohol Maps** increase access to data for planning, program development and local solutions. These resources are supporting planning, communication, education, and mobilization to inform decision makers about population-level, primary prevention interventions that prevent and reduce excessive alcohol use.

Launched in June 2022, OHA-PHD's **Rethink the Drink (RtD)** is a mass reach communications brand working to change social norms and advance program, policy and environmental strategies that reduce excessive alcohol use and related harms at a population level. Oregon is the first state in the nation to invest in communications infrastructure to reduce adult excessive alcohol use at this scope, with evaluation results highlighting numerous short and medium-term successes, including:

- Campaign messaging that reached millions of people and had one of the highest recall rates recorded by evaluators compared to other health campaigns in Oregon
- Over 42,000 unique visitors accessed the campaign website

Evaluation results from the first and third campaigns have been positive overall. The campaigns made the most difference in terms of increasing conversations about alcohol, eliciting self-reflection around alcohol use, and increasing intentions to reduce alcohol consumption among those who excessively drink. Additionally, those who saw the campaign were more aware of the presence of alcohol in their environment and how that presence can be problematic for their community. Those who saw the campaign were also more supportive of local-level strategies to address excessive alcohol use.
More information is available at www.rethinkthedrink.com.

OHA's new CDC **Comprehensive Suicide Prevention Grant** provides 5 years of funding to prevent and reduce the impacts of suicide among adults in Oregon. Priority populations include rural and remote geographical areas, older adults, and veterans. Funding supports strategies across three tiers, including locally based, health care systems, and protective environments that reduce excessive alcohol through increasing the price of alcohol, reducing outlet density, raising awareness of the link between excessive alcohol use and suicide, and disseminating data for program and policy development.

OHA also works with communities directly funded by the Substance Abuse Mental Health Services Administration (SAMHSA) to implement eight **Drug-Free Communities (DFC) and two Strategic Prevention Framework (SPF)** grants in Oregon. OHA was awarded a five-year **SPF-Partnerships for Success (PFS)** grant in 2023 to reduce the onset and progression of substance/polysubstance misuse among high priority populations disproportionately impacted by alcohol and overdose in Oregon. The project aims to: 1) Strengthen state capacity to identify and address alcohol misuse and overdose as a polysubstance use impacting

overlapping priority populations in Oregon and; 2) prioritize strategies to build capacity with communities experiencing the impacts of overdose and alcohol misuse.

Overdose Prevention
OHA-PHD and OHA-BHD collaboratively implement a wide range of overdose prevention programming to reduce substance use and substance use disorder, reduce harms associated with substance use, and reduce overdose deaths. These initiatives focus resources to maximize support for community-level interventions that promote culturally tailored solutions to address stigma and negative health outcomes associated with substance use. Priority populations include but are not limited to American Indian/Alaska Native communities, Black/African American communities, people who use drugs, youth and young adults, individuals who have experienced previous accidental overdose, individuals who have been involved with the carceral system, and individuals with inadequate access to resources that impact quality of life.

Since 2020, OHA-PHD's **Overdose Prevention & Education Program (ODPEP)** has funded 11 local public health authorities (LPHAs) to increase local capacity for multisector coordination, community outreach, and prevention. Many of these LPHAs represent multi-county regions, covering 23 of Oregon's 36 counties. These regions represent communities with high rates of overdose. To date, OHA's PHD and BHD have braided funding from SAMHSA and the CDC to implement this Initiative. SUPTRS BG funds began supporting this initiative in October 2023. ODPEP Coordinators collaborate with pharmacies, law enforcement and first responder agencies, schools, judicial systems, community organizations, and others to implement locally tailored interventions that target populations impacted by substance use and overdose. ODPEP Coordinators serve as key resources for overdose prevention by fostering relationships to strengthen community networks; supporting healthcare providers and health systems; providing prevention support and technical assistance; establishing community linkages to care; conducting prevention education and outreach; expanding school-based prevention programming; and more.

In 2024, the Oregon Opioid Settlement Prevention, Treatment, and Recovery (OSPTR) Board allocated $13.7M to strengthen statewide primary prevention infrastructure. The **opioid settlement primary prevention investment** provided an additional $9.5M to the OHA-PHD ADPEP program to enhance local prevention programming and to expand the local preventionist workforce. It also allocated $3.7M to community-based organizations (CBOs) and regional health equity coalitions (RHECs) to increase culturally and linguistically specific capacity for primary prevention. Finally, the OSPTR Board allocated $450,000 to train and certify 100 new Certified Prevention Specialists. OHA-PHD is administering 58 new grantee contracts in support of this one-time investment. The majority of these new primary prevention initiatives began on January 1, 2025, and projects will conclude by June 30, 2027.

Oregon established the **Prescription Drug Monitoring Program (PDMP)** in 2011 as a healthcare tool to enhance providers access to patients' comprehensive prescription histories. Oregon retail pharmacies contribute data on specific prescription drugs dispensed to patients, including schedule II-V controlled substances, and drugs of interest as determined by the OHA, currently, gabapentin. These medications place patients at risk for overdose, side effects, and increased effect when combined with alcohol and/or other drugs, risk for physical dependence, and risk for developing patterns of drug abuse. The PDMP allows providers to determine what medications are appropriate for individual patients. Patient data is secure and can only be accessed by individuals using the proper authentication. Over 31,000 practitioners and pharmacists have authorized access to the PDMP in Oregon. Additionally, the PDMP is a robust tool for prescribers to assess their prescribing practices to ensure that as standards and recommendations change their prescribing practice are updated as well. The PDMP provides

multiple assessment tools, including, peer comparison reports which allow prescribers to self-assess compared to their same specialty peers and clinical alerts which allow prescribers to view their patients who have received prescriptions which may increase risk of negative outcomes.

In 2023, OHA-PHD launched the **Overdose Prevention Dashboard** which displays mortality, emergency department discharge, and hospital discharge data. This dashboard presents annual, statewide, county-level, and demographic trends for 11 drug categories, including fentanyl, heroin, and stimulants. OHD-PHD launched the **Opioid Overdose Updates Dashboard** in 2024 to replace a static quarterly report. This dashboard compiles monthly preliminary overdose data from the State Unintentional Drug Overdose Reporting System (SUDORS) and the Oregon Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE), focusing on total opioid overdose events statewide and by county. In 2025, OHA-PHD completed a novel, multi-year initiative to integrate EMS data into Oregon ESSENCE to further enhance Oregon's syndromic surveillance infrastructure. OHA-PHD launched the **EMS Overdose Map**, which displays current and historical illicit opioid overdose EMS data by county and census tract. EMS provides granular location data that is valuable for monitoring overdose events and other health emergencies.

Since 2011, CDC and SAMHSA funds have supported the annual **Oregon Conference on Opioids + Other Drugs, Pain + and Addiction Treatment (OPAT)** to educate attendees about evidence-based and community-informed pain management, prevention, tertiary prevention, and substance use disorder treatment. Attendees include the medical community, social service agencies, public health agencies, behavioral health organization, community-based organizations, Tribal health representatives, peer support specialists, and others. Since 2018, CDC and SAMHSA funds have supported an **annual Tribal Opioid Summit** in partnership with the Northwest Portland Area Indian Health Board. The Tribal Opioid Summit brings together Tribal leaders, healthcare providers, public health professionals, community advocates, and individuals with lived experience to unite in shared purpose and collaboration. OHA-PHD also supports the annual **Peerpocalypse Conference,** a national convergence of leaders, emerging leaders, innovators, and the peer community. Peerpocalypse serves as a peer education and training opportunity by bringing the peer community together to share information, skills, and experiences.

OHA-PHD recently launched several initiatives to expand technical assistance and support to local prevention partners. The **Substance Use & Overdose Prevention Continuum Digest** is a live, web-based Smartsheet dashboard updated weekly. A monthly GovDelivery Newsletter complements the Digest and together they serve as resource hubs for community organizations, local public health authorities, public safety agencies, and state staff. There are nearly 500 subscribers to these resources as of July 2025.

OHA-PHD established three **Communities of Practice (COPs)** in 2024 to bring together local, state, and community-based partners to discuss topics and share resources associated with Communications, Public Health and Public Safety Partnerships, and Data and Surveillance. These Communities of Practice convene partners to share best practices, resources, and experiences.

In 2025, OHA-PHD launched the **2025 Overdose Prevention Virtual Learning Series** to support local prevention partners in building their knowledge and capacity in various aspects of prevention-related work. Learning Series topics have included Oregon's Overdose History & Landscape, Communicating with Purpose, Primary Prevention 101, Utilizing Data to Make a Local Impact, Project Evaluation, and more.

OHA-PHD launched the **Opioid Settlement Learning Collaborative** in 2024 to help local jurisdictions share information, discuss spending plans, and exchange resources related to opioid settlement funds. The collaborative meets monthly, covering a wide range of topics such as allowable uses of settlement funds, best practices in spending, needs assessments, and tracking expenditures.

Since 2023, OHA-PHD has also supported **Peer Support for Peer Support Specialists (PS4SSS)** support groups. This initiative aims to strengthen support systems among members of the peer-delivered services workforce to build connection and reduce burnout. A 2024 evaluation found that PS4SSS help foster connections with others, support retention, foster connection with self, build confidence to do job, improve work satisfaction, ease work burnout, address compassion fatigue, and supported progress toward career goals.

b. Other OHA-PHD Initiatives

OTHER OHA-PHD PREVENTION INITIATIVES

Since April 2022, OHA-PHD's **Community Based Organization (CBO) Equity Funding Collaborative** has funded over 170 CBOs to center health and community priorities by implementing community-driven, culturally, and linguistically responsive projects. Eight programs collaborated to braid funding towards advancing OHA's strategic goal. Twenty CBOs are implementing school-based prevention, resource navigation, and social-emotional well-being services. Seven CBOs are conducting overdose prevention projects. 94 CBOs, including 15 specifically supporting youth, address the social determinants of commercial tobacco use (through funding from the "Tobacco and E-Cigarette Tax Increase for Health Programs" (Ballot Measure 108).

OHA-PHD convenes a 20-member statewide **Youth Advisory Council (YAC)** to support public health efforts in schools and communities to address the secondary impacts of the COVID-19 Pandemic. The YAC has formed partnerships with youth-serving community-based organizations and include youth with diverse lived experiences and geographic and cultural identities. All youth identify as being from a population disproportionately impacted by COVID-19 and other health impacts.

School Based Health Centers (SBHC) work with children, adolescents, and their families to provide primary care and linkage to other mental and behavioral health services. SBHC's also sponsor youth engagement and youth participatory action research projects related to substance use.

c. Measure 110

Ballot Measure 110, the Drug Addiction Treatment and Recovery Act, now adopted into Oregon Revised Statutes (ORS) 430.383 through 430.393, created a funding program to establish Behavioral Health Resource Networks (BHRNs). The Oversight and Accountability Council determines how funds are distributed.

The Measure 110 (M110) program, administered by the OHA Behavioral Health Division under the Single State Agency (SSA) for substance use disorder services, funds Behavioral Health Resource Networks (BHRNs) in every county to deliver low-barrier prevention, tertiary prevention, treatment, recovery, housing, and ancillary supports. BHRNs make screening, health assessment, treatment, and recovery services for drug addiction available to those who need and want access to those services.

M110 grantees include community-based organizations, Community Mental Health Programs (CMHPs), and Tribal and culturally specific providers. Networks coordinate referrals, identify gaps, and align with Medicaid, public health, and crisis response systems. Services address SUPTRS BG priority populations, pregnant and parenting individuals, people who inject drugs, individuals with or at risk for HIV/AIDS, and those in need of primary prevention, through naloxone distribution, treatment access, housing, peer support, transportation, and population informed programming.

d. Behavioral Health Division Prevention

Prevention services are conducted in multiple counties through Mental Health Promotion and Prevention funding, administered by the OHA Child and Family Behavioral Health Unit. These state funded projects prioritize activities supporting mental wellness to build awareness of mental health, normalize help-seeking and increase protective factors. SUD prevention is done at OHA in the Public Health division and described above.

Oregon has several well established, evidence-based programs for parents of younger children that can assist in preventing the development of SED. For older children and youth Gen PMTO and Trauma Focused Cognitive Behavioral Therapy (TF-CBT) are available evidence-based practices that help mitigate the impact of trauma and early development of behavioral issues so that they don't develop into more serious emotional disorders. These evidence-based practices are outlined below.

Parent-Child Interaction Therapy (PCIT)

PCIT is an empirically supported dyadic treatment for children ages 2-7 years old and their parents or caregivers. Worldwide research shows that it is effective for families from diverse cultures and communities. PCIT provides live practice for parents through coaching with a wireless communication device by a trained therapist who views the parent and child through a one-way mirror. It teaches parents to develop a warm, responsive relationship with their children, and to selectively reinforce pro-social and adaptive behavior while also learning to safely and consistently provide developmentally appropriate consequences to change children's negative behaviors. An adaptation of PCIT for toddlers (ages 12-24 months) teaches parents to become more attuned and responsive to their young child while helping toddlers develop emotional and behavioral self-regulation.

National research indicates PCIT can also be adapted for children with anxiety disorders, developmental delays, children on the autism spectrum, children who have experienced chronic trauma, families who are involved with child welfare because of harsh physical discipline, and mother-child dyads following episode(s) of domestic violence. The average length of treatment is 16 to 20 weeks. The use of standardized instruments for data collection demonstrates improved functioning during treatment.

This year there are high fidelity PCIT programs serving Medicaid eligible families at 35 locations, in 10 Oregon counties (CMHP programs primarily). Most Oregon PCIT programs successfully switched to providing PCIT via telehealth services during the pandemic. Currently there are approximately 130 trained staff on PCIT treatment teams, including four PCIT Agency Trainers, and two certified Regional Trainers authorized by PCIT International, Inc. to train across Oregon. All OHA funded PCIT sites receive on going consultation, training and fidelity monitoring by OHA contracted certified Regional PCIT trainers.

Since September of 2023, there have been four statewide trainings. The next one is scheduled for October 2025. In addition to each clinical training there is always a session for the supervisors and administrators who will provide support for the provision and sustainability of fidelity PCIT in their respective agencies.

Child-Parent Psychotherapy (CPP) is an intervention for children from birth through six years who have experienced at least one traumatic event and are consequently experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD). The primary goal of CPP is to support and strengthen the relationship between a child and their parent or caregiver to restore the child's sense of safety, attachment, and appropriate affect and to improve the child's cognitive, behavioral, and social functioning.

OHA has been providing funding annually since 2014 for CPP training annually, including 18 months of reflective supervision/ consultation. Oregon has 32 certified CPP clinicians providing services (many in the CMHP setting), with 24 in the current 18-month reflective supervision/consultation cohort. A new cohort will begin in January 2026.

The current goals of this project are to: 1) implement CPP with fidelity, utilizing CPP fidelity tools through provision of mental health promotion and intervention services, behavioral health clinics, and Oregon Relief Nurseries to at-risk families, 2) utilize the Devereaux Infant Toddler Assessment to measure outcomes, and 3) continue ongoing consultation, supervision, and networking between CPP-trained therapists to maintain fidelity to the model over time.

Generation Parent Management Training- Oregon (Generation PMTO) is a family-based, trauma informed intervention with over 50 years of research demonstrating its effectiveness. Generation PMTO, sometimes called GenPMTO, is effective for families with children ages two-17 years experiencing significant social emotional or behavioral problems such as depression, hyperactivity, non-compliance, substance use, lying and stealing, or other maladaptive behaviors.

Generation PMTO can be used as a preventive program and as a treatment program. It and can be delivered through individual family treatment, group parent training in agencies or via telephone/video conference delivery. Generation PMTO providers are encouraged to tailor the services to meet the needs of diverse populations, family circumstances and service provider type.

OHA began a five year roll out of Generation PMTO in 2019 with a pilot project of one program. The goal of this project was to increase access to this effective family intervention across Oregon, especially in rural areas where masters' level behavioral health staff are in limited supply. During the COVID-19 health emergency in 2020, Generation PMTO providers successfully switched to providing this service via telehealth. Currently Generation PMTO is provided in 11 counties at 14 locations including group delivery in schools.

Due to workforce hiring and retention challenges, the planned expansions in 2021 did not happen. There is active planning with the Generation PMTO Leadership Committee and Oregon Health Authority for sustaining current service levels while continuing to provide training and certification for therapists to become coaches, and the two groups have collaborated in developing a budget plan for GenPMTO Infrastructure in Oregon.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

In 2020-2021 the Oregon Health Authority contracted with a nationally certified TF-CBT trainer to provide all training and consultation necessary for certification, for 115 outpatient mental

health therapists serving Medicaid eligible clients. An additional 120 training slots were offered in 2021-2023. Training was offered in October 2023 and Spring 2024. Oregon Health Authority continues to provide training and consultation with this trainer. A new cohort began training in the Spring of 2025.

TF-CBT is a well-supported evidence-based treatment for children and adolescents three-18 years of age impacted by trauma, and their parents or caregivers. TF-CBT has been evaluated and refined during the past 25 years to help children and adolescents across many cultures after trauma. Average treatment is 12-14 sessions provided in an outpatient setting and can be provided via telehealth.

Research shows that TF-CBT successfully resolves a broad array of emotional and behavioral difficulties associated with single, multiple and complex trauma experiences such as physical or sexual abuse, domestic violence, and community violence, an unexpected death of a loved one, natural disasters and war.

e. Tribal Behavioral Health including Prevention

The Tribal Behavioral Health Plan encompasses multiple service elements, which include: Alcohol and Other Drugs Prevention (TAD 352), Tobacco Prevention (TAD 353), Community Behavioral Health and SUD (TAD 354), Intoxicated Driver Program Fund (TAD 355), Housing Assistance (TAD 356), State Opioid Response Grant (TAD357), Mental Health Services (TMH 304), Veterans Behavioral Health (TMH 305), Youth Suicide Prevention (TMH 306), Workforce Clinical Supervision (TMH 307), Workforce Other Incentives (TMH 308) and Residential Housing (TMH 309).

The Tribal Alcohol and Other Drugs Prevention (TAD 352) and Tobacco Prevention (TAD 353) fall underneath this overall Behavioral Health plan and contract with the Nine Federally Recognized Tribes of Oregon and the State's sole designated Urban Indian Health Program, the Native American Rehabilitation Association of the Northwest.

These programs distinctly utilize Oregon 22 Tribal Based Practices for SUD, Mental Health, Prevention in Oregon (ORS 414.672 and they are required to acquire and maintain credentials as Certified Prevention Specialists, in accordance with OAR 415-056-0045. Prevention program plans largely follow the six Center for Substance Abuse Prevention (CSAP) strategies and program grantees closely follow the work of Hawkins & Catalano from the Social Development Research Group, out of the University of Washington for Risk and Protective Factors.

The tribes do utilize practices on what used to be maintained on the National Registry of Evidence-Based Programs and Practices (NREPP) list. Tribes, specifically for their (commercial) tobacco prevention program work are also heavily focused on building up their tobacco cessation infrastructure, including cessation training classes but also close-loop referral systems work. Regular check-ins, with the tribes and NARA do take place, including in their Nine Tribes Quarterly Behavioral Health meetings, which have been taking place for nearly three decades, where the entire Continuum of Care is encompassed, consistent with their overall Behavioral Health Plans. Half of this meeting is specifically devoted towards prevention efforts (SUD, Tobacco and Suicide). Additionally, in 2024, the Behavioral Health Division reinstituted the Tribal Specific Certified Prevention Specialist Cohort.

f. Youth Suicide Prevention

Youth Suicide Prevention remains a priority and a plan for 2026-2030 is in the final stages of being written and disseminated. Oregon has a higher suicide rate (13.5 per 100,000) for youth ages 15-24 than the national average (9.9 per 100,000) for the year 2023. Oregon has the 11th highest youth suicide rate in the United States. Suicide prevention work is available in more detail in this report.

Adult Suicide Prevention

The data in the recent report shows: In 2023, 868 Oregonians, ages 18 years and older, lost their lives to suicide, the 11th highest adult rate in the nation. The 23-year trend shows that the age-adjusted rate for suicide in Oregon (19.4 per 100,000) is significantly higher than the United States rate (14.1 per 100,000).

The suicide death rate is highest among males throughout the lifespan. The highest is among older men, reaching a rate of 93.7 per 100,00 for men ages 85+.The suicide death rate for females increases with age until age 59. The highest rate for women is between ages 55-59 (17.07 per 100,000). But it declines with age thereafter. Veteran suicide rates continue to be significantly higher than non-veteran rates. In 2024, more women (53.7 percent) presented in Emergency Departments (EDs) and Urgent Care Centers (UCCs) for suicide-related visits than males (46.3 percent).

Despite limited funding for adult suicide prevention, there have been some notable accomplishments within the past year. The CDC Comprehensive Suicide Prevention federal grant helped fund these accomplishments. The report details the progress made on the 95 initiatives listed in the 2023–2027 Adult Suicide Intervention and Prevention Plan (ASIPP) through the following: the Oregon Health Authority, OHA's contractors, community partners, and adult-serving state agency partners.

Several initiatives were chosen for first-year implementation from ASIPP. Many initiatives had to be modified or eliminated due to funding limitations. In a fully funded ASIPP, an evaluation team and an advisory committee would have been in place before other work.

1. ***Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.***

a. Oregon Health Authority (OHA) State Mental Health Authority

In 2019, OHA, the state mental health authority, became the first health agency in the country to declare an ambitious statewide goal to eliminate health inequities, and to do so by 2030. That means establishing a health system where all people in Oregon can reach their full health potential and well-being. Health inequities are differences in health outcomes that stem from social, economic, and other factors which cause people in some communities to have higher rates of health problems — such as infant death, chronic disease and shorter life spans — than people in other communities.

Naming our goal of eliminating health inequities by 2030 is bold and aspirational. It sets a daily intention for us as an agency: in our work, systems, policies and practices. We want every decision, every action, every allocation of resources to move us toward this goal every day. And we know that means shaking up entrenched ways of thinking and doing so that we can ensure Oregon becomes a place where everyone has a chance to thrive. When people are prevented from accessing good health care by barriers such as high costs, bias, and a lack of trained providers or convenient services, it impacts the broader community. OHA will continue

to focus on eliminating those barriers that prevent both individual people and the broader community from being healthy and accessing the care that every person in Oregon deserves. OHA is committed to the following five goal pillars:

1. Transforming behavioral health;
2. Strengthening access to affordable care for all;
3. Fostering healthy families and environments;
4. Achieving healthy Tribal communities; and
5. Building OHA's internal capacity and commitment to eliminate health inequities.

The Behavioral Health Division helps Oregonians achieve physical, mental and social well-being by providing access to health, mental health and addiction services and supports to meet the needs of Oregon's adults and children. We accomplish this through collaboration with individuals, their families, counties, other state agencies, providers, advocates and communities.

b. Centering Health Equity (child)

Child and Family Behavioral Health has developed a framework to focus our OHA health equity goal by 2030 in all our work, inclusive of trauma informed principles and practices. CFBH commits to center youth and families to build a system that will work for all. There are sub-populations of youth with SED, co-occurring conditions and youth living in rural and frontier areas who experience behavioral health care disparities with limited to no access to services, that Oregon is working to address.

CFBH continues to work to promote better integrated mental health and intellectual/ developmental disability (I/DD) services and supports throughout our service system. OHA is committed to meaningfully integrate the voices of youth and families with lived experience, Tribes and communities of color, LGB identified youth (and their families') voices, and youth with disabilities into the work, to address gaps, create access to responsive programming and treatment options, address workforce issues, and find inclusive, trauma informed ways to work together to support all youth with behavioral health needs in Oregon.

c. Child and Family Behavioral Health Team - Array of services and supports

Children, youth and families need an array of services and supports to meet their individual needs. This graphic illustrates the full continuum as defined in the 2021 The Evolution of the System of Care Approach. Oregon has most of these services and supports and has been steadily working over the past five years to implement mobile response stabilization services (MRSS), intensive in-home behavioral treatment (IIBHT), to further refine and support fidelity Wraparound programs and to expand the available continuum of care for young adults ages 14-25.

These services are all distinct to the child and family behavioral health system which serves children, youth and young adults from 0-25 years of age. Whenever possible, services are available statewide and that remains our goal. Services and supports are offered through the community local mental health agencies (LMHAs), and through providers contracted with Coordinated Care Organizations which manage the Medicaid benefit in Oregon.

Children with serious emotional disorders (SED) are assessed and served throughout the System of Care: outpatient mental health, outpatient SUD co-occurring programs, intensive outpatient programs, community-based programs such as MRSS and IIBHT, through fidelity Wraparound, in psychiatric day treatment, in psychiatric residential, in SUD co-occurring residential, and in the secure inpatient programs, and for episodic care in acute care psychiatric settings. Additionally, we have an expedited assessment program, EASY

(Expedited Assessment Services for Youth) which provides rapid assessments for youth with complex, urgent behavioral health needs. Youth receive expedited assessments in their communities in three urban counties and under specific contracts in two rural regions. Of those referred, 85% are believed to have an intellectual/developmental disability. Further description of this program will be entered in Section IV Environmental Factors, under section 1.

CFBH funds school-based access to behavioral health in fifteen counties in Oregon, primarily rural counties that do not have a school-based health center. Services are provided by mental health clinicians and skills trainers from county programs (CMHPs, our LMHA) to students and families in grades K-12, without regard to ability to pay or insurance coverage. Mental health consultation, attendance at multidisciplinary meetings in the school setting and providing supports where needed are also roles of the clinicians. Services are designed to address communities that have been historically underserved. Services are required to reduce the impact of adverse childhood experiences and improve resilience.

d. Medicaid Division

OHA sought federal partnership through an 1115 Demonstration Waiver, focusing on strengthening the state's continuum of care for SUD treatment. Approved by the Centers for Medicare & Medicaid Services (CMS) in April 2021, the waiver set Oregon on a path to implement evidence-based practices, enhance provider capacity, and integrate culturally responsive and co-occurring disorder services across the state's behavioral health landscape. This waiver expanded service delivery options so beneficiaries with a wider range of needs would have access to the appropriate level of care.

Central to the approved waiver is the focus on enhancing residential and inpatient treatment services as a crucial component in the continuum of substance use addiction benefits. It accomplishes this by permitting Oregon to receive federal funding for Medicaid services for individuals with a substance use disorder in residential treatment facilities with more than 16 beds or Institutions for Mental Disease (IMDs). This waiver increases the service array for OHP members with substance use disorder to include **Community Integration Services**, composed of housing and employment support. Oregon implemented this benefit to help people transition from institutional and residential settings to their own homes within their communities.

Key initiatives have included **codifying flexibilities in Oregon Administrative Rules (OAR)**, adopting a consistent **American Society for Addiction Medicine** (**ASAM) framework**, and **improving provider licensing/certification and staffing**.

Oregon has extended its efforts beyond integration services, creating pathways for **crisis intervention** and **early recovery support**. These expanded services have not only strengthened the state's continuum of care—they have also successfully reduced emergency department utilization statewide.

Oregon believes this waiver will continue to achieve its purpose of increasing capacity to enhance SUD treatment and create a full continuum of care while also respecting the unique nature of Health Care for American Indians and Alaskan Natives (AI/AN) in the state. Indian Health Care Providers intertwine traditional and cultural values in their programs, utilizing Tribal Based Practices. Oregon has recognized Tribal Based Practices equivalent to Evidence Based Practices in legislation, HB 3110 (2011) and SB 134 (2019). Due to the importance of making available high quality and culturally competent services to AI/ANs, Oregon allows Indian Health Care Providers that qualify as an IMD to offer just one form of medication as part of MAT onsite, either an FDA-approved antagonist or partial agonist. Spirituality, ceremonies,

and cultural practices are used to support those in recovery. There are concerns that a mandate could conflict with these traditional values that are integral to the operations of these programs, and we do not want to disrupt this well-established recovery community.

The current 1115 OHP waiver makes Oregon the first state to keep children on OHP covered from birth to age six. Starting January 1, 2023, this means families do not need to renew OHP benefits to keep children covered and can get the health care their child needs in their most formative years.

The 2022-2027 waiver also allows Oregon to keep OHP members ages six and up covered for two years before they need to renew (instead of one), cover more preventive health services for people from birth to age 21, cover health-related social needs, starting in 2024 for eligible OHP members. This includes support for food, housing, and climate-related resources.

Health-related Social Needs and Health Equity

Where we are born, live, learn, work, play, and age can affect our health and quality of life. Access to health care, healthy foods, and safe housing is important to our health. By supporting these social needs through OHP coverage, the 2022-2027 waiver helps Oregon better coordinate services for people when they most need stability, dismantle policies that discriminate against people of color, Tribal communities, people with low income, people with disabilities, others from underserved communities, and align with other health policy initiatives in our state to achieve health equity. Achieving health equity will help Oregon to improve the lives of individuals who face historic and contemporary injustices, increase individual, family and community resilience, and reduce health disparities for groups most affected by injustice and discrimination.

Determinations about eligibility requirements are currently in process. In 2024, OHA planned to first cover these benefits for OHP members in life transitions. This includes: Youth ages 19 to 26 with special health care needs, youth involved with child welfare, including youth leaving foster care at age 18, people experiencing homelessness or at risk of homelessness, people who are transitioning from Medicaid-only to both Medicaid and Medicare coverage, people released from settings such as jail, residential facilities, and Oregon State Hospital, and people who experience weather-related emergencies. The Governor or federal government declares weather emergencies.

e. 988 & Behavioral Health Crisis System Unit

In 2020, the National Suicide Hotline Designation Act was passed, calling for the adoption of a three-digit number to assist people experiencing a behavioral health crisis and providing a central access point for services and supports. In July 2022, the National Suicide Prevention Lifeline's 10-digit number transitioned to "988" and expanded services to include support for any mental health or substance use crisis. In response to this national mandate, Oregon passed HB 2417 (2021) and HB 2757 (2023), which directed OHA to remove barriers to quality behavioral health crisis services and to build a crisis continuum aligned with the Crisis Now Model and the Mobile Response and Stabilization Services (MRSS) model. This coordinated crisis system aims to provide three pillars of support: "someone to call" (988), "someone to respond" (mobile crisis intervention teams) and "a safe place to go" (crisis receiving and stabilization centers).

Pillar I: Someone to Call
988 offers individuals and their loved one's immediate support for behavioral health issues. Oregon 988, staffed by Lines for Life and Northwest Human Services, is available 24 hours a

day, 7 days a week, via call, text and chat, offering people compassionate care and support from trained crisis counselors. Services and supports for 988 callers are offered via interpreter in over 250 languages, as well as directly in Spanish (call, text and chat) and American Sign Language via videophone. 988 crisis counselors can direct people to local resources and services within their community to meet the needs of everyone in crisis, regardless of acuity level. 988 crisis counselors are trained to address behavioral health crises and can request a mobile crisis intervention team if an in-person respond is needed, decreasing the reliance on other first responders and emergency departments.

Pillar II: Someone to Respond

Mobile Crisis Intervention Services (MCIS) and Mobile Response and Stabilization Services (MRSS) for youth and their families offer a local, in-person response when needed. All counties are required by Oregon Administrative Rule to have two-person Mobile Crisis Intervention Teams available 24/7. New standards include specific requirements for children, youth and young adults that follow national best practices (MRSS). In-person teams (which may be comprised of a clinician (Qualified Mental Health Associate or Qualified Mental Health Professional), a peer support specialist, family support specialist, Emergency Medical Technicians, nurses, etc.) assist in the delivery of age-appropriate screening and assessments, performed in a compassionate manner. MCIS and MRSS teams are trained to respond to crisis situations regardless of the individual's age or insurance type. If a 988 caller needs in-person care, 988 call centers coordinate closely with mobile crisis intervention teams to ensure a warm handoff to services and supports.

Pillar III: A Safe Place to Go

Crisis Receiving Centers and Crisis Stabilization Centers are vital components of the crisis services continuum. Developing appropriate capacity statewide will provide safe alternatives to emergency department care and prevent unnecessary criminal justice system involvement for people in crisis. While funding options are investigated, OHA is engaging with community members and Community Mental Health Programs (CMHPs) to identify what types of crisis facilities are needed throughout the state. 988 call centers will work closely with these services in the future to ensure callers connect smoothly with the most appropriate level of in-person care.

OHA does not directly provide service for mental health and substance use service delivery. Rather, OHA provides funding, technical assistance, and oversight to community providers such as 988 centers and Community Mental Health Programs (CMHPs). OHA's role in this area focuses on the following priorities: monitoring service quality and ensuring that all Oregonians interacting with crisis services receive timely, clinically appropriate, effective, and compassionate support, monitoring resource and technical assistance needs to ensure providers are empowered to support the full range of crisis care, supporting workforce development for providers, including recruitment, retention, training, and wellness initiatives to ensure adequate staffing for all levels of care, providing reliable, sustainable program funding to enable long-term planning, integration of services, and growth to meet rising mental health and substance use service demand.

2. ***Describe the roles of the State Mental Health Agency, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.***

OHA assists local mental health authorities (LMHAs) in the establishment and financing of community mental health programs (CMHPs) through intergovernmental grant agreements called County Financial Assistance Agreements (CFAAs) used to fund services and supports

not covered by Medicaid. In allocating these funds, the Oregon Health Authority observes the following priorities:

1. To ensure the establishment and operation of community mental health programs for persons with mental or emotional disorders in every geographic area of the state to provide some services in each category of services described in ORS 430.630;
2. To ensure survival of services that address the needs of persons within the priority of services under ORS 430.644 (Priorities for services provided by community mental health programs) and that meet authority standards.
3. To develop the interest and capacity of community mental health programs to provide new or expanded services to meet the needs for services under ORS 430.644 and to promote the equal availability of such services throughout the state; and
4. To encourage and assist in the development of model projects to test new services and innovative methods of service delivery.

Over the past year, staff in the OHA Behavioral Health Division have worked with representatives from Oregon's LMHAs and CMHPs to redesign the CFAA. The goal is to give OHA better tools for oversight and performance monitoring, while also giving CMHPs more flexibility to design programs and use CFAA funds in ways that best meet the behavioral health needs of their communities. The new CFAA becomes effective January 1, 2026, and extends through June 30, 2031. Initial funding awards will be for services and supports provided between January 1, 2026, and June 30, 2027; however, future funding allocations will be awarded in alignment with the state's subsequent fiscal biennium (e.g. July 1, 2027 through June 30, 2029).

The new CFAA replaces an antiquated and siloed funding structure with a more streamlined structure focusing on the core service areas required of each CMHP:

- System Management and Coordination
- Crisis Services
- Involuntary and Forensic Services
- Outpatient and Community-Based Services
- Residential and Housing Support Services
- Behavioral Health Prevention and Promotion
- Block Grant Funded Services
- Invoiced Services

The new CFAA clearly identifies the services and supports required of each CMHP within each of the core service areas and prioritizes resources for the most vulnerable Oregonians. Additionally, the new CFAA structure provides OHA with improved oversight opportunities by implementing comprehensive reporting that incorporates actual expenditure information provided by the LMHAs/ CMHPs and actual utilization data collected through state mandated data systems.

a. Adult Mental Health (Integrated Co-occurring Disorders initiative)

Integrated Co-Occurring Disorders (ICOD) treatment provider organizations demonstrate their eligibility to serve Medicaid members with co-occurring mental health, substance use, gambling, and developmental disorders through a combination of certification, policy alignment, trained staff, and ongoing education. To qualify, an organization must be certified or licensed by OHA as a Behavioral Health Provider. This certification ensures that the provider meets the regulatory standards necessary to deliver behavioral health services within the Medicaid system.

In addition to holding the appropriate certification or licensure, the organization must maintain written policies and procedures that reflect the Oregon Administrative Rules specific to Integrated Co-Occurring Disorders. These documents serve as a framework for how the organization delivers integrated services and ensures consistency with state guidelines.

Equally important is the organization's ability to demonstrate that its practitioner staff are both credentialed and trained to provide a full spectrum of services. This includes assessment, diagnosis, and treatment for mental health conditions, substance use disorders, and problem gambling. The organization must also offer peer support services and psychiatric medication evaluation and management. These services must be delivered by qualified professionals capable of addressing the complex needs of individuals with co-occurring conditions. Furthermore, any practitioner assigned to ICOD treatment responsibilities is required to complete twenty hours of specialized training within twelve months of being assigned to these duties. This ongoing education ensures that staff remain equipped to provide high-quality, integrated care that aligns with best practices and regulatory expectations. Through this combination of licensure, policy, clinical capability, and training, ICOD treatment provider organizations establish their readiness to effectively serve Medicaid members facing co-occurring disorders.

Programs that have demonstrated eligibility are approved by OHA to provide integrated co-occurring disorders services and are eligible to receive enhanced payments for qualifying services. Coordinated Care Organizations participate in a Directed Payment Program in relation to these services. There are over thirty community-based treatment provider organizations currently approved to provide services. Over one thousand practitioners are providing integrated co-occurring disorders services at these organizations. There are two organizations that specifically provide these services to youth.

OHA administers free training – both required training and optional trainings – community of practice events, structured technical assistance, and program development consultation support to eligible organizations. OHA also will ensure ongoing eligibility through Integrated Co-Occurring Disorders site visits – taking place virtually or on site. The Integrated Co-Occurring Disorders model began implementation in January of 2023.

As a program under Oregon Administrative Rules, integrated co-occurring disorders programs prioritize access to services for individuals dealing with intravenous drug use, especially for pregnant persons. Oregon Integrated Co-Occurring Disorders programs practice a tertiary prevention approach, with practitioners receiving additional training in tertiary prevention practices.

Further, by definition, the eligible/approved providers and practitioners of Integrated Co-Occurring Disorders services are trained and have capacity to provide services for individuals dealing with co-occurring disorders and SMI.

b. <u>Civil Commitment Team</u>

Civil commitment is a process in which a judge decides whether a person alleged to be mentally ill should be required to accept mental health treatment. When a civil commitment petition has been filed, an investigator from the Community Mental Health Program (CMHP) investigates the need for the commitment. Depending on the investigator's decision: the case may be dismissed without a hearing, the person may go into a diversion program, or a hearing may be held.

A person can be committed if the judge finds by clear and convincing evidence that the person has a mental disorder and, because of that mental disorder, is dangerous to self or others, or unable to provide for basic personal needs like health and safety.

A person can also be committed if the judge finds that the person is diagnosed as having a major mental illness such as schizophrenia or manic-depression, and has been committed and hospitalized twice in the last three years, is showing symptoms or behavior similar to those that preceded and led to a prior hospitalization and, unless treated, will continue, to a reasonable medical probability, to deteriorate to become a danger to self or others or unable to provide for basic needs.

If the person is committed, the person may be hospitalized or may be required to undergo treatment in some other setting.

HB 2005 (2025) will go into effect on January 1, 2026, and will bring about a significant shift in Oregon's approach to civil commitment. The Intensive Services Unit will integrate the law into ongoing training of certified mental health investigators and examiners throughout Oregon. These statutory changes set the stage for updating and integrating other system partners with the goal of harmonizing the interpretation and implementation statewide. HB 2005 will impact the following areas of civil commitment in Oregon: definitions of physical harm and serious physical harm as they relate to dangerousness of persons alleged to have mental illness (PAMI), standards for dangerousness that can be "reasonably foreseeable" given a PAMI's history, current state and trajectory if no emergency treatment is required via civil commitment, diversion as a tool to provide more time for healing/stabilization in efforts to avoid civil commitment when appropriate, and expansion of the use of advanced directives for mental health. Declarations of Mental Health Treatment (DMHT) will be honored in emergency situations whenever possible, and the preferred treatment requested is appropriate and available.

3. ***Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served".***

a. HIV Care and Treatment Program of the HIV/STD/TB (HST) Section of the Public Health Division

The HIV Care and Treatment Program of the HIV/STD/TB (HST) Section of the Public Health Division provides information, referral, and access to treatment for persons with mental health and substance use disorders. Under the Ryan White funded AIDS Drugs Assistance Program (locally known as CAREAssist), almost all persons living with HIV are eligible for financial assistance for insurance premiums and deductibles and copayments for services and medications used in the treatment of mental health and substance use disorders.

Within the Part B, Ryan White funded case management program, a psychosocial screening tool is used annually to identify persons interested in accessing mental health resources and/or substance use treatment. For eligible clients, Ryan White financial assistance for mental health supportive services are available for outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to

render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

People living with HIV who have co-occurring mental health and substance use disorders are disproportionately impacted by unstable housing. Within the HOPWA funded housing programs administered by the Public Health Division, one program specifically provides housing and support service assistance to people living with HIV with behavioral health issues that could be barriers to housing. Additionally, a direct referral system is in place to ensure linkage to care and referral to Ryan White case management for persons transitioning out of the Oregon Department of Corrections, many of whom have a mental health and/or substance use disorder.

Starting in 2019 the HST Section has also obligated $10 million over five years to support low barrier housing and in-home intensive wrap around support services for people living with significant behavioral health barriers to housing and healthcare. All Part B Case Managers and Housing Coordinators are required to complete a robust online training schedule within 30 days of hire that includes a variety of topics including motivational interviewing, acuity scales, information and referral and use of trauma informed approaches. An online “HIV Prevention Essentials” course, which is required of individuals providing publicly funded HIV testing and other prevention services, also includes principles related to cultural responsiveness, tertiary prevention and a trauma informed approach. HIV Care and Treatment works closely with HIV and STI Prevention programs to ensure streamlined and coordinated services across the HIV continuum.

HIV and other sexually transmitted infections, such as syphilis and gonorrhea, are reportable diseases. In Oregon, local county health departments are responsible for HIV/STI Partner Services. This includes case investigation and follow up, such as eliciting partner information, assisting with notifications around exposure, and linking people to testing and treatment as needed.

A key component of HIV/STI Partner Services also includes referrals to services such as mental health, substance use treatment, and tertiary prevention (e.g. syringe access) programs. Additionally, as part of the interview that takes place with individuals diagnosed with HIV or an STI, questions are posed concerning substance use which allows epidemiologists at the state and local level to track data regarding use of illicit substances as a behavioral factor for HIV/STIs. Given nearly all HIV positive persons in Oregon are insured, or are insurable with the assistance of CAREAssist, most financial barriers to mental health and substance use treatment are removable. The bigger barriers related to access are systematic in nature, for example provider shortages and access to culturally competent providers, particularly in rural areas of the state. HST has prioritized several projects that focus on ameliorating health disparities.

We currently have a statewide contract with Familias en Accion, to promote HIV/STI education, testing and other sexual health resources to Latino/x/e communities in Oregon and support the African American AIDS Awareness Action Alliance, which promotes HIV/STI and mental health awareness to African-Americans in the Portland metro area. Additionally, HST contracts with other community-based agencies to promote or provide community-based, HIV/STI testing, as well as support with service navigation using a status neutral approach. HST works closely with OHA’s Saves Lives Oregon team fill gaps related to tertiary prevention supplies and services, as allowable.

HST uses a combination of funding, such as state general funds and some federal funding, to support HIV/STI and tertiary prevention programming, including use of staff time and

reimbursement for the purchase of syringes and biohazard/disposal containers not otherwise available through the State's Clearinghouse. Tertiary prevention programming in Oregon is generally offered in three ways, a fixed location (e.g., a community-based or health department location/office), a mobile van which visits multiple locations at fixed days/times each week, and/or through home or community-based delivery. HST also provides mini grants, as well as capacity building and technical support to entities who want to begin providing tertiary prevention programming or services in the State.

b. TB services

In 2022, 15.5% of individuals diagnosed with TB Disease in Oregon had disclosed a history of substance abuse in the year prior to their diagnosis. Out of the 71 individuals with confirmed TB disease who shared this information, 11 reported engaging in excessive alcohol consumption, intravenous drug use, or non-intravenous drug use.

The OHA Tuberculosis Program engages in essential activities, which include:
1. Technical Assistance and Education: The program provides expert guidance and educational resources to local health departments, healthcare facilities, correctional facilities, private medical providers, and other relevant parties. Guidance covers TB screening and medical management of both tuberculosis disease and infection.
2. Data collection, reporting, and analysis: The program gathers, complies, and analyzes comprehensive data related to TB. The program ensures that statewide policies and regulations regarding TB align with the insights drawn from this data.
3. Supporting local health departments: The program provides the support needed to ensure detection and treatment of TB infection and disease. This includes providing medications needed for appropriate treatment and ensuring fair and ethical treatment of individuals with TB.

The program provides direct support to local health departments by providing medications for TB treatment, covering expenses for chest X-rays, and offering financial assistance (when possible) for housing, food, or transportation to facilitate patient adherence to treatment plans. Funding for the TB Program is derived from both the Centers for Disease Control and Prevention, as well as the State of Oregon General Funds.

c. Maternal and Child Health Reproductive Program

Oregon's Family and Child Health (FCH) Section of the OHA-PHD has a long history of collaborating both within the Public Health Division and across the OHA to support pregnant women and parents with mental health and substance use disorder needs. FCH also partners with local public health departments, community- based organizations, and federally recognized tribes to address the root causes of mental health and substance use disorders.

FCH provides funding to 211info, a nonprofit organization that empowers Oregon communities by helping people identify, navigate, and connect with the local resources they need, to support maternal and child health information and referral services statewide that include mental health/substance abuse and other resources.

FCH partners with the Oregon Department of Human Services to implement Federal legislation that requires that states operate a program that 1) gives providers tools to develop Family Care Plans for families of prenatally substance exposed infants, and 2) collects data for annual reporting on the numbers of substance exposed infants and Family Care Plans developed.

In collaboration with partners including local health departments and tribes, the FCH section supports home visiting programs. Home visiting is a proven strategy for strengthening families

and improving the health status of women and children. Programs are voluntary and serve families with a variety of risk factors including mental health and substance use disorders.

The FCH Section works to support healthy pregnancies through the Oregon Mothers Care (OMC) program which assists pregnant women to access a variety of prenatal services including mental health and substance use services as needed. OMC screens and provides referrals for both behavioral health and alcohol and other substance use needs.

Oregon's Pregnancy Risk Assessment Monitoring System (PRAMS) is administered by the FCH section with support from the Centers for Disease Control and Prevention (CDC). PRAMS collects data monthly on maternal attitudes and experiences prior to, during, and immediately after pregnancy from a representative sample of Oregon people giving birth. The survey also asks people about their mental health and substance use during this period of their life.

The FCH Section supports the Oregon Maternal Mortality Review Committee (MMRC). During case review meetings members of the Oregon MMRC determine if deaths are directly related to pregnancy, discuss factors leading to and surrounding each death, and decide whether the outcome was preventable. Based upon each case that is reviewed, they discuss recommendations that can be made to prevent future maternal deaths. The most recent report from Oregon's MMRC found that among pregnancy-related deaths, nearly half of underlying causes of death were due to mental health issues and/or substance use disorders.

d. Child and Family Behavioral Health (Services)

Services to children, youth and their families in Oregon are generally provided through the community mental health programs (LMHA), in coordination with the Coordinated Care Organizations, who administer the Oregon Health Plan for Medicaid enrollees. For children who are not covered under Medicaid, services are still available and statutorily required to be provided by the community mental health program.

In addition, the CCO's retain networks of providers for more specialized aspects of care for children and are required to ensure service delivery to them through this network. There are services in all 36 counties for all children in Oregon regardless of their insurance or ability to pay. These services are inclusive of children with SED, children with co-occurring mental health and substance use treatment needs, and children with co-occurring mental health and intellectual/developmental disabilities treatment. Access to services in recent years has been impacted by a severe workforce shortage in Oregon described elsewhere in this document.

e. EASA team

The Oregon Health Authority funds the Early Assessment and Support Alliance (EASA), a network of programs across Oregon that provide rapid identification, support, assessment, and treatment for youth ages 12 to 27 who are experiencing the early signs of psychosis. EASA is designed as a transitional program, with the goal of providing the education and resources an individual experiencing first episode psychosis needs to be successful in the long-term. Available in 29 Oregon counties, EASA programs are effective, two-year programs with long-lasting results.

The EASA program is a Coordinated Specialty Care (CSC) program, which is a team-based, multi-element approach. EASA programs include all key roles and services outlined in Coordinated Specialty Care programs, including individual and family therapy, case management, supported employment, family education, primary care coordination and pharmacotherapy. EASA programs also use peer delivered services and occupational therapy.

As a coordinated specialty care program, EASA uses multiple EBPs as a multi-element approach including cognitive behavioral therapy (CBT) for psychosis, Individual Placement and Support (IPS), multifamily group therapy, psychoeducation, motivational interviewing, evidence-based prescribing and elements of Assertive Community Treatment (ACT), although the EASA program does not use the entire fidelity model of ACT.

Community education, early identification and outreach occur to engage young people regardless of funding or other barriers. Feedback-informed treatment and integration of participatory decision-making takes place at all levels. EASA is evidence-based care providing comprehensive strengths-based assessment and treatment planning, family partnership and multi-family psychoeducation, evidence-based support for work, school and career development, substance use services integrating motivational interviewing and a tertiary prevention approach, intensive coordination of care within the team and with community partners and gradual transition to long-term supports over a two-year period.

f. Women's Residential Services

Oregon has ten specialized residential programs serving pregnant and parenting women with substance use disorder. These programs deliver trauma-informed, evidence-based care and comprehensive wrap-around services, including case management, parenting skills development, peer support, housing coordination, transition planning, and other recovery support coordination.

Collaboration with Oregon Department of Human Services, Child Welfare Division, it integral to these programs, aiming to prevent child removal and promote family reunification when possible.

In select rural areas, programs benefit from *Nurture Oregon,* an integrated care model that combines prenatal and postpartum healthcare with substance use and mental health treatment, peer recovery support, and coordinated services to better meet the unique needs of pregnant and postpartum women using substances.

These programs are geographically distributed statewide and receive referrals from a variety of sources including Coordinated Care Organizations, healthcare providers, child welfare, withdrawal management programs and self-referral. The system is essential to improving outcomes for women and children across Oregon.

In addition to pregnant and parenting residential programs, there are residential programs for women without children who require a higher level of care. These programs are for people who meet ASAM criteria for level 3-3.7 levels of care, providing intensive evidence-based clinical services, case management and other vital service coordination.

g. State Opioid Response

In September 2024, Oregon received the three-year SOR 4 grant administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), totaling $15.2 million per year. The Oregon State Opioid Response (SOR 4) grant focuses on regions and populations with high rates of opioid use disorder (OUD) or stimulant use disorder (StimUD), high overdose rates, and low substance use disorder (SUD) treatment participation.

Oregon's SOR grant aims to: 1) Enhance youth-centered and school-based prevention activities 2) Strengthen overdose prevention and intervention services 3) Increase access to substance use disorder treatment 4) Expand recovery support services 5) Develop the substance use disorder workforce

Funded services focus on regions and populations with limited access to SUD treatment and high rates of opioid use disorder, stimulant use disorder, and overdose; address disparities in treatment access and overdose among Tribal communities and communities of color; and support prevention and recovery services. Key principles that have guided the development of proposed goals, objectives, and activities. These principles align with other statewide strategic planning efforts and shape how Oregon plans to utilize SOR resources to increase, expand, and improve primary and tertiary prevention, overdose prevention, treatment, recovery support, and workforce development programs.

To help guide Oregon's SUD work, OHA developed a syndemic conceptual model as part of a NIDA-funded study based on the Institute of Medicine's continuum of health services and Social Determinants of Health framework. Oregon's SUD Syndemic Model identifies relevant linkages and partners and organizes and aligns the state's continuum of evidence-based SUD services and interventions to support people with SUDs and related health issues. This syndemic model is used as the primary framework to guide SOR strategies.

Two major efforts within the State Opioid Response include the Save Lives Oregon Initiative that includes statewide naloxone distribution efforts, and the Peer Recovery Initiated in Medical Establishments plus HIV, Hepatitis C and syphilis screening, referred to as PRIME+. The Save Lives Oregon Initiative launched in 2000 and currently there are over 400 agencies participating. Agencies include community-based organizations, substance use treatment programs, behavioral and public health agencies, uniformed first responder agencies and more. The Save Lives Oregon Initiative activities include the development and distribution of communications resources and materials, monthly learning collaboratives, technical assistance and the distribution of supplies, including naloxone, in every county of Oregon. Since its inception, agencies participating in Save Lives Oregon participating have distributed over 790,000 doses of naloxone to people who use substances or are at risk of opioid overdose with over 20,000 community opioid overdose reversals reported to the initiative.

In the 2024-2025 school year, the Save Lives Oregon Initiative partnered with the Oregon Department of Education to distribute naloxone to over 665 public, private, charter, colleges and universities. In the school initiative's follow up evaluation survey, respondents reported deploying naloxone to reverse overdoses onsite 7 times at middle and high schools during the 2024-2025 school year.

The PRIME+ Program is a comprehensive syndemic model that uses peer mentors to reach people in need of treatment for overdose, infections or other substance use related health services. As of September 2024, there were 76 PRIME+ peers working within 21 organizations in 24 of Oregon's 36 counties. Between December of 2022 and September of 2024, PRIME+ peers served 3,928 participants with 25,738 participant contacts logged. The PRIME+ program uses a modified Government Performance and Results Act survey collected at PRIME+ peer service intake and a 6-month follow up. Changes from intake to 6-month follow-up include (a) substance use decreased, past 30 day average (b) Emergency Department (ED) visit decreased for substance use related issues, past 6-months (c) depression decreased, past 30 days, (d) anxiety decreased, past 30 days, (e) housing increased, housed past 30 days, (f) employment increased, percent employed, (g) HIV testing increased, percent every tested and (h) hepatitis C testing increased, percent ever tested.

Lastly, many PRIME+ teams also participate in the State Opioid Response (SOR) Peer Assisted Telemedicine for Hepatitis C and Syphilis (PATHS) intervention, a real-world expansion of a peer assisted telemedicine intervention for hepatitis C and syphilis following a successful randomized clinical trial. Peer specialists support people who use drugs or are in early recovery in accessing infectious disease testing, hepatitis C pretreatment screening, and linkage to telemedicine HCV treatment clinicians, and support participants in medication initiation and adherence.

Oregon Health & Science University (OHSU) clinicians with specialty training in working with people who use drugs provide streamlined access to care. The intervention relies on dedicated community-based peer outreach and support, “on-demand” clinical care, and partners positioned to enact systems change. The PATHS team provides training, technical assistance, and clinical coordination to peer teams and partners implementing the model. Between March 2021 and June 2024, PATHS expanded to 18 of Oregon's 36 counties. In that time, PATHS diagnosed 198 rural PWUD with HCV. One hundred sixty-seven (84.3 %) linked to telemedicine and of these, 145 (86.8 %) initiated treatment. Of those who initiated treatment, 91 (62.8 %) completed treatment, of which 61 (67.0 %) are cured.

h. M110 team

Measure 110 (M110) funds Behavioral Health Resource Networks (BHRNs) in all 36 counties to organize and deliver low-barrier substance use services at the regional, county, Tribal, and local levels. Each BHRN is a coordinated network of community-based organizations, Community Mental Health Programs (CMHPs), and culturally specific and Tribal providers that offer prevention, tertiary prevention, treatment, recovery, and ancillary supports.

Networks meet regularly to coordinate referrals, integrate with Medicaid and public health systems, and identify service gaps. Services target SUPTRS BG priority populations, pregnant and parenting individuals, people who inject drugs, individuals with or at risk for HIV/AIDS, and those in need of primary prevention, through interventions such as naloxone distribution, treatment access, housing assistance, peer recovery mentoring, and population informed care.

i. DUII program

The criminal legal system and arrest for driving under the influence of intoxicants (DUII) is a common way that individuals make their first contact with treatment or education for substance misuse.

Oregon’s DUII services system was developed in 1984. The intent of the system is to reduce impaired driving recidivism among DUII services participants and increase recovery rates for DUII services participants with substance use disorder (SUD), and coordination among community response partners involved in the DUII system. DUII education and treatment for un-and underinsured people is funded through the Intoxicated Driver Program Fund. Funds are allocated as Intoxicated Driving Program Funds (IDPF) via direct contracts with 41 outpatient treatment providers.

Treatment providers offer DUII Education and Treatment services to indigent individuals that have received either a Diversion or Conviction DUII from Oregon courts. OHA utilizes a contracted vendor to support the installation and operation of the Ignition Interlock Device (IID). The IID costs associated with the installation and maintenance of an ignition interlock device required as a result of a DUII in Oregon for indigent individuals when directed by a judge. Note that treatment services are for individuals with substance use disorder, while education is for individuals who do not meet criteria for a clinical diagnosis.

j. ACT Services Team (Adult)

ACT is currently available in 34 of the 36 counties in Oregon with a standardized criteria of prioritizing adults 18 years and older with a serious and persistent mental illness as a primary diagnosis. Within the 41 certified ACT Teams, there are three specialized ACT service providers that operate with additional criteria noting underserved population focus: 1) Native American Rehabilitation Association of the Northwest-population informed for Indigenous populations; 2) Forensic Assertive Community Treatment (FACT) Team-specializing in supporting individuals with serious and persistent mental illness using a forensic and criminogenic approach to reduce recidivism and 3) Outside In specializing in the young adult

population utilizing strategic mental health and substance-use/ co-occurring treatment strategies embedded within ACT for participants ages 18-25 years and houseless. Specialized strategies include various prevention tactics to support a youth under the age of 18 years transitioning into adulthood.

In the past, Oregon utilized a modified ACT Fidelity Scale that unfortunately was not producing the intended positive outcomes. As a result, Oregon Health Authority implemented a complete restructure of the ACT landscape. This restructure entailed the following improvement measures:

(1) Standardized Referral Process: this includes a single form with various risk factors that align with ACT criteria, including substance-use both current & historical, family connections and various other level of functioning risk-factors. This Universal Referral Form is required for any individual seeking ACT services to enforce health equity ensuring every person(s) is evaluated by the same criteria. This process requires every person to receive communication on their referral which additionally promotes ease of access and is intended to strengthen local level care coordination. If conclusion of a referral is to accept for admit into ACT services the best practice guidance is to meet with the individual within seven (7) calendar days as a proactive mechanism to minimize the time-gap in the community a person remains without supports. OHA has noted improvements in local level collaborations as this expansion measure evolves. Short-term evaluation of this progress has indicated positive improvements in our efforts to increase capacity of ACT services.
(2) Oregon ACT teams are currently in transition to follow the Tool for Measuring ACT (TMACT) starting January 1, 2026, as opposed to the former Oregon Modified scale; which has allowed Oregon Health Authority to create a standard of care. With the support from TMACT co-author Maria Monroe-DeVita Ph.D, this transition includes a new Center for Excellence with a local university who is well known for their accomplishments in research. This includes updating technical assistance efforts to our ACT providers by creating new trainings on substance use treatment tactics and field safety which were not available in previous ACT trainings. In addition to these new trainings, the Center will be creating best practice guidance protocols for transitioning ACT participants to lower level of care. This guidance will include evaluation factors that are tracked every quarter (or sooner if clinically necessary) during the lifespan of ACT services for each individual that include relapse intervention strategies, recidivism, recovery goal benchmarks that are person centered and encouragement of reunification with Natural Supports (children, siblings, parents, etc.) if legally attainable.

Included in this transition, Oregon Health Authority will be making updates within the Oregon Administrative Rules for ACT Services to reflect new benchmark fidelity ratings for transparency and tracking purposes of certified ACT Programs. This benchmark will include an incentive for high fidelity programs to extend certification timeline. OHA goal is to encourage higher fidelity outcomes as research reflects high fidelity increases positive outcomes. The new Center for Excellence will be delegated the duty to conduct fidelity reviews and submitting the comprehensive reports to Oregon Health Authority who will remain the certification oversight to ensure billing accuracy.

All ACT Teams in Oregon are required to have the following core specialist staff at a minimum: Employment Specialist, Co-Occurring Disorder Specialist, Peer Specialist, Nurse, Prescriber and Team Lead. As per the eight Core Principles of ACT, Oregon promotes the multidisciplinary team concept as being a fixed point of responsibility to ensure all treatment plans are person-centered and the end goal being that of a person attaining recovery goals, i.e. positive impact from services to the extent that acuity level of need has reduced.

k. <u>Older Adults</u>

OHA funds the Older Adult Behavioral Health Initiative which is in its 10th year. This Initiative places geriatric BH specialists in all 36 counties in Oregon within the CMHP. The Initiative provides the following – promotion of cross-sector collaboration to enhance coordination and better health outcomes for older adults, workforce development trainings to build the capacity of our BH workforce to better assess and treat the BH needs of older adults. These trainings are offered in multiple formats including webinars, in-person conferences and asynchronous training, health and wellness promotion and BH prevention directly to older adults using evidence-based best practices in community-based settings such as senior centers, subsidized housing and churches, and through complex care consultation, where the specialist consults with multiple community partners on complex clients who frequently fall through the cracks and recidivate.

We have offered an annual Geriatric Behavioral Health Conference for the past 8 years. This conference has cutting edge themes and key topics highlighting the intersection of aging, mental health and substance misuse. The goal of the conference is to enhance the capacity of Oregon's CMHP, ACT providers and others to better serve older adults.

Oregon is also invested in mitigating social isolation and loneliness identified as a public health epidemic by the former Surgeon General. OHA funds the Senior Loneliness Line (SLL) a warm line that older adults and their caregivers can call for support, resources and social contact. The SLL receives approximately 1200 calls a month. One successful program is the Pen Pal Intergenerational Program where elementary age school children write letters to older adults in long term care promoting intergenerational social connection.

Through the Initiative and in coordination with OHA Public Health Division CDC Comprehensive Suicide Prevention Grant we are providing PEARLS (Program to Encourage Active and Rewarding Lives) – an EBP developed and tested at the University of Washington. We have adapted PEARLS to be delivered in a 6-session group format in community settings where older adults naturally gather. This is an upstream suicide prevention intervention in its 3rd year. Through the same CDC grant we were also able to train the specialists in CALM, which focuses on lethal means reduction (firearms reduction) and distribution of firearms lock boxes. Through the Initiative we also train providers in QPR (Question Persuade Refer), a suicide prevention training. With our 988 team we have facilitated the development of a 988 communications plan that targets older adults to increase awareness and utilization.

Oregon has also saturated the state with MHFA (Mental Health First Aid) across sectors in rural and urban counties and with different section of the workforce – for example in-home care givers. Through the Initiative we added on the older adult module to MHFA.

We have created a set of training modules for asynchronous learning on substance use disorder in older adults and providing ADL care for individuals with serious mental illness. The goal is to have a well-qualified and trained workforce.

We have created older adult specific trainings and modules for our mobile crisis workforce so that they can meet older adults in crisis with compassion and competence.

Older adults with SMI are served in our CMHP and our Certified Community Behavioral Health Clinics (CCBHC). In addition, CCBHCs are able to see Medicare only clients. In Assertive Community Treatment (ACT) almost 20% of the clients are older adults with SMI. There are a few CMHPs that have developed a specialized older adult programs and teams.

Many of our Federally Qualified Health Centers (FQHC) and RHC have integrated behavioral health in primary care where some older adults with SMI receive mental health services. These same primary care settings also offer Screening Brief Intervention Referral to Treatment (SBIRT) for alcohol misuse.

Enhanced Care Facilities/Enhanced Care Outreach Services (ECF and ECOS) --These programs are a collaborative partnership between OHA Behavioral Health Division and DHS Aging and People with Disabilities (APD). Services are designed to support individuals with complex mental health and complex physical health needs that require a higher level of support than typically provided in a standard care setting.

Programs emphasize person-centered rehabilitative mental health treatment while continuing to work toward transitioning individuals into the most integrated community setting possible. OHA is responsible for collaborating with APD on managing program referrals, and for working with local providers regarding program administration and strengthening coordination between systems. There are nine Enhanced Care Facilities that are either APD licensed residential care facilities or units within intermediate care facilities dedicated to serving individuals who qualify for this service. These programs have higher staffing ratios than traditional APD licensed settings, and mental health staff on-site 7 days a week. Mental health staff work closely with APD in developing strategies to support individuals in meeting their goals. Enhanced Care Outreach Services provides intensive mental health services to individuals living in standard APD licensed settings.

Services, for the most part, are delivered in the community in an outreach model. Treatment services for both ECF and ECOS programs are delivered by designated local mental health providers who have knowledge and competencies in working with the aging population and understand the interplay between physical and mental health.

For Complex Case Consultation and Care Transitions The older adult team within OHA works closely with Oregon State Hospital staff and Aging and People with Disabilities to discharge and or divert individuals with complex needs to the most appropriate level of care in the community. Oregon also has the statutory PASRR program where individuals identified with SMI indicators on a screener before being admitted to a licensed nursing facility receive a comprehensive mental health evaluation and person-centered recommendations.

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths, and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Substance Use and Mental Health Services Survey (N-SUMHSS), the Behavioral Health Barometer, Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS), the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. ***Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention service***

a. <u>OHA Strategic Plan</u>

When people are prevented from accessing good health care by barriers such as high costs, bias, and a lack of trained providers or convenient services, it impacts the broader community. OHA will continue to focus on eliminating those barriers that prevent both individual people and the broader community from being healthy and accessing the care that every person in Oregon deserves.

OHA is committed to the following five goal pillars:
1. Transforming behavioral health;
2. Strengthening access to affordable care for all;
3. Fostering healthy families and environments;
4. Achieving healthy Tribal communities; and
5. Building OHA's internal capacity and commitment to eliminate health inequities.

For the Transforming behavioral health pillar the intent is to build a behavioral health system that works for every child, teen, adult and family experiencing mental illness or harmful substance use by expanding integrated, coordinated and culturally responsive behavioral health services when and where people need them, guided by people with lived experience.

Affordable care works to ensure 100% of people in Oregon have easy access to affordable healthcare, prioritizing communities most harmed by health inequities.

Fostering healthy families and environments that equitably promote health and well-being, especially among communities most harmed by health inequities, by expanding access to: 1) preventive health services and supports, including for new parents and families before and after birth; 2) safe and accessible housing; 3) healthy food and nutrition; and 4) climate resilience.

In honoring the relationships with the Nine Federally Recognized Tribes of Oregon, Urban Indian Health Program, and other health partners, Oregon Health Authority commits to support the ultimate goal of achieving healthy Tribal communities. This empowers Tribal individuals, families and communities across Oregon to achieve optimal health and wellness, through a shared vision of providing opportunities to learn and experience healthy lifestyles through a fully funded continuum of health rooted in traditional and culturally specific practices.

Establish, maintain, and resource the internal infrastructure and accountability mechanisms necessary to acknowledge, reconcile, and redress racism and other forms of discrimination and oppression that undermine the health, well-being and opportunities of people across Oregon.

b. Child and Family Areas of Assessment

Child and Family Behavioral Health (CFBH) reviews best practices for System of Care and aims to bring current services in line with the recommendations in the document. CFBH also relies heavily on family and youth and other community engagement, which includes a weekly forum (2024 summary) for family members, a 9-month effort in 2024 for both youth engagement (report) and community engagement sessions that produced two summary documents and a series of recommendations for Oregon Health Authority.

Coordinated Care Organizations, Network Adequacy

Network adequacy is measured and reported annually by the Medicaid division. Three core metrics, provider counts, network stability and provider-to-member ratios are tracked. The Oregon Administrative Rule for network adequacy is located here. The data from this report and community engagement reveals that there are significant geographic disparities for those living in rural and frontier areas. An extreme example from 2024 is Eastern Oregon, where the mental health provider-to-member ratio for youth is 1:2,116 and 1:2,885 for SUD.

Oregon House Bill 3046 (2021) requires further monitoring of mental health parity. The 2024 report shows compliance for managed care organizations, Coordinated Care Organizations, and partial compliance across all domains for fee-for-service members. This report does not contain child-specific data.

Care Coordination

Quality and availability of appropriate levels of care coordination continue to be a challenge for some populations of youth in Oregon. Risk stratification methods used by Coordinated Care Organizations (CCOs) to organize their work can present challenges to identifying and meeting the unique needs of youth with complex behavioral health needs and challenges. In 2024, Oregon amended and amplified Oregon Administrative Rules for care coordination, 410-141-3500 (definition), 410-141-3860, 410-141-3865 and 410-141-3870.

Tribal youth who may not be enrolled in a CCO and are therefore served in a fee-for-service model, are less likely to access care coordination, as are certain populations of youth covered outside of the CCOs. OHA does maintain a contract with a professional review organization that provides some care coordination for youth not enrolled in a CCO.

Other barriers to care coordination include inflexibility in information sharing related to limitations of the 42 CFR, which regulates privacy consent for youth in SUD treatment. Would a business

associate agreement be one way to overcome this barrier? Some technical assistance around how to do that would be welcomed.

Effective care coordination would be a benefit for youth waiting for high levels of care because of capacity issues. This can be difficult to orchestrate during a waiting period and even after youth are admitted to facilities due to challenges engaging with the youth, and the chaotic environments these youth may be in while awaiting appropriate services. The complex nature of the youth's behavioral health challenges is not always fully addressed. CFBH and Medicaid staff meet regularly with some of the larger CCOs to provide technical assistance but overall, there is a need for expanded training and more careful hiring and supervision of care coordinators among some CCOs.

c. Public Health Division

To date, needs assessment and gaps analyses activities, including review of current surveillance and evaluation data, highlight the following key prevention related program and policy needs and gaps:

Excessive Alcohol Use Prevention: Consistently effective interventions to raise the price of alcohol in Oregon, access to comprehensive alcohol screening, referral, and treatment benefits, maintaining state control for distilled spirits, increasing regulation of alcohol outlet density, retail environments and limiting exposure to and access to alcohol, increasing investments for current County and Tribal funded prevention programs and infrastructure through existing and new funding streams, building capacity for broader local implementation of effective and informed prevention strategies, identifying new funding sources to fund organizations serving communities disproportionately impacted by SUD, and expanding state infrastructure for data and surveillance, evaluation and substance use prevention mass-reach communications.

Overdose Prevention: Cross-agency, multi-sector planning and coordination aligned with the Alcohol and Drug Policy Commission, OHA Tribal Behavioral Health Plan, the OHA Strategic Plan, and Healthier Together Oregon, integrated approaches across the SUD continuum of care and increased population informed communications, resources, and services, non-stigmatizing public communications to raise awareness of substance misuse and overdose risk, naloxone leave-behind programs to increase naloxone availability among high-risk populations, through hospitals, jails, and first responders, expanded and stable funding to ensure statewide coverage of Overdose Prevention & Education Program Coordinators (currently fund only 11 LPHAs covering 23 counties), community-level prevention interventions co-developed with highest priority populations and communities that address intergenerational substance use and root causes of factors that contribute to substance use and overdose, and training and technical assistance for Emergency Medical Services personnel to support initiation of medication for opioid use disorder and referrals to treatment services.

Data sources for primary prevention

The Oregon Health Authority maintains and monitors several population-based data sources to identify primary prevention needs related to substance use prevention and overdose. Oregon ensures timely collection, analysis, and reporting of data through OHA-PHD's existing surveillance and evaluation systems.

Key data systems used to track excessive alcohol, substance use and overdose in Oregon include: Oregon Student Health Survey (SHS), Oregon Behavioral Risk Factor Surveillance System; National Survey on Drug Use and Health (adult risk behavior surveys); National Institute on Alcohol Abuse and Alcoholism; Oregon Health Authority Vital Statistics reports; Fatal Accident Reporting System (FARS); Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE); Emergency Medical Services (EMS), Prescription Drug Monitoring Program (PDMP); and State Unintentional Drug Overdose Reporting System (SUDORS).

The SHS is an annual census-based survey of Oregon 6th, 8th and 11th-grade students. All public schools with students in these grades are invited to participate. The Survey covers a wide range of topics that include school climate, possible youth development, mental well-being, physical health, substance use, problem gambling, violence, and other risky behaviors among Oregon youth. Data and reports from the survey are provided to all participating schools and school districts, and state and county data reports are posted publicly.

OHA-PHD is aligning all data and evaluation activities with broader data initiatives underway at OHA, including Public Health and Behavioral Health Data modernization and new infrastructure for implementation of data systems.

d. Medicaid

Since the implementation of the 1115 SUD Waiver, Oregon has continued to face significant challenges. Overdose deaths have risen both nationally and within the state. Among Medicaid beneficiaries in Oregon, drug overdose deaths increased dramatically from 762 in 2021 to 1,223 in 2023. Synthetic opioids, particularly fentanyl, became the leading cause of overdose deaths in Oregon starting in 2022, later than the national trend. Additionally, psychostimulant-related deaths, such as those involving methamphetamine, remain disproportionately high in Oregon compared to national averages. In 2022, the state's meth overdose death rate reached 17.7 per 100,000—well above the national average of 10.5 per 100,000. Opioid-stimulant combinations contributed to over 40% of overdose deaths in Oregon, and in 2023, deaths involving methamphetamine (1,390) and fentanyl (1,247) were nearly equal in number, underscoring the dual threat posed by these substances.

Amongst these concerning trends, the waiver has yet to fully implement the Community Transition Services option, which is intended to assist individuals transitioning from institutional settings or provider-owned and operated congregate living arrangements. This service, capped at $5,000 per member per lifetime regardless of the number of services provided, remains unavailable due to implementation delays. In response to these challenges, we are committed to improving the system across all substance use categories.

We have emphasized the inclusion of Contingency Management (CM) as a service and strategy in our 1115 SUD Waiver extension request. With support from third-party reporting by the Oregon Health & Science University Center for Health Systems Effectiveness, we are analyzing data to identify high-impact actions that can strengthen access to care and build a more comprehensive continuum of services.

Efforts are also underway to implement necessary updates to the Oregon Medicaid Management Information System (MMIS) Provider Portal, while we continue exploring alternative options for launching Community Transition Services.

Furthermore, we aim to adopt the American Society of Addiction Medicine (ASAM) 4th Edition criteria by revising rules, licensing and certification frameworks, and payment models to continue improved access to integrated, coordinated, and population informed SUD services.

e. 988 section

Oregon's behavioral health needs assessments and a 2025 Secretary of State Audit have revealed several critical gaps in the system, particularly impacting populations served under the Mental Health Block Grant. Systemic and infrastructure challenges include a lack of funding for both the construction and ongoing operation of crisis stabilization centers, insufficient transportation support for individuals in crisis to access essential community resources, and inadequate language access services—such as interpreters for mobile crisis teams. Additionally, there is limited support for the Nine Federally Recognized Tribes of Oregon in the development and delivery of crisis system services.

4. ***Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority***

Children's Continuum of Care

Key gaps and challenges in the children's continuum of care include navigating and access to higher levels of care for families, locating behavioral health services and supports when needed, availability of residential treatment for youth with behavioral health disorders who also have concurrent medical conditions such as diabetes or a seizure disorder, transitional care and stepdown options from higher levels of care, and the need for more quality available care coordination. Community members identified workforce shortages and particularly in rural settings, access to care, also elevated in rural settings, and the need for overall workforce and parent training across a variety and breadth of topics.

Key data sources:

Oregon Health Authority Child and Family Behavioral Health Performance Indicators, April 2023 https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/Performance%20Indicators%20Report_Apr2023.pdf

Oregon Health Authority Child and Family Behavioral Health Performance Indicators, April 2023 https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/Performance%20Indicators%20Report_Apr2023.pdf

2024 Mental Health Statistics Improvement Program Survey https://www.oregon.gov/oha/hpa/analytics/pages/mental-health-statistics-improvement-program-survey.aspx

2024 Mental Health Statistics Improvement Program Survey https://www.oregon.gov/oha/hpa/analytics/pages/mental-health-statistics-improvement-program-survey.aspx

2024 Oregon Student Health Survey https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/SURVEYS/Pages/SHS-2024-Results.aspx

2024 Intensive In-Home Behavioral Health Treatment (IIBHT) services https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/IIBHT-Annual-Report-2024.pdf

2021-2025 Youth Suicide Intervention and Prevention Plan (YSIPP) https://apps.state.or.us/Forms/Served/le8875.pdf

Youth Suicide Prevention remains a priority and a plan for 2026-2030 is in the final stages of being written and disseminated. Oregon has a higher suicide rate (13.5 per 100,000) for youth ages 15-24 than the national average (9.9 per 100,000) for the year 2023. Oregon has the 11th highest youth suicide rate in the United States.

In 2024, Oregon increased the amount of youth suicide prevention programming to span prevention, intervention and postvention work, adding 425 more trainers to suicide prevention programs, and having nearly 2,000 trainers statewide in all 36 counties. Trainers who speak languages other than English and who are Tribal or Indigenous are among this group. In 2025,

93 percent of 2024 priority initiatives in the Youth Suicide Intervention and Prevention Plan 2021-2025 were on track for ongoing work/completion. Oregon continues with a Garrett Lee Smith award spanning 2022-2027 and Comprehensive Suicide Prevention grant through 2027. Suicide prevention work is available in more detail in this report.

Oregon is expanding suicide prevention to address suicide risk in specific groups with disparate rates of suicide. In 2025, the Oregon legislature allocated $1M in state general fund to this effort. Among non-Hispanic youth ages 5-24 in Oregon, African American females had the highest rates of emergency department visits for suicide ideation and attempts. Suicide rates have not decreased for youth of color, in contrast to a 27% reduction in suicide since 2018 for white non-Hispanic youth. Numbers of suicides among non-Hispanic youth in Oregon are overrepresented relative to their population.

Behavioral Health in School Settings

CFBH has school-based access to behavioral health in fifteen counties in Oregon, primarily rural counties that do not have a school-based health center. Services are provided by mental health clinicians and skills trainers from county programs to students and families in grades K-12, regardless of ability to pay or insurance coverage. Students and families can access services in 36 of 197 school districts due to current funding limitations. Many of these communities are isolated enough geographically, or have limited economic conditions for families, that this provides the only point of access to behavioral health care for these students.

Workforce availability is also limited because of geography, or the economic situation in a community. OHA is consistently asked for a broader reach for these services in additional communities; additional funding is necessary due to the corollary services that support school based mental health which are not billable. Technical assistance to support providers with training in evidence-based practices, trauma informed services and supports, and funding models that work in other states would be welcome.

Wraparound Expansion

The Wraparound community in Oregon is requesting Wraparound for all so that any youth with complex needs in two systems can be served. They are seeing that Wraparound could provide early support in connecting youth to other child-serving systems, such as intellectual/developmental disabilities (I/DD) or mental health settings, reducing the likelihood that youth must continue to fail within existing settings, and escalate in their needs, before gaining Wraparound support.

CFBH would like to expand Wraparound to include all youth in Oregon, especially for youth who may not have had a prior mental health assessment, have private insurance, have Medicaid as secondary insurance or who are not enrolled with a Coordinated Care Organization. Wraparound could also be expanded for youth who are multi-system involved with complex needs but may not have a mental health diagnosis. Wraparound can benefit multi-system involved youth who have not yet entered the mental health system – in early childhood, juvenile justice, or child welfare settings.

Wraparound expansion is also needed as prevention and for young children. The value in supporting youth/families in this way is that they gain knowledge of systems, of special education, and of the system which helps families learn how to navigate the system, respond to a crisis, co-regulate, access resources, and advocate. This can reduce the potential for more challenging problems as a youth grows older. This approach provides cost savings such as reducing out-of-school suspensions, hospitalizations, child welfare involvement and other adverse outcomes.

Expanding Wraparound could include having trained Wraparound Care Coordinators and peer support providers in multiple systems outside of mental health – for example, in the juvenile justice system, public health system (integrated health/MH such as certified community behavioral health centers), education system, and child welfare system. Wraparound providers would complete the same training currently offered in Oregon and be dispersed in other environments – creating more reach and access and honoring the System of Care Framework and Wraparound principle of being community-based. Having access in these community-based settings increases access to those in rural and frontier areas, youth and families of color, and LGB youth.

At the end of 2024, there were 1242 youth actively enrolled in Wraparound in Oregon (Oregon Health & Science University Research Electronic Data Capture (REDCap)). The average age of youth actively enrolled at this time is 12.29 years, with a range of 1-21 years.

There are several barriers that create need for funding for Wraparound expansion: programs may not have clinicians to do mental health assessments or update mental health assessments, youth may not wish to engage with the mental health provider and/or complete a mental health assessment, the process to engage in Wraparound may not feel population informed to individual youth or families, programs may be structured as non-profits and not have billing infrastructure or a mechanism to bill Medicaid, multi-system involved youth are involved in state programs who do not have Medicaid – such as Oregon Youth Authority (OYA) for example, or a youth with juvenile justice (JJ)/OYA or JJ/SUD, and some Tribal youth, and requiring mental health services does not fit with the family voice and choice principle in Wraparound. Some providers require the youth to see a therapist in their agency to oversee the mental health assessment and partnering treatment plan. Outside of family voice and choice, this may be a therapist who may not be aware of the needs of distinct population groups and generally this service is provided in the clinic (not honoring the community-based principle of Wraparound).

Funding could be a resolution for barriers by reducing/eliminating the need for Medicaid and insurance billing. Technical assistance for reducing these barriers or for alternative payment models would be welcomed.

Assessment Services

CFBH has a program to expedite assessments for youth with complex behavioral health challenges. Expedited Access to Services for Youth (EASY) was established in 2022 and has recently expanded under contract to additional counties in Oregon. Of those referred, 85% are believed to have an intellectual/developmental disability. Further description of this program will be entered in Section IV Environmental Factors, under section 1. The need remains high and additional expansion is desired.

Transition Planning across levels of care in the children's system

Youth and families have provided feedback that transition planning and services between varying levels of care are generally lacking, and anecdotal evidence suggests that this leads to problematic outcomes. Efforts are being made to revise existing Oregon Administrative Rules for different levels of care to require documentation of transition planning and ensure that it takes place.

Lack of available services for youth in Child Welfare and other youth in crisis

Frequently, youth with the highest and most complex needs have difficulty accessing services to meet their needs. This is especially true for youth in crisis, and for youth in child welfare who may end up in temporary lodging (no available child welfare placement) because of a lack of behavioral health supports adequate for their needs. The behavioral health system for youth in Oregon has insufficient capacity at several levels, notably residential and intensive treatment

services, and this can result in a lack of available services when a crisis occurs for a family or a particular youth. Youth with histories of aggressive behavior and youth with co-occurring BH and I/DD are particularly challenged in getting the care they need in our current system due to stigma, lack of training, and provider shortages.

Efforts are being made in increase capacity in Oregon, with a new psychiatric residential facility opening in early 2026 to serve younger children ages six -13 in Boardman, which is outside the Interstate 5 corridor where most other psychiatric residential facilities in Oregon are located. The 2025 Oregon legislature has recognized the need for greater capacity and awarded $10M to OHA for capacity development and work has commenced on this. Oregon maintains capacity data through the Referral Capacity Management System which is administered by OHA and in which all the licensed residential facilities participate.

Access for groups who experience disparities

Populations of youth who experience disparities to access are youth who are traumatized and externalize trauma with aggression, youth who are disabled, youth of color, youth who identify as LGB, indigenous and Tribal youth, youth who demonstrate sexually harming behavior, and any of these youth who reside in rural or frontier settings. CFBH is working to eliminate disparities in care and access, which persists across systems and settings.

Whenever possible, the needs of these youth are elevated, and services developed to meet their needs. Youth engagement done completed in 2024 indicates the need for training for youth providers in general but especially around the needs of youth identifying as LGB. In 2025, a training series was offered under contract with the Trevor Project to teach providers to become better allies with youth in this population. CFBH has also collaborated with the Oregon Department of Human Services Office of Developmental Disabilities Services to provide recommendations for training for providers of I/DD for LGB identified youth, and for youth with trauma histories. A cross-agency workgroup was established in the summer of 2025 to address concerns between the I/DD and BH systems. Technical assistance for supporting these underserved populations and funding mechanisms to do so would be welcomed.

Family and Youth Peer Support

Oregon Administrative Rules for EASA, Intensive In-Home Behavioral Health Treatment (IIBHT) and for Intensive Services (psychiatric day treatment, psychiatric residential treatment, substance use disorder residential treatment and secure inpatient residential programs), and for Fidelity Wraparound, contain requirements that family and youth peer support be offered in those settings/treatment programs. Other treatment settings encourage but do not require family and youth support.

Co-occurring SUD/MH

Oregon has five residential SUD facilities for youth, two which offer co-occurring treatment, and one that serves children as young as 12 years of age. Oregon has over 100 outpatient substance use disorder programs, many offer co-occurring treatment but exact numbers, with expertise for ages 13-17, are unknown. Many outpatient programs are affiliated with, or even part of, a local community mental health program, so care for mental health and SUD concerns may be more readily available depending on the local structure. Some areas of the state, in particular rural/frontier areas, may have more limited SUD treatment services, or none, available in the immediate locale. Oregon does not have a detoxification program for youth but does have four available beds should that be needed at one of the inpatient SUD treatment facilities.

In the 2025 legislative session $7M was allocated to expanding the Intensive In-Home Behavioral Health Treatment model to pilot programs and teams that can be responsive to co0occurring SUD/MH.

Co-occurring BH/ Intellectual/Developmental Disabilities (I/DD)

Oregon CFBH works closely with the Oregon Department of Human Services Office of Developmental Disability Services (ODHS/ODDS) area to coordinate care needs for youth with co-occurring behavioral health and I/DD treatment needs. The two systems are set up very differently and this can create challenges for shared care coordination. Ensuring policies that do not rely on exclusionary criteria for any point in the continuum of care has been a starting place to address some of the gaps. Senate Bill 1557 (2024) and SB 729 (2025) prohibit providers from denying access for assessment treatment and services solely based on an individual having intellectual/developmental disabilities. Continued work to identify data indicators that demonstrate the disparities in care for I/DD youth with behavioral health needs is taking place.

CFBH is exploring the use of a psychiatric monitoring tool for medication prescribing to improve prescribing practices for this population, and improved workforce training. Technical assistance would be welcomed for use of the Diagnostic Manual, Intellectual Disability (DMID-2), tools to understand needs of this population, and ways to assess existing workforce knowledge to more accurately target training efforts. CFBH is using the ECHO virtual training model to reach more providers and therapists.

OHA is a sponsor of an annual summit event bringing systems, providers and community together to better support this complex and dynamic population at the Oregon Youth IDD Mental Health Summit.

Workforce

Community engagement feedback indicates that training and other supports are needed by the Oregon behavioral health workforce serving children and families. The following areas have been identified as particular needs to focus on: Co-occurring MH/ I/DD – Consultation, trainings and ongoing communication; co-occurring mental health and substance use disorder (SUD) – Developing new capacity and ensuring that providers are proficient in treatment; Wraparound, IIBHT and MRSS, consultation availability for case review; Suicide Prevention, Intervention and Postvention; treatment utilizing evidence-based practice models; technical assistance, supervision and coaching of peer support specialists; and a pilot for centralizing peer coaching and supervision resources.

Youth and Young Adults in Transition Continuum of Care

CFBH serves youth and young adults ages 0-25; we are still building out the young adult continuum of care. Youth and young adults experiencing other disorders (substance-induced psychosis, psychosis-like experiences that do not meet DSM criteria, Major Depressive Disorder, Anxiety disorders, Trauma disorders, and more) need access to population informed and developmentally appropriate services that can meet them where they're at in the community and engage them, but such programs are currently limited. Oregon now has 6 Young Adult "HUB" programs that are specialized to the needs of young adults ages 14-25 inclusive of a recent expansion and programs that are in the process of coming online. Access to non-EASA-eligible Early Serious Mental Illness (ESMI) services for youth and young adults in transition, remains a challenge in Oregon, as EASA is diagnostically restrictive.

The other ESMI gap area is for young adults needing more community-based residential and intensive levels of care, particularly those who are at risk of Temporary Lodging due to aging out of Child Welfare/DHS services or experiencing homelessness in addition to ESMI. Expansion of Young Adults in Transition Residential Treatment homes, particularly in rural areas, is an ongoing need.

Adult Mental Health (Integrated Co-occurring Disorders (ICOD) initiative)

The Integrated Co-Occurring Disorders (ICOD) Program has identified a range of needs based on multiple assessments, reports, and ongoing engagement with providers and stakeholders. These needs were informed by studies such as the Co-Occurring Disorders Gap Analysis, a reimbursement study by Mercer, and a current program evaluation that is still underway. Additional insights were drawn from reports by the OHA Ombuds and technical assistance activities involving approximately thirty treatment providers. These activities included the use of validated assessment tools like the DDCAT, DDCMHT, and the Oregon ICOD Snapshot Tool, all of which align with evidence-based treatment models for co-occurring disorders.

Four broad areas of need have emerged: workforce development, policy alignment, operational improvements, and system-wide enhancements. Workforce challenges include the need for specialized clinical training to effectively treat individuals with co-occurring disorders who also experience intellectual and developmental disabilities, serious mental illness, or eating disorders. In terms of policy, there are regulatory inconsistencies that must be reconciled, particularly those between HIPAA regulations for mental health and 42 CFR Part 2 for substance use treatment, as well as discrepancies in background check requirements for direct care providers.

Operational needs involve better integration of physical health services into the ICOD framework and greater support for harm reduction efforts through funding and technical resources. On a system level, there is a pressing need to expand enhanced residential levels of care for individuals with serious mental illness and co-occurring disorders, to increase ICOD treatment capacity in existing mental health residential settings, and to establish recovery-oriented housing for those managing co-occurring mental health, substance use, and gambling disorders.

While the ICOD Program can dedicate internal analyst time to address policy and operation's needs, advancing solutions in the areas of workforce development and broader system improvements will require additional funding and action at the legislative or executive leadership level.

988 and Crisis System gaps and challenges

Workforce shortages further exacerbate challenges within the crisis system. The state faces a severe deficit of behavioral health professionals, especially in rural and underserved areas. There is also a notable lack of population informed and linguistically specific providers, and high levels of burnout and turnover persist due to administrative burdens and low compensation.

Service delivery gaps are also significant. Oregon lacks adequate residential treatment capacity for both youth and adults, and there is limited integration of substance use disorder (SUD) treatment into youth behavioral health models. Moreover, population informed services remain insufficient across the continuum of care.

These gaps disproportionately affect several priority populations, including children and youth with serious emotional disturbances (SED), adults with serious mental illness (SMI), individuals with or at risk of SUD, Tribal communities, ethnically and linguistically diverse populations, and people involved in the criminal justice system.

5. ***Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.***

a. Public Health Division Prevention Team

Preventing substance misuse and improving access to high quality, affordable, population informed, and linguistically appropriate substance use disorder (SUD) services remains a stubborn and persistent challenge in Oregon. Oregon's SUD rate (21.6% in 2022-2023) is significantly higher than the U.S. rate (17.2%), with about one in ten Oregonians having a drug use disorder (12.7%) (2022-2023 NSDUH). Polysubstance use, involving more than one drug type, accounted for more than half (66.5%) of overdose deaths in 2023 (Oregon State Unintentional Drug Overdose Reporting System [SUDORS]).

Communities experiencing the highest impacts related to excessive alcohol use and illicit drug overdose in Oregon are young adults (18-34) and adults (35-55) from: non-Hispanic Black populations, American Indian/Alaska Native (AI/AN) populations, and communities with high rates of poverty and economic disinvestment, including persons who experience housing instability and homelessness

Alcohol Misuse. Oregon has the 15th highest per capita alcohol consumption in the U.S. with per capita consumption above U.S. rates (2.8 vs. 2.8 gallons of ethanol) (2022 NIAAA). Alcohol use is suspected prior to or during drug use for 1 in 5 unintentional/undetermined drug overdose deaths (20.1%) in Oregon (2020-2023 SUDORS).

While binge drinking among Oregon 8th and 11th graders has decreased, it has remained high among Oregon adults: at 14.7% in 2001 and 16.3% in 2023 (BRFSS), with binge drinking among young adults (ages 18-34) at 22%. 18.3% of adults report excessive drinking (either binge or heavy drinking) in the past month (2023), with more men (21.2%) than women (15.4%) reporting excessive drinking.

Impacts (Alcohol) Non-Hispanic Blacks in Oregon have an alcohol-related death rate of 66.3 per 100,000, which is higher than non-Hispanic whites (55.2 per 100,000). (2019-2022, Oregon Vital Records). The rate of alcohol-related deaths among AI/AN groups (110.9 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. We are aware that systemic racism, discrimination, oppression, toxic stress, and trauma continue to perpetuate disproportionate health impacts.

Opioids and other Drugs. Oregon experienced a decrease in fatal overdoses from 2023 to 2024 for the first time since 2016. Despite this decrease, Oregon is continuing to experience high rates of overdoses from illicitly manufactured fentanyl and non-opioid drugs such as methamphetamine. In 2024, 1,440 people died from an unintentional or undetermined overdose in Oregon. Approximately 97% of those deaths were attributed to opioids and/or stimulants, and more than half of those deaths involved both opioids and stimulants. Among fatal overdoses, 989 (68.7%) deaths were attributed to fentanyl and 919 (63.8%) deaths were attributed to methamphetamine. The majority (82%) of overdose events in Oregon occurred in urban counties, although the crisis also has affected rural and frontier counties (2024 SUDORS).

Community Impacts (Overdose). High rates of overdose death continue to occur among Non-Hispanic-Black and American Indian/Alaska Native (AI/AN) communities, who experienced overdoses at more than double the rate of White communities (2.5 and 2.4 times higher, respectively) from 2020 to 2023. Black populations had the highest overdose death rate in Oregon (73.8 deaths per 100,000 people) during this timeframe. A large majority (91.5%) of overdose deaths occurred among persons 18 to 64 years old. Nearly 18% of Oregonians who experienced a fatal overdose were also reported as having an alcohol use problem. Alcohol contributed to nearly 12% of overdose deaths, and 10.4% of

decedents had a blood alcohol level >= 0.08% on postmortem toxicology (2020-2023 SUDORS).

Needs Assessment and critical prevention gaps in the SUD continuum of care

Under the leadership of the Oregon Alcohol and Drug Policy Commission (ADPC), Oregon's comprehensive 5-year strategic plan outlines an overall vision, goals, and strategies for modernizing Oregon's substance use prevention, treatment, and recovery system. The ADPC plan shares a strategic goal area with the Public Health Division's State Health Improvement Plan, Healthier Together Oregon. Oregon's Tribal Behavioral Health Plan also outlines goals and strategies to address gaps in Tribal investments. All plans support OHA's overall strategic goal of eliminating health inequities by 2030. Since 2022, the Oregon Legislature has invested over $1 billion in Oregon's behavioral health system, laying the foundation for change in parts, but not all areas, of the SUD continuum of care, with almost no new funding allocated to substance use prevention. In 2020, Oregon voters approved the Drug Addiction Treatment and Recovery Act (Ballot Measure 110). A component of this bill allocated funding for 53 new Behavioral Health Resource Networks (BHRNs) covering all Oregon counties and 11 Tribes and Tribal health organizations to provide outreach, referral, tertiary prevention, outpatient, and residential treatment services, but with no designated funding for prevention.

In 2024, OHA conducted a SUD financial analysis of behavioral health services with recommendations for addressing funding, program, and infrastructure gaps across the SUD continuum. The analysis identified that Oregon greatly lacked the SUD workforce needed. In prevention, the gap was significant with a need of 968 Certified Prevention Specialists (CPS) but less than 100 existing.

Substance use prevention is categorically funded through federal sources and limited state general revenue funds which further contributes to a fragmented funding, program, and policy landscape. However, in 2020, the "Tobacco and E-Cigarette Tax Increase for Health Programs" (Ballot Measure 108) raised the tobacco tax and allocated 10% of new revenue (approximately $50 million) to address tobacco related health inequities in Oregon. These funds have been used to support geographic and community-based organizations (CBOs) and regional health equity coalitions (RHECs) to address the root causes of tobacco use which can reduce overall substance use in tandem. Oregon's Opioid Settlement Prevention, Treatment and Recovery (OSPTR) Board has allocated over $90M in state opioid settlement funds, with only $13.7M going toward primary prevention investments. Oregon cities and counties receiving opioid settlement funds reported that, collectively, only 5% of subdivision funding supported primary prevention initiatives in Fiscal Year 24.

a. Tribal Behavioral Health

The land we now call Oregon is home to Nine Federally Recognized sovereign nations that have called this place home since time immemorial. All American Indian and Alaska Native people in Oregon, regardless of Tribal enrollment, are Oregon citizens and are entitled to receive the services provided by OHA.

As part of our government-to-government relationship with these nations, OHA takes direction from the Tribes in how best to support their communities. Behavioral health is a top priority and is approached, comprehensively. Beginning on January 1, 2025, intergovernmental agreements were established between OHA and the Nine Federally Recognized Tribes of Oregon to hold the bulk of behavioral health funding in one contract. This new contracting process has streamlined upwards of fifteen separate contracts, thereby reducing administrative burden to the Tribes and creating one point of contact through the Tribal Behavioral Health liaison position who is responsible for administering these contracts.

TAD 352 Alcohol & Other Drugs (AOD) Prevention: To plan, implement and evaluate strategies that prevent substance abuse by reducing risk factors and increasing protective factors associated with alcohol and other drugs in Oregon Tribal Communities.
TAD 353 Tribal Tobacco Prevention: Addresses commercial tobacco and nicotine use and reduces tobacco-related health inequities through the prevention and management of chronic disease related to commercial tobacco and nicotine.
TAD 354 Tribal Community Behavioral and SUD: Builds upon resilience, assists individuals; youth and adults, to make healthier lifestyle choices, and to promote recovery from substance use disorders.
TAD 355 Intoxicated Driver Program Fund: Supports the delivery of eligible services to Oregon residents who have been adjudicated in an Oregon court for Driving Under the Influence of Intoxicants (DUII) or Minor in Possession (MIP) and who are indigent.
TAD 356 Housing Assistance: To plan and implement strategies that reduce access to barriers in housing, by providing community education for available resources in local/Tribal communities.
TAD 357 Tribal State Opioid Response Grant: Addresses the opioid overdose crisis by providing resources for increasing access to FDA-approved medications for opioid use disorder (MOUD), and supporting the continuum of prevention, treatment, and recovery support services for OUD and other concurrent substance use disorders.
TMH 303 Tribal Mental Health Start-Up for Mobile Crisis Services: To improve behavioral health crisis services to be population informed and developmentally appropriate. Crisis services are inclusive of crisis call lines, community based mobile crisis intervention services, and crisis stabilization services.
TMH 304 Tribal Mental Health Services: Improves the mental health of individuals and families.
TMH 305 Tribal Veterans Behavioral Health: Increases access to behavioral health services, and/or increases the availability of military-specific behavioral healthcare services for the veteran and military population.
TMH 306 Tribal Youth Suicide Prevention: Creates wellness for Oregon young people (ages 0-24) ensuring that young people can build connectedness, to cope well when life is hard, and to access help when needed.
TMH 307 Tribal Workforce Clinical Supervision: Clinical Supervision Program will provide access to clinical supervision for licensed psychologists, licensed marriage and family therapists, licensed professional counselors, licensed clinical social workers, masters' level social workers, and substance use disorder treatment staff who are certified supervisors to provide supervised clinical experience to associates.
TMH 308 Tribal Workforce Other Incentives: To increase the behavioral health system's capacity to provide population informed care that is deeply embedded in equity-centered responsiveness, de-stigmatization of services, promotion of restorative healing and community empowerment.
TMH 309 Tribal Residential and Housing: The funding appropriation is an investment in Oregon's community-based behavioral health and substance abuse treatment systems, specifically for increasing statewide capacity of licensed residential facilities and housing serving people with behavioral health conditions.
While these comprehensive intergovernmental agreements reduce administrative burden and allow for comprehensive assessment, planning, implementation and evaluation of Tribal Behavioral Health needs to take place on an ongoing basis, there remains a significant need for fiscal support due to the wide ranging and persistent needs of the AI/AN population in Oregon. The Nine Federally Recognized Tribes of Oregon are rurally located and therefore have limited access to the wide variety of services available to those in urban locales. Rurally located individuals often lack transportation, childcare and other resources to access services. Additionally, Tribal Nations do not have a tax base that allows for other

revenue to be generated and therefore rely on Indian Health Services and the State to help support the provision of behavioral health services.

The AI/AN population in Oregon, similar to the rest of the country, continue to suffer significantly higher rates of substance abuse, mental health crises, disease and death by suicide and overdose more than any other populations as evident through the data presented throughout this application. It is critical and necessary that funding continue to be made available through federal and state partnerships with the Nine Federally Recognized Tribes of Oregon and the Oregon designated Urban Indian Health Program (UIHP).

The primary needs of the Nine Federally Recognized Tribes of Oregon and the Native American Rehabilitation Association of the Northwest (our State's sole designated Urban Indian Health Program (UIHP)) being addressed are as follows:

1) Clarification on budget spending and budget spending timelines. Tribes and our UIHP want to know and clarify what is allowed to be spent and this question comes up frequently. It is very important to them to stay within the spending guidelines of the State Block Grant but also to comply with federal requirements. They sometimes require extensions or request them, to spend down their funds. This is often triggered by local administrative changes or the time it takes for them to receive their funds.

2) Reporting requirements are consistent with SAMHSA regulations that the state receives for this contract. We do not add "extra" reporting requirements as we do not want to create unnecessary administrative burden for the Tribes and our designated UIHP. There has been an effort to encourage more consistent and detailed reporting, and this has shown improvement in line with the Tribes being trained, not only for their Certified Prevention Specialist (CPS) credentials, through their CPS Cohort but also in their Certified Alcohol and Drug Counseling (CADC) credentialing. Reports continue to show improvement in alignment with program plans submitted to State staff, more detail is being provided, over time and this is being done on a more consistent basis. This trend has been followed, over the past three years and we continued to monitor these reporting improvements, but we also continue to provide training opportunities. This helps Tribal programs "tighten up" on their program plans, write more realistic plans, execute those plans and report on them, more accurately. They are doing the work but the emphasis to capture the work that they are doing and work with them to share that work with us still under way.

3) Tobacco cessation work has really taken off with the Tribes and the designated UIHP. Much training has taken place and continues to take place around Tobacco Cessation. As many as four different programs are being utilized, two adult focused and two youth focused for American Indians and Alaskan Natives, specifically. Tribes are also building up their local infrastructure around closed loop referrals for these services. We've contracted with the Northwest Portland Area Indian Health Board to assist the Nine Federally Recognized Tribes in Oregon and NARA-NW. Some strides in these programs have been made but more work needs to continue and will continue to be done along these lines with our contracted partners in this work.

4) Data sharing, so that Tribes can make an informed decision with their Behavioral Health programs is an area where improvement is taking place but could also grow. Oregon Senate Bill 841 (2025) authorizes the Oregon Health Authority to enter into agreements with federally recognized Tribes to share public health and prescription drug monitoring program (PDMP) data, allowing Tribes to manage disease reporting and investigate public health issues, including the opioid crisis, within their

communities. This legislation enhances data sharing and strengthens public health efforts by empowering Tribes to receive and investigate disease reports and access PDMP data. There is also a stressed importance and concern around Tribal Data Sovereignty with the Nine Federally Recognized Tribes of Oregon. Senate Bill 841 did pass but it's counterpart, which could strengthen the data sharing agreements and Tribal Data Sovereignty, did not pass. Oregon Health Authority Tribal Affairs staff, Behavioral Health staff and other subject matter experts will continue to work with Tribes on these issues.

b. Children with serious emotional disorders, co-occurring SUD/MH or co-occurring MH/ I/DD

Children and youth with serious emotional disturbances or substance use disorders: Access to care for children with SED continues to be a challenge for Oregon related to workforce and diminished capacity from the pandemic. In recent years we have begun expanding our continuum and it now includes intensive in-home behavioral health treatment (IIBHT), mobile crisis (in development) and continued efforts to divert children and youth from the emergency department whenever possible. We have improved our ability to collect data from residential providers on referrals and capacity and are working to develop more residential beds, with 37 additional beds opening in the next two years.

Substance Use treatment programs for youth are residential and outpatient settings that include family, individual and group therapy. Therapy assists youth to review the reasons they use substances, habits that lead to substance use and recommends lifestyle changes they can make to disrupt those habits, and the impacts of peer groups and peer pressure. Other services include monitoring through urinalyses, and discussion of life events that may have impacted substance use, family involvement support, and peer support mentorship. Children under age 12 often need a treatment plan matched to their developmental level and skills and should not be treated with older adolescents 13 to 17 years old. Adolescents are most appropriately treated with their peers and not with adults. Youth Detox services are available (two beds) for ages 12 –17 using Medically Assisted Treatment. Youth residential treatment Level 3.3 is available for ages 12 - 17, and Youth residential treatment Level 3.5 with Co-Occurring Disorders is in development.

Oregon CFBH works closely with the Oregon Department of Human Services Office of Developmental Disability Services (ODHS/ODDS) area to coordinate care needs for youth with *co-occurring behavioral health and I/DD treatment needs*. The two systems are set up very differently and this can create challenges for shared care coordination. Ensuring policies that do not rely on exclusionary criteria for any point in the continuum of care has been a starting place to address some of the gaps. Senate Bill 1557 (2024) and SB 729 (2025) prohibit providers from denying access for assessment treatment and services solely based on an individual having intellectual/developmental disabilities. Continued work to identify data indicators that demonstrate the disparities in care for I/DD youth with behavioral health needs is taking place.

CFBH is exploring the use of a psychiatric monitoring tool for medication prescribing to improve prescribing practices for this population, and improved workforce training. Technical assistance would be welcomed for use of the Diagnostic Manual, Intellectual Disability (DMID-2), tools to understand needs of this population, and ways to assess existing workforce knowledge to more accurately target training efforts. CFBH is using the ECHO virtual training model to reach more providers and therapists.

c. <u>EASA Team</u>

One local team serves teens and young adults, providing psychiatry, nursing, counseling/social work, occupational therapy, supported employment and peer support, in a multi-disciplinary approach.

Community education, early identification and outreach occur to engage young people regardless of funding or other barriers. Feedback-informed treatment and integration of participatory decision-making takes place at all levels.

EASA is evidence-based care: it provides comprehensive strengths-based assessment and treatment planning, family partnership and multi-family psychoeducation, evidence-based support for work, school and career development, substance abuse services integrating motivational interviewing and a tertiary prevention approach, intensive coordination of care within the team and with community partners and gradual transition to long-term supports over a two-year period.

Service access inequity by geographic location can be a gap in some parts of Oregon. Rural programs often aren't able to offer or sustain multi-disciplinary team staff, particularly Occupational Therapists, Employment Specialists, Peer Specialists, and Nurses.

Access to appropriate and adequate step-down care when an EASA participant is transitioning out of the program has been a challenge for providers to find and an area of feedback consistently given by EASA family members and participants themselves. The EASA model requires transition planning, but the only options in most parts of the state are Treatment As Usual (adult outpatient care).

Technical assistance needs are for program sustainability information and funding including utilizing commercial insurance and assistance preparing to publish updated research on outcomes of CSC for ESMI population.

d. Women's Residential Services

Oregon has ten specialized residential programs serving pregnant and parenting women with substance use disorder. These programs deliver trauma-informed, evidence-based care and comprehensive wrap-around services, including case management, parenting skills development, peer support, housing coordination, transition planning, and other recovery support coordination.

Collaboration with Oregon Department of Human Services, Child Welfare Division, is integral to these programs, aiming to prevent child removal and promote family reunification when possible.

In select rural areas, programs benefit from *Nurture Oregon,* an integrated care model that combines prenatal and postpartum healthcare with substance use and mental health treatment, peer recovery support, and coordinated services to better meet the unique needs of pregnant and postpartum women using substances.

These programs are geographically distributed statewide and receive referrals from a variety of sources including Coordinated Care Organizations, healthcare providers, child welfare, withdrawal management programs and self-referral. The system is essential to improving outcomes for women and children across Oregon.

In addition to pregnant and parenting residential programs, there are residential programs for women without children who require a higher level of care. These programs are for people who meet ASAM criteria for level 3-3.7 levels of care, providing intensive evidence-based clinical services, case management and other vital service coordination.

e. State Opioid Response

State Opioid Response Grant

The Recent Scope of OUD, SUD, and Overdose Mortality in Oregon

Substance use is prevalent in Oregon, leading to higher-than-average rates of substance use disorder (SUD) and opioid use disorder (OUD). Among the states, Oregon has the second highest prevalence of past month illicit drug use (24.0%) and the highest prevalence of illicit drug use other than marijuana (4.4%). Oregon also ranks sixth for the highest prevalence of prescription pain reliever misuse (3.8%) and fourth among the states for the highest percentage of the population with SUD (21.9%).1 Among Oregonians enrolled in Medicaid in 2022, 6.1% had a SUD diagnosis, 2.3% had an OUD diagnosis, and 2.3% had a stimulant use disorder (StimUD) diagnosis.

In 2022 in Oregon, there were 1,288 overdose deaths.3 The number of drug overdoses per 100,000 population in 2022 was 30.2, up 18% from 25.6 in 2021.3 Oregon experienced a massive 22.8% increase in the number of reported overdose deaths in the 12 months ending December 2023—the third greatest increase in the United States.

Most of the rise in overdose deaths can be attributed to increases in synthetic opioid and psychostimulant-involved deaths. Over 42% of overdose deaths involved opioids with stimulants and over 65% of deaths were caused by fentanyl, 58.4% were caused by methamphetamine, and 9.4% were caused by heroin alone or in combination with other drugs.4 Between December 2022 and December 2023, the 12-month-ending provisional number of overdose deaths involving synthetic opioids increased 43.9% (from 859 to 1,236), and those involving psychostimulants rose 34.4% (from 767 to 1,031).

State Opioid Response Grant Areas of Greatest Need

Oregonians aged 18 to 25 have the highest prevalence of opioid misuse (4.7%) and prescription pain reliever misuse (4.4%) and the second highest prevalence of SUD (35.7%) among the states. In the State Opioid Response Grant among Medicaid enrollees, the prevalence of use disorders is highest among those aged 35 to 44 (11%); American Indian or Alaska Native (10.5%), White (7.9%), and non-Hispanic people (7.6%); males (6.7%); and those living in the Southwest (7.4%), Southwest-Coast (7.3%), and Northwest Rural regions (6.9%).2 Compared to the state average, Black and African American people have a higher prevalence of SUD (7.3% vs. 6.1%) and StimUD (2.9% vs. 2.3%). People living in rural communities have a higher prevalence of SUD (6.3% vs. 6.1%), and people in urban areas have a higher prevalence of OUD (2.4% vs. 2.3%). In addition to the Northwest Rural region, people living in the Southwest (2.9%), Eastern (2.4%), and Portland Tri-County (2.4%) regions have higher than average rates of OUD, and people in the Southwest-Coast (2.9%) and Central (2.6%) regions have higher rates of StimUD.

Rates of overdose emergency department (ED) visits increased 16.3% between 2018 and 2023. In 2023, the overdose-related ED visit rate among men was 6.6% higher than women and has increased 43.5% since 2020. Overdose ED visit rates are also higher than the state average among those aged 15 to 19 (513.1), 25 to 34 (454.1), 20 to 24 (412.8), and 35 to 44 (359.8). Overdose ED visit rates increased by 60.3% among those aged 35 to 44 between 2018 and 2023.6 In terms of location, overdose-related ED visit rates are highest among people from rural areas (283.4), and in the Southwest (321.7), Mid-Valley (288.2), and Southwest-Coast (278.0) regions.6 Overdose-related hospitalizations are highest among people from urban areas (101.5) and in the Southwest-Coast (159.3) and Southwest (111.5) regions.

The number of drug overdose deaths per 100,000 was highest among Black and African American (86.6) and American Indian or Alaska Native (76.8) people; and males (43.5) generally, but especially those 35 to 44 (79.4).3 Over 22% of people who died of overdose in Oregon experienced houselessness or housing instability.

Across eight geographic regions, unintentional and undetermined drug overdose death rates were highest in the Southwest-Coast (39.4), Southwest (34.9), and Portland Tri-County (32.3) regions.

Strengths, Unmet Service Needs, and Critical Gaps in Oregon's Service System

One of Oregon's strengths to combat the overdose crisis is the Save Lives Oregon/Salvando Vidas Oregon (SLO/SVO) Initiative, created in 2020, which offers tertiary prevention-related training and technical assistance (TTA) and provides life-saving supplies, through a Clearinghouse, to organizations and Tribal communities across Oregon. Despite recent gains in tertiary prevention education and fatal overdose prevention, there is more to be done in Oregon to reach unmet treatment needs. In 2022, 23.5% of Oregonians were classified as needing SUD treatment, but only 20.9% received treatment.

Among the states, Oregon has the highest percentage of individuals aged 18 to 25 who need substance use treatment. Among Medicaid enrollees, an estimated 59.0% (out of 31,209 enrollees with an OUD diagnosis) needed but did not receive treatment and 72.7% needed but did not receive medication for opioid use disorder (MOUD). Across all SUDs, and among those with StimUD, unmet need is even greater. Among those with a SUD diagnosis, 68.4% needed but did not receive treatment, and for those with a StimUD diagnosis, 77.1% of individuals did not receive treatment. Males, those aged 45 to 64, Black and African American and American Indian or Alaska Native people, and people living in rural communities and the Southwest and Southwest-Coast regions had higher than average prevalence's of SUD and lower than average rates of SUD treatment.

Other critical service gaps in Oregon include those related to overdose intervention. In 2022, there was at least one opportunity for intervention in 71.9% of drug overdose deaths. Nearly half of decedents potentially died in the presence of a bystander, and among those bystanders, only 29.1% provided an overdose response. Overdose reversal medication (ORM) was administered in only 26.5% of opioid-involved deaths.

Regions Where Opioid and Stimulant Use, SUD, and Hospitalization are Prevalent

Opioid and stimulant use, SUDs, and hospitalizations are the most prevalent in the Southwest, Southwest-Coast, and Portland Tri-County regions and rural communities in Oregon. People living in the Southwest and Southwest-Coast regions face greater rates of SUD, substance use-related hospitalizations and overdose-related ED visits and hospitalizations, unmet SUD and OUD treatment needs, and fatal overdoses. The Southwest region has higher rates of OUD and SUD-related ED visits, and the Southwest-Coast has higher rates of StimUD. Although all other regions experienced stable or decreasing rates in overdose-related hospitalizations, rates in the Southwest-Coast increased by 10% between 2018 and 2023.

After the Southwest and Southwest-Coast regions, the Portland Tri-County region has the third highest rate of drug overdose deaths and also has a higher rate of OUD. Rural communities experience higher than average rates of SUD and SUD-related ED visits and hospitalizations and lower than average rates of SUD treatment.

Naloxone Distribution and Saturation Plan

Estimating Saturation and Approach to Generate Saturation Estimates

Using 2017 data, Irvine et al.'s national modeling study estimated that Oregon would need to distribute 82,000 community-based ORM kits or 84,000 pharmacy-initiated kits to reach saturation and maximize the probability of ORM use during a witnessed overdose, to avert 240 annual deaths. In 2017, Irvine et al. considered Oregon a heroin and prescription opioid epidemic state. No updates to modeling ORM saturation estimates have been made to Irvine et al.'s study, and since then, fentanyl has come to predominate the opioid drug

supply in Oregon. The annual number of overdose deaths involving fentanyl has increased 880%, from 86 in 20178 to 843 in 2022. Between 2017 and the most recent data (2022), opioid overdose deaths in Oregon nearly tripled, and thus, the need for ORM has dramatically increased.

Utilizing services from a SAMHSA TTA provider during the SOR 3 grant, OHA SOR staff worked to develop a more accurate estimate of ORM saturation. Through these TTA meetings, it was determined that Oregon's ORM distribution plan, which primarily focuses on getting ORM into the hands of people who use drugs (PWUD), is targeting the appropriate populations and numbers, and is aligned with Oregon's strategic priorities. The SAMHSA TTA provider offered additional resources and referred OHA staff to the Delaware SOR team to learn how their state calculates their ORM saturation number(s). Based on information gleaned from these meetings, and in the current environment involving a rise in fentanyl, Oregon has determined that it will need to continually assess the data and revise saturation estimates, as needed.

Based on past overdose data and utilizing knowledge from SAMHSA TTA, Oregon proposes to multiply the previous estimate of ORM kits needed to meet saturation by the percentage increase in opioid overdose deaths (see above). Oregon's best current estimate to reach ORM saturation is approximately 233,000 doses annually. This is likely an underestimate, however, given the continued unpredictability and shifts in the drug supply.

Estimated Annual Naloxone Need

OHA began distributing ORM to community-based entities through the SLO/SVO Harm Reduction Clearinghouse in late 2020. As of January 2024, 881 entities, of which 596 were schools, have partnered with the SLO/SVO Clearinghouse and distributed 391,000 ORM doses.9 Schools received a one-time allotment for ORM for on-campus overdose response. The remaining 285 entities were community-based organizations that distributed ORM directly to PWUDs in communities around the state. According to Oregon All Payer Claims data,10 5,871 ORM units were paid for by commercial insurance and were dispensed through pharmacies in 2022. Based on these estimates, the state needs at least an additional 97,000 annual doses of ORM to meet saturation estimates, although this estimate is likely vastly understated.

Naloxone Supply Gaps

OHA's ORM saturation plan has focused primarily on reaching people with the highest probability of experiencing or witnessing an overdose,11 through distribution to organizations and entities directly distributing to PWUDs and their social networks. In 2023, SLO/SVO expanded its supply Clearinghouse with opioid settlement funds to offer supplies, such as ORM, to a broader range of partners. While Oregon continues to prioritize the distribution of ORM to partners that directly distribute to people who are using substances, OHA now provides access to state-funded ORM for rural special districts, schools, colleges, and school-based health centers (SBHCs). Since the expansion, 596 schools, colleges, universities, and SBHCs have enrolled, which suggests a high level of unmet need. A supply gap likely still remains for youth and young adults, and Oregon will continue to find ways to expand reach to this age group.

f. <u>Assertive Community Treatment (ACT) Team</u>

In Oregon, the ACT system is compiled of various stakeholders in a tiered hierarchy that all contribute to, assuring that ACT is that of quality care and is upheld per the evidence-based model. In the past, Oregon's ACT service data reflected not only a decline in the number of individuals receiving this service, but also that individuals were not achieving favorable numbers to reduce acute re-admissions nor reducing recidivism. Our community members

who needed ACT services were not gaining the intended outcome objective of the service. This acknowledgement led OHA to revamp the entire ACT system.

Both behavioral health providers (certified ACT Teams) and Coordinated Care Organizations play a significant role in collecting and reporting data that is designed to capture their responsibility within the ACT system, with the Oregon Health Authority being the governing and final decision entity of all certifications. Any provider in Oregon must go through the outlined procedure to be recognized as an ACT program. This is to ensure that any behavioral health agency who would like to offer this service, is thoroughly trained and learns all the reporting requirements that come with this certification.

The data revamp that occurred in 2024 is aligned with the TMACT transition and is the top tier evaluation process that is used to assess needs and possible trends/gaps. OHA currently has two separate methods of data collection that strategically captures a well-rounded picture of ACT participants in Oregon. OHA's new direct data system, collects all PHI including but not limited to: date of birth, racial and ethnicity identifiers, gender, living situation (that can be updated at any time to reflect current status), diagnosis, treatment status, date of treatment, where the treatment was delivered, cost of service and discharge date.

The new Center for Excellence will be collecting additional data indicators in late Fall 2025 to add to OHA's direct data, allowing full assessment of the providers overall treatment delivery tactics and evaluation of success and/or integrity of ACT service implementation. By compiling both data sets, the Center for Excellence will be responsible for providing full comprehensive analysis report each quarter, and a full needs assessment annual report which will include published fidelity outcome data. The annual report will include overall analysis of Oregon ACT landscape fidelity highs/lows & improvement needs, capacity, recidivism/hospital admit rates, crisis call reductions/increases, community-based treatment/reintegration focus, relapse reduction and correlation of treatment strategies, health equity gaps/ease of access and fiscal impact and/or needs.

The specific indicators the Center for Excellence will be collecting to contribute to the comprehensive reports will be quantitative data for referrals received, admits, denials, waitlists, individuals served, crisis calls to the ACT Team directly (not Mobile Crisis/988), dispatches for crisis calls by the ACT Team (not Mobile Crisis Team/988), non-Medicaid participants, planned discharges (Graduates/planned transitions to lower level of care) and Unplanned discharges (i.e. incarceration, acute setting admit, whereabouts unknown, assault towards an ACT Team member and client choice/moved out of area).

In addition to data collection, OHA has created an ACT Advisory Committee that consists of equal representation of three ACT Team Leads in each geographic area of urban, rural and frontier communities. Alongside the ACT direct service staff, there is representation of two Coordinated Care Organizations (CCOs) that also cover the three geographic locations. The Center for Excellence, Oregon State Hospital designee and OHA ACT policy oversight staff member also attend; however, the priority objective is for Team Leads and CCOs to provide recommendations on form/template creations by the Center or OHA, identify barriers/local level trends or request training topics for the overall ACT system. This platform is to ensure advocacy and needs awareness at the local level are brought to the Center for Excellence and to OHA attention timely and efficiently for effective strategy planning. With this more condensed meeting group, these discussions can be more thoughtful and specific to planning.

Additional platforms created by OHA that contribute to the needs assessment analysis are: the bi-monthly ACT Learning Collaborative which is an OHA hosted virtual platform for any ACT direct service staff to attend and have routine direct access to OHA for the purposes of receiving updates, trainings, give program updates, local level networking and

discuss any barriers/concerns with other ACT direct service staff. This platform has been extremely helpful in assessing needs and trends as the direct service staff are very open and honest with concerns, needs and discussion often goes into the intricacies of real situations within recent history. This is as close to real-time as any previous technical assistance platform Oregon had in place.

The Center for Excellence is expected to do site visits for each certified ACT Team at least once a year. In addition to this, there is current strategy planning (approved by ACT Advisory Committee) to do quarterly geographic stakeholder meetings with the objective to bridge gaps at the local level and increase awareness of ACT services. This new platform is part of the goal to expand ACT service capacity in a structured manner by first providing accurate criteria and education on how to navigate the behavioral health system to obtain the service. This has not been done for ACT services in Oregon in the past.

Community Engagement: These platforms are held virtually with various topics and allow for direct feedback from any community member on topics. This creates a mechanism of communication that may not be afforded with other platforms as they are open to the public, not just behavioral health staff/invitation only.

g. Transition age youth into adulthood

The adult services unit and the child and family behavioral health unit are working together to build better transitional services from adolescence through transition age youth and into adulthood. Due to several gaps, young adults ages 18-21 years may experience a decrease of services as they transfer from an adolescent residential system, which addresses a much broader set of issues, to an adult residential system which focuses on formal SMI populations.

Some transition age youth demonstrate a high need for treatment in the child system while they may not immediately qualify for services in the adult system, due to transitional symptoms compounding developmental regression. We are continuing to work at improving these transitions by better defining terms to help with transition of services needs from child to adult services. We are developing specialized services that specifically meet this transitional populations' needs, such as Adult Foster Homes which only serve this population and not older, more disabled adults.

h. Plans to Address Unmet Needs and Gaps in 988 and Crisis System

Oregon is implementing a multi-pronged strategy to address these gaps, aligned with allowable activities under the Mental Health Block Grant. Infrastructure and crisis system investments include $37 million to expand behavioral health residential treatment capacity, $10 million for youth residential treatment and SUD services, and $48 million to expand Certified Community Behavioral Health Centers (CCBHCs) statewide.

To address workforce shortages, the state is investing in Behavioral Health Workforce Incentives through HB 2024, which provides scholarships, tuition assistance, loan forgiveness, and stipends for graduate students. Retention grants are also being offered to client-facing staff and population-informed providers to reduce turnover and support long-term workforce sustainability.

Equity and access initiatives are central to Oregon's approach. These include a $1 million investment in population-informed youth suicide prevention programming, the creation of a Flexible Housing Fund to support patients transitioning from the Oregon State Hospital, and prioritization of interpreter services and language access across the crisis system.

Finally, Oregon is committed to ongoing collaboration with the Nine Federally Recognized Tribes of Oregon to ensure Tribal communities are equitably supported in the development and implementation of crisis services, particularly in rural and frontier areas.

i. **Older Adults**

Areas of greatest need for older adults are the availability of Medicare providers to provide evidence- based counseling, psychotherapies and medication management. The expansion of Medicare licensure types to include Licensed Professional Counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs) does not appear to have had much impact in the short term.

Primary care teams are not well prepared and qualified to identify and assess for the behavioral health needs of older adults. Depression is often underrecognized and undertreated in primary care.

The lack of behavioral health services in our long-term care settings such as nursing facilities and assisted living facilities is another area of need. Low reimbursement, lack of a provider network and lack of knowledge are the primary reasons for the lack of services. This remains an urgent issue.

Lack of a robust guardianship program for older adults with behavioral health needs is problematic. This often leads to older adults languishing for long periods of time in hospitals and critically in emergency departments, referred to as ED boarding. This issue is further exacerbated by the lack of a residential care system that meets the needs of older adults with behavioral health needs in addition to the impact of aging, cognitive decline and complex medical comorbidities. There is an urgent need to develop residential capacity to meet the needs of this complex care population.

We need to identify and raise awareness of ageism and its intersectionality and effects on behavioral health and health outcomes. Age is an equity issue. Lack of access in community mental health programs (CMHPs) due to workforce shortage, lack of training and appropriate licensure is another barrier. Expanding the non-traditional workforce by training community health workers (CHW) and peer support specialists in older adult behavioral health would be key to improving access. This requires funding to build this workforce. We do not currently have any peer certification for older adult behavioral health.

The lack of CMHPs in Oregon investing in developing their capacity to serve older adults is an urgently needed initiative as Oregon's population of older adults is projected to reach 1 million by 2030. Older adults should be identified as a priority population in all CMHPs. Older adults with brain injury and others with intellectual and developmental disabilities have a hard time accessing behavioral health services. This is primarily due to the lack of training for our current CMHP staff.

There are no age-specific SUD programs for older adults and residential treatment facilities that accept older adults with activities of daily living (ADL) care needs. There are no older adult specific opioid misuse programs or initiatives in Oregon despite statewide funding opportunities.

The fastest growing demographic for homelessness is older adults, often among those with a serious mental illness. There are no homeless shelters designed specifically for older adults (universal design) or navigators to help older adults with cognitive decline access services or eviction prevention programs.

Lack of transportation continues to be a social determinant of health that impacts older adults across Oregon. With a lack of a robust transit system in many Oregon communities, older adults are often isolated if they cannot drive. Coordinating volunteer run transportation programs is an urgent need.

j. **State Opioid Response Areas of Greatest Need**

Examining 2020-2023 OHA SUDORS data across geographic regions, drug overdose death rates were highest in Portland (Region 1) and Southwest-Coast (Region 4) (Table 3). The highest rates of drug overdose death occurred among middle-aged people (aged 25-44 and 45-64), males, non-Hispanic Black and American Indian/Alaskan native individuals, and people experiencing homelessness (21% of people who die of overdose in OR are homeless).[4]

Rates of Emergency Department (ED) visits related to non-fatal overdoses show similar trends, except that rates are higher among women than among men and higher among young adults aged 10-24 and people aged 25-44 than among other age groups (Table 3). In 2024, the number of suspected non-fatal overdoses reported by EDs decreased by 11% in Oregon. Additionally, between 2023 and 2024 rates of suspected all-drug overdose among people aged 25-34 and 45-54 decreased 17% and 18%, respectively. ED visits for drug overdose are highest in Portland (Region 1), Southwest-Coast (Region 4) and Northwest Rural (Region 3). Rates of stimulant-related overdose ED visits are highest among young adults aged 18-24 and among Black and American Indian/Alaskan native (AI/AN) individuals and take place most frequently in the Portland metro and Southwest-Coast regions. Rates of opioid overdose ED visits are highest among those aged 25-44, among American Indian/Alaska Native and Black individuals, and take place most frequently in the Portland and Southwest-Coast regions. Compared with the number of illicit opioid overdose related Emergency Medical Services (EMS) encounters in 2022, the number of similar encounters peaked in 2023, increasing by 65% over the previous year. Although the number of EMS encounters then decreased in 2024 by 18% compared to 2023, the number of encounters in 2024 numbers was still 34% higher than it was in 2022. Increases in 2023 illicit opioid overdose EMS encounters compared to 2022 were highest in Portland/Region 1 (76%) and the Northwest Rural region (72%).

Table 3. Populations with Highest Rates of Overdose Deaths and Overdose ED Visits

	Overdose Deaths		*Overdose-related ED Visits*	
	Demographics (Rate Per 100,000)	*Regions* (Rate Per 100,000)*	*Demographics (Rate Per 100,000)*	*Regions* (Rate Per 100,000)*
All Drugs	Age 25-44 (69.7), Age 45-64 (68.7) Male (41.6), NH Black (73.8), NH AI/AN (71.1)	Portland (56.3), Southwest-Coast (30.8)	Age 10-24 (351.3), Age 25-44 (322.4), Black (529.9), Female (233.8)	Portland (279.4) - Southwest-Coast (264.3, Eastern (254.8)
Opioids	Age 25-44 (38.4) Age 45-64 (29.6) Male (31.0) NH Black (55.1), NH AI/AN (53.2)	Portland (43.3), Southwest-Coast (25.0)	Age 25-44 (173.6), Male (107.6), Black (241.8), AI/AN (192.7)	Portland (127), Southwest-Coast (105.1), Eastern (78.8)

Stimulants	Age 25-44 (28.7), Age 45-64 (33.5), Male (27.3), NH Black (56.6), NH AI/AN (51.0)	Portland (39.0), Southwest-Coast (21.7)	Age 10-24 (20.9), Age 25-44 (16.8), Male (12.6), AI/AN (26.3), Black (23.7)	Southwest-Coast (12.8), Portland (12.1)

Source: SUDORS (2020-2023 data), ED discharge data (2024). AI/AN=American Indian/Alaskan Native. †Rate is unstable due to counts less than 20.

**SAMHSA substate regions include: Region 1: Portland (Multnomah County); Region 2: Portland Metro (Clackamas and Washington Counties); Region 3: Northwest Rural (Benton, Clatsop, Columbia, Lane, Lincoln, Linn, Marion, Polk, Tillamook, and Yamhill Counties); Region 4: Southwest-Coast (Coos, Curry, Douglas, Jackson, and Josephine Counties); Region 5: Central (Crook, Klamath, Deschutes, and Jefferson Counties); Region 6: Eastern (Baker, Gilliam, Grant, Harney, Hood River, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, Wheeler Counties)*

Environmental Factors and Plan:

1. **Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG**

   Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral health needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

   A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: The Essential Aspects of Parity: A Training Tool for Policymakers; Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States.

   The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.1 Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care

settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

1Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx

Please respond to the following items:

1. *Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including details on efforts to increase access to services for:*
    a. *Adults with serious mental illness (SMI)*
    b. *Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)*
    c. *Pregnant women with substance use disorders.*
    d. *Women with substance use disorders who have dependent children.*
    e. *Persons who inject drugs*
    f. *Persons with substance use disorders who have, or are at risk for, HIV or TB*
    g. *Persons with substance use disorders in the justice system.*
    h. *Persons using substances who are at risk for overdose or suicide.*
    i. *Other adults with substance use disorders.*
    j. *Children and youth with serious emotional disturbances (SED) or substance use disorders.*
    k. *Children and youth with SED and a co-occurring I/DD*
    l. *Individuals with co-occurring mental and substance use disorders.*

a) Adults with serious mental illness: Access to services by those with Serious and Persistent Mental Illness (SPMI) comes through a variety of avenues, planned and situational. Planned efforts include healthcare screenings at behavioral and physical health settings as well as systemic screenings at the Coordinated Care Organization (CCO) level based on health indicators. Situational opportunities for engaging potential participants into services may include mobile crisis as well as hospital, medical and dental visits. In addition, law enforcement and/or court processes such as Aid and Assist are opportunities to identify those with SPMI

needs and offer a variety of services the participant is interested in pursuing, even if by provider perspective those interests are not central to SPMI core services, such as housing, clothing, food and emotional support through either formal or informal services, paid or unpaid supports.

b) The IMPACTS (Improving People's Access to Community-based Treatment, Support, and Services) program is a production of the 2019 legislative session and a program administered jointly between the Oregon Health Authority and Oregon's Criminal Justice Commission. The goal of this program is to serve the most vulnerable in our community who have challenges both in the criminal justice system and within the healthcare system. The program currently serves 11 counties and 5 tribal organizations in 15 projects, with one project being a joint project across two counties. The program serves Oregonians in urban, rural, and frontier communities, supporting law enforcement entities and healthcare organizations operationalize creative solutions to working with some of the hardest to reach clients – metaphorically and literally. Some examples of projects include: in one county integrating the emergency room alert system with the jail booking system so that care coordinators and outreach workers can respond to both situations more efficiently and with the most appropriate resources; hiring and training mental health staff to work in law enforcement settings as sworn team members and civilian team members; funding sobering centers; providing family therapy as prevention for younger generations on a reservation; and others. The efforts of these counties and these tribal organizations has increased access to services by increasing number of available programs, opening up access points in nontraditional spaces, and supporting people where they are through coordinated and collaborative outreach.

c) Pregnant women with substance use disorders: Nurture Oregon is an integrated care model providing pregnant people who use substances with peer recovery support services, prenatal and postpartum care, substance use and mental health treatment, and service coordination. Oregon Health Authority Health (OHA) Systems Division is building on a 2015 Multnomah County pilot to expand and adapt the program around the state. The pilot Project Nurture model was associated with increased prenatal visits, reduced placement of children in foster care, and cost savings. The Oregon legislature mandated the expansion of the pilot Project Nurture to focus on rural areas and sites reaching underserved families. The expansion funded 5 rural and frontier counties, and sites began services in 2021. Nurture Oregon's mission is to keep families healthy and unified by providing quality, integrated care. Nurture Oregon envisions a state where pregnant people who use substances receive safe, supportive, stigma-free care.

Core program elements of Nurture Oregon include: Clinicians who can provide prenatal and postpartum care Substance use disorder treatment, including access to medications Peer recovery support Community outreach to engage families Pediatric care for infants Case management team Trauma-informed mental health counseling and services Facilitated support groups with Nurture Oregon pregnant participants Other available services such as doula care, housing support, or home visiting nurse Partnership in developing Plans of Care Nurture Oregon teams are expected to develop relationships in the community: Transparent relationship with local DHS Child Welfare Coordination with hospitals for maternity stay Supported access to social services Community outreach to develop referral pathways and engage participants directly

d) Women with substance use disorders who have dependent children: The Oregon Health Authority (OHA) provides coordination and fiscal support for specialized programs serving women with substance use disorders (SUD), their children, and their families. Though residential SUD treatment is a Medicaid covered service, OHA provides indigent funding for individuals who are not eligible for Medicaid, who demonstrate a need for financial assistance based on an income below 200% of the current federal poverty level and obtain inadequate healthcare coverage, including but not limited to, healthcare coverage that does not cover all of

the services or are limited to a inadequate number of days. Indigent funding for women's residential treatment is funded through service elements 61 and supported Capacity for Dependent Children, whose Parents are in Adult Substance Use Disorder Residential Treatment is funded through service element 62. There are currently 12 women's SUD residential programs that serve women and children their dependent children simultaneously. SUD residential services are a statewide resource. Program Description The women's specific residential programs in Oregon provide trauma-informed SUD treatment for pregnant and parenting women. Each program is responsible for providing evidence-based clinical interventions, which include case management, parenting skills, thinking and behavior modification, peer delivered services, case management, community support networking, recovery housing coordination, transition planning and other recovery support services coordination. Who Qualifies for Treatment? Individuals 18 years of age or older who are unable to live independently in the community; cannot maintain even a short period of abstinence from substance abuse; need 24-hour supervision, treatment, and care; and meet the treatment placement criteria indicated in the American Society of Addiction Medicine (ASAM) Level 3.1 – 3.7. Purpose of Residential Treatment Services to support, stabilize, and rehabilitate Individuals and to permit them to return to independent community living. To provide a structured environment for an Individual on a 24-hour basis, consistent with Level 3.1 – 3.7 treatment, including assessment, placement, treatment using evidence-based practices, and help transitioning to lower level of care.

e) Persons who inject drugs: Oregon prioritizes persons who are IV drug users to improve accessing residential care. Measure 110 is a health-based approach to addiction and overdose. Established by Oregon Voters in November 2020 and subsequently codified into law through Senate Bill 755 in 2021, Measure 110 established Behavioral Health Resource Networks (BHRNs) – a network of comprehensive, community-based services and supports to people with substance use disorders or harmful substance use. Each Oregon County has at least one BHRN. Funding was also established for each of the nine Federally recognized Tribes of Oregon through a set aside. Each BHRN must provide trauma-informed, culturally specific and linguistically responsive services to all who want or need them, free of charge. Services include but are not limited to: Screening for health and social service needs, screening and referral for substance use disorder and appropriate outside services. Additionally available are low-barrier substance use disorder treatment, peer support services, housing supports and supported employment.

f) Persons with substance use disorders who have, or are at risk for, HIV or TB: Each individual accessing residential treatment services are tested for TB and provided immediate referral to treatment and resources if test is positive. Individuals are screened for other communicable diseases such as HIV if at high-risk referral is made for testing. Prior to entering treatment, individuals have access to harm reduction services and interim services and supports such as safe consumption and needle exchange services to help reduce the risk of communicable diseases.

g) Persons with substance use disorders in the justice system: Residential programs work closely with local jails and drug court systems to help with access to care pathways. Medicaid partners are working with CMS and county jails and state Department of Corrections for access to care and care coordination prior to release.

h) Persons using substances who are at risk for overdose or suicide: All residential programs have access to the medication Naloxone and by rule individuals accessing care within a residential program must have access to MOUD to help reduce the risk of overdose. Each residential program screens for suicide and provides needed care/support for individuals with co-occurring conditions. Save Lives Oregon/the Oregon Harm Reduction Clearinghouse makes overdose reversal medications available to individuals whether or not they are engaged

in treatment. Safer use supplies are provided as well. These interventions keep people who are at risk of overdose safer so that they can enter treatment if they choose.

i) Other adults with substance use disorders: Oregon has received extra funding during the 2023 legislative session to expand workforce and to increase/expand access to residential care throughout the state. Oregon is conducting a review of residential and inpatient SUD level of care for network adequacy to address any gaps. Increased residential reimbursement by 30% to help improve workforce and help modernize system of care. Implemented several web-based portals, so individuals can locate residential programs. Providing enhanced payment for culturally and linguistically specific programs to expand access to specialty care.

j) Children and youth with serious emotional disturbances or substance use disorders: Access to care for children with SED continues to be a challenge for Oregon related to workforce and diminished capacity from the pandemic. In recent years we have begun expanding our continuum and it now includes intensive in-home behavioral health treatment (IIBHT), mobile crisis (in development) and continued efforts to divert children and youth from the emergency department whenever possible. We have improved our ability to collect data from residential providers on referrals and capacity and are working to develop more residential beds, with 37 additional beds opening in the next two years. Substance Use treatment programs for youth are residential and outpatient settings that include family, individual and group therapy. Therapy assists youth to review the reasons they use substances, habits that lead to substance use and recommends lifestyle changes they can make to disrupt those habits, and the impacts of peer groups and peer pressure. Other services include monitoring through urinalyses, and discussion of life events that may have impacted substance use, family involvement support, and peer support mentorship. Children under age 12 often need a treatment plan matched to their developmental level and skills and should not be treated with older adolescents 13 to 17 years old. Adolescents are most appropriately treated with their peers and not with adults. Youth Detox services are available for ages 12 – 17 using Medically Assisted Treatment. Youth residential treatment Level 3.1 is available for ages 12 - 17, and Youth residential treatment Level 3.7 with Co-Occurring Disorders is in development.

k) Oregon CFBH works closely with the Oregon Department of Human Services Office of Developmental Disability Services (ODHS/ODDS) area to coordinate care needs for youth with co-occurring behavioral health and I/DD treatment needs. The two systems are set up very differently and this can create challenges for shared care coordination. Ensuring policies that do not rely on exclusionary criteria for any point in the continuum of care has been a starting place to address some of the gaps. Senate Bill 1557 (2024) and SB 729 (2025) prohibit providers from denying access for assessment treatment and services solely based on an individual having intellectual/developmental disabilities. Continued work to identify data indicators that demonstrate the disparities in care for I/DD youth with behavioral health needs is taking place.

CFBH is exploring the use of a psychiatric monitoring tool for medication prescribing to improve prescribing practices for this population, and improved workforce training. Technical assistance would be welcomed for use of the Diagnostic Manual, Intellectual Disability (DMID-2), tools to understand needs of this population, and ways to assess existing workforce knowledge to more accurately target training efforts. CFBH is using the ECHO virtual training model to reach more providers and therapists.

OHA is a sponsor of an annual summit event bringing systems, providers and community together to better support this complex and dynamic population at the Oregon Youth IDD Mental Health Summit.

l) The Integrated Co-Occurring Disorders program was directed through legislation passed in 2021, and implementation led to services provided under the program beginning January 1st, 2023. The legislative directive includes integration of treatment of MH and SUD, I/DD and

problem gambling within an integrated model of service delivery. While the program does not specifically differentiate services for youth, children or adults on the system level, the OHA Integrated Co-Occurring Disorders office provides support and tailored assistance for existing programs specializing in services for youth and children in adding Integrated Co-occurring Disorders services. OHA has provided start up grants, as part of the legislative direction, for existing MH and SUD programs wishing to develop integrated COD services. Practitioners providing services within the program are required to complete 20 hours of specific training developed by the program. A portion of this training addresses harm reduction and integrated approaches to care. Like all Oregon SUD programs, the Integrated Co-Occurring Disorders program prioritizes access to services for pregnant women, parents of minor children, and intravenous drug users, and people dealing with communicable diseases. Further, to improve access to services, OHA revised Oregon Administrative Rules regarding entry and assessment for SUD and MH services to allow for a more flexible intake process that allows a low barrier to initial service access. The Integrated Co-Occurring Disorders program has worked with the Medicaid 1915i team in developing supports for Integrated Co-Occurring Disorders programs in their provision and capacity to provide higher quality care and services for individuals dealing with co-occurring disorders, including SMI and I/DD.

2. *Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.*
    a. *Please describe how this system differs for youth and adults.*
    b. *Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.*
    c. *How many IT-COD teams do you have? Please explain.*
    d. *Do you monitor fidelity for IT-COD? Please explain.*
    e. *Do you have a statewide COD coordinator? Yes ☒ No ☐*

    The Integrated Co-Occurring Disorders (ICOD) system works to enhance and improve quality and capacity of services provided by existing SUD and MH treatment programs already providing services. The ICOD system does not differentiate between youth and adult MH services by supporting both lifespan programs in implementing ICOD services. The ICOD program is underwritten by specific Oregon Administrative Rules in both outpatient and SUD residential – that are infused the IDDT (IT-COD) model. Practitioners that provide services in ICOD programs are required to complete 20 hours of training. A portion of this training is on the IDDT model, and the clinical approaches that are part of the model. There are 35 programs approved to provide ICOD services as informed by the IDDT model. OHA ICOD program will be implementing a fidelity review process beginning in January 2026. The program is administered by a 1.0 FTE Operations and Policy Analyst with assistance and support from colleagues on the Strategic Initiatives team.

3. *Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:*
    a. *Access to behavioral health care facilitated through primary care providers.*
    b. *Efforts to improve behavioral health care provided by primary care providers.*
    c. *Efforts to integrate primary care into behavioral health settings.*
    d. *How the state provides integrated treatment for individuals with co-occurring disorders.*

    In 2015, Oregon was selected by the U.S. Department of Health and Human Services (HHS) as one of eight states to receive a planning grant to test new strategies to improve

accessibility, quality, and outcomes of services provided in community mental health centers certified as CCBHCs. The Oregon Health Authority (OHA) subsequently submitted an application to the Substance Abuse and Mental Health Services Administration (SAMHSA) to be considered for participation in the 2017-2019 CCBHC Demonstration Program. In December 2016, Oregon was selected as one of eight demonstration states. The CCBHC demonstration was designed to provide whole-person care to individuals with behavioral health needs, including those with substance use disorder (SUD), serious behavioral health needs, and those with a dual diagnosis (i.e., behavioral health needs with comorbid SUD).

CCBHCs integrate behavioral health and substance use disorder treatment with primary care services and address social determinants of health that can influence health outcomes. CCBHCs are required to serve anyone regardless of insurance status or ability to pay. The CCBHCs in Oregon are overseen by OHA. Twelve clinics were certified as CCBHCs when Oregon's demonstration program began on April 1, 2017. As of 2024 there are 14 CCBHCs. In 2025, OHA has applied to update the Medicaid State Plan to include CCBHCs and in the legislative session allocated funds to expand the clinic model further across the state.

OHA partners with Oregon Health and Science University to provide the Oregon Psychiatric Access Line (OPAL) for both Adults and Kids (children) known as OPAL A or OPAL K. These services allow Primary Care Physicians (PCP) or any prescriber in Oregon free access to Psychiatrists for consultation and case level support. In 2023, access was added to the children's line to add Developmental Pediatrician to address questions on diagnosis, medication and case level consultation.

OHA has provided start up grants, as part of the legislative direction, for existing MH and SUD programs wishing to develop integrated COD services. Practitioners providing services within the program are required to complete 20 hours of specific training developed by the program. A portion of this training addresses harm reduction and integrated approaches to care. Like all Oregon SUD programs, the Integrated Co-Occurring Disorders program prioritizes access to services for pregnant women, parents of minor children, and intravenous drug users, and people dealing with communicable diseases. Further, to improve access to services, OHA revised Oregon Administrative Rules regarding entry and assessment for SUD and MH services to allow for a more flexible intake process that allows a low barrier to initial service access.

4. *Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:*
    a. *Adults with serious mental illness (SMI)*
    b. *Adults with substance use disorders.*
    c. *Adults with SMI and I/DD*
    d. *Children and youth with serious emotional disturbances (SED) or substance use disorders.*
    e. *Children and youth with SED and I/DD*

ICOD providers coordinate care within their programs, on integrated teams.
Adults with serious mental illness: Care Coordination intensity is on scale with serious mental illness being the population receiving the most services. Intensive Care Coordination for Serious and Persistent Mentally Ill (SPMI) populations are facilitated into and out of the state hospital, acute care psychiatric and medical hospitals, residential treatment programs, adult foster homes, supported and independent living settings. In addition, allied services will be included in the care coordination to serve the participants such as outpatient medical / behavior health services, in-home services through the Coordinated Care Organization (CCO)

(such as diabetic or wound care), medical and non-medical transportation as well as pharmacy.
Agencies who facilitate care coordination depends somewhat on funding: 1) Choice Model will facilitate care coordination for all SPMI no matter the funding, representing many Community Mental Health Programs (CMHPs) and some CCOs, 2) care coordination for populations not reaching the service needs of the SPMI population will be facilitated by the medical or behavioral health home, monitored and evaluated by the CCO in collaboration with CMHPs and other contracted providers, 3) population health and need for generalized care coordination of services is facilitated by the CCO through a variety of behavioral and physical health screenings. Care coordination is based on the participant's person-centered plan which is facilitate by the Independent Qualified Agent with the participant as the lead informant of needs and chosen services and supports.
Adults with substance use disorders: CCO provides Care Coordination and Intensive Care Coordination (ICC) for Members with Behavioral Health disorders in accordance with OAR 410-141-3860 and 410-141-3870 and the applicable Contractual obligations found in sections in Ex. B, Parts 2 and 4 of the CCO contract. CCOs ensure that all Care Coordinators work with Provider team members to coordinate integrated care. This includes but is not limited to coordination of physical health, Behavioral Health (mental illness and/or substance use disorders), **intellectual and developmental disability**, DHS, Oregon Youth Authority, Social Determinants of Health, Oregon Department of Veterans Affairs, United States Department of Veterans Affairs, and Ancillary Services. CCOs ensure coordination and appropriate Referral to ICC to ensure that Member's rights are met and there is post-discharge support. CCOs authorize and reimburse for Care Coordination and ICC Services, in accordance with OAR 410-141-3860 and 410-141-3870. Care Coordination and Case Management are covered Substance Use Disorder services and supports under the State Plan Amendment for all Oregon Medicaid Members. CCOs track and coordinate for reassessment triggers and ensure there are multiple rescreening points for Members based on reassessment triggers for ICC. CCOs are obligated to support access and coordinate care for Non-Covered Services as well as non-emergency medical transportation services. CCOs ensure members have a lead provider or primary care team to manage member care and coordinate all member services. Support appropriate flow of relevant information, through a standardized approach to effectively plan, communicate, and implement transition and care planning and follow-up. CCOs coordinate with residential Behavioral Health service Providers, including Providers outside of Contractor's Service Area, for their members receiving both Medicaid-Funded and non-Medicaid-funded residential addictions and Behavioral Health services. CCOs coordinate with the Oregon State Hospital, other State institutions, and other Behavioral Health Hospital settings, to facilitate Member transition into the most appropriate, independent, and integrated Community-based settings. CCOs are obligated to develop Culturally and Linguistically Appropriate tools for Provider use to assist in the education of Members about roles and responsibilities in communication and Care Coordination c) Children and youth with serious emotional disturbances or substance use disorders: Similar to adult behavioral health, the CCOs are obligated under their contract and in accordance with previously cited OARs to provide care coordination, intensive care coordination and exceptional needs care coordination, to children with SED based on presenting need. Oregon has fidelity Wraparound to coordinate services when youth are accessing multiple systems of care. The Wraparound facilitation and care coordination are coordinated by the CCOs in conjunction with local community mental health programs. Care coordination for SUD disorders is also done by the CCOs.

5. *Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.*

The Integrated Co-Occurring Disorders (ICOD) system works to enhance and improve quality and capacity of services provided by existing SUD and MH treatment programs already providing services. The ICOD system does not differentiate between youth and adult MH services by supporting both lifespan programs in implementing ICOD services. The ICOD program is underwritten by specific Oregon Administrative Rules in both outpatient and SUD residential – that are infused the IDDT (IT-COD) model. Practitioners that provide services in ICOD programs are required to complete 20 hours of training. A portion of this training is on the IDDT model, and the clinical approaches that are part of the model. There are 35 programs approved to provide ICOD services as informed by the IDDT model. OHA ICOD program will be implementing a fidelity review process beginning in January 2026.

6. *Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD), including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults*.

The ICOD system has developed specific required and optional trainings for MH and SUD practitioners working in ICOD programs that address screening, assessment and treatment of co-occurring disorders for people with Intellectual and Developmental Disabilities. The trainings focus on developing clinical competence and confidence in creatively adapting evidence-based approaches for use in services for people with I/DD. There is no specific differentiation in supports for ICOD programs between youth and adults.
The OHA Child and Family Behavioral Health (CFBH) Unit has several areas of partnership with the Oregon Department of Human Services (ODHS) Office of Developmental Disabilities Services' current efforts to improve intellectual/developmental disability (I/DD) and mental health (MH) service delivery when they are co-existing, or dually diagnosed conditions. Our two systems have a history of difficulty working together well, and we are working to break down those barriers. HB 5529 (2021) directed OHA and ODHS to identify barriers for people with dually diagnosed I/DD and mental health concerns, and to assess and form recommendations to address barriers. The resulting report lists several recommendations to address the complex systemic barriers for children and adults, and the CFBH unit is committed to supporting these efforts: Work to develop improved communication between systems; Develop processes and systems to ensure that behavioral health services are person-centered; Support efforts to address the ongoing workforce shortage; Explore strategies to coordinate Medicaid supports so individuals have a single, person-centered plan; Work with the legislature to address statutory changes to support individuals with co-occurring disorders. Additional legislation in SB 1557 (2024) added language to statute for providers, Coordinated Care Organizations and others stating that access to assessment, treatment and services could not be denied based on an individual having IDD. Since 2013, the Oregon Youth IDD Mental Health Summit has brought families, providers, and state partners together to address best practices and collaboration between the I/DD and mental health systems, and to break down barriers to accessing services. The ARC Oregon is the coordinating partner for the annual Summit. The 2025 summit was held in person in August 2025 with participants from all over the state and multiple systems including Developmental Disability Services, Mental Health, Oregon Department of Human Services and Education. The CFBH unit has contracted with NADD to train staff from both the I/DD and mental health systems on effectively addressing co-occurring conditions. This training is designated to break down the discomfort that clinicians often feel from both systems, providing them with tools, adaptations, and education on ways to work with this population of young people. Over the past four years, CFBH has eliminated intelligence quotient (IQ) restrictions for programs in which there had been exclusionary criteria for treatment, including the Early Assessment and Support Alliance (EASA) program, psychiatric residential treatment facilities, and behavioral rehabilitation services (BRS). We have also developed new treatment programs including Intensive In-Home Behavioral Health Treatment (IIBHT) and Mobile Response and Stabilization Services (MRSS)

which are specifically to be available for all youth, regardless of intellectual ability. We continue to work to ensure that the full continuum of mental health treatment is available for youth with co-occurring disorders.

2. **Evidence-Based Practices for Early interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for MHBG**

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among individuals and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations [Note: MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with SMI or SED]. The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5TR (APA, 2022). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic, or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

*States may implement models that have demonstrated efficacy, including the range of services and principles identified by the Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals experiencing first episode of psychosis (FEP). RAISE was a set of federal government-sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.*

States shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that

address the needs of individuals experiencing early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount, the state receives under this section for a fiscal year as required, a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI programs	Number of
CSC Coordinated Specialty Care	**28**

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
$1,516,632	$1,516,632

3. Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.

   EASA programs are required to bill for all Medicaid-eligible service, which includes all direct services provided to the program participant and their family. Programs also bill commercial insurance when able but experience significant challenges with certain CSC services such as Supported Employment.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI.

   The Oregon Health Authority funds the Early Assessment and Support Alliance (EASA), a network of programs across Oregon that provide rapid identification, support, assessment, and treatment for youth ages 12 to 27 who are experiencing the early signs of psychosis. EASA is designed as a transitional program, with the goal of providing the education and resources an individual experiencing first episode psychosis needs to be successful in the long-term.

   Available in 29 Oregon counties, EASA programs are effective, two-year programs with long-lasting results. The EASA program is a Coordinated Specialty Care (CSC) program, which is a team-based, multi-element approach. The EASA programs include all key roles and services outlined in Coordinated Specialty Care programs, including individual and family therapy, case management, supported employment, family education, primary care coordination and pharmacotherapy. The EASA programs also use peer delivered services and occupational therapy.

As a coordinated specialty care program, EASA uses multiple EBPs as a multi-element approach including CBT for psychosis, Individual Placement and Support (IPS), multifamily group therapy, psychoeducation, motivational interviewing, evidence-based prescribing and elements of Assertive Community Treatment (ACT), although the EASA program does not use the entire fidelity model of ACT.

5. Does the state monitor fidelity of the chosen EBP(s)? **Yes** ☒ **No** ☐
6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? **Yes** ☒ **No** ☐
7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI.

Rapid access to care is part of the EASA model, which includes access to a medication provider within 7 days of being accepted into the program. Outcomes data is collected quarterly from all programs and analyzed by the EASA Center for Excellence. Oregon EASA outcomes include reduced hospitalizations, and other costly higher levels of care, higher engagement in services than "Treatment as Usual," improved quality of life and participants meeting their mental health treatment goals

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

Provider network pilot project which seeks to provide urgent supports and access to services such as early psychosis screenings for counties experiencing staff shortages; increased engagement, coordination and providing training to the Nine Federally Recognized Tribes of Oregon; adapting the currently used Support Education and Support Employment models to better meet the needs of young adults; updating the EASA practice guidelines (fidelity model) which have not been updated since 2013.

9. Please list the diagnostic categories identified for each of your state's ESMI programs. Schizophrenia Spectrum Disorders: Schizophrenia, Delusional Disorder, Brief Psychotic Disorder, Schizophreniform Disorder, Other Specified Schizophrenia Spectrum and Other Psychotic Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, Schizoaffective Disorder, Bipolar Disorder with Psychotic Features.

10. What is the estimated incidence of individuals experiencing first episode psychosis in the state?

In 2023 EASA served 774 individuals identified as experiencing early psychosis, and 746 in 2024. We know that EASA does not capture every individual experiencing early psychosis, so the incidence rate is higher than the total served. OHA and the EASA Center for Excellence are currently working on a project to receive and analyze All Payer All Claims data to see how many individuals were seen in emergency rooms across Oregon with EASA-eligible (and other non-eligible psychosis) diagnoses to compare to EASA numbers served.

11. What is the state's plan to outreach and engage those experiencing ESMI who

need support from the public mental health system?

The EASA model includes a requirement for all teams to conduct tailored community education and outreach planning and engagement. The EASA Center for Excellence (C4E) also provides statewide education and outreach supports and activities: 1) C4E statewide marketing and social media campaign: C4E contracted with an adolescent-focused consultant to create a statewide social media campaign, which is a new resource EASA teams can use, and also provides information to those seeking services online 2) “no wrong door approach”-- working with all local teams to develop transparent, streamlined processes within their community mental health agencies to ensure individuals with ESMI are connected to appropriate care. 3) EASA Family Leadership council members also provide feedback about pathways to care and suggestions for areas of outreach.

12. Please indicate area of technical assistance needs related to this section.

Program sustainability information and funding including commercial insurance. Publish updated research on outcomes of CSC for ESMI population

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person- centered planning (PCP) is a process through which individuals develop their plan of service based on their chosen, individualized goals to improve their quality of life. The PCP process may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers, and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from **https://acl.gov/news-and- events/announcements/person-centered-practices-resources**

Please respond to the following items:

1. Does your state have policies related to person centered planning? **Yes** ☒ **No** ☐

(If no, describe any action steps planned by the state in developing PCP initiatives in the future.)

2. Describe how the state engages people with SMI and their caregivers in making health care decisions and enhances communication.

In Oregon, we attempt to engage individuals and their caregivers in all health care decisions through process, policy, and procedure. Oregon Administrative Rules drives this work by requiring that treatment planning and placement must abide by person-centered service planning. Additionally, as a state, we can utilize the Declaration for Mental Health Treatment (DMHT – often referred to as a psychiatric advanced directive), which supports providers, hospitals, and emergency responders in knowing how a person best receives care and intervention, as well as things like where this person respects the care providers, where they trust providers, and where they will accept care, beyond what medications to take.

3. Describe the person-centered planning process in your state.

A person-centered planning process is underscored in Oregon by the person-centered service plan as required by federal rules related to 1915i services. In Oregon, this really means that residential placements and treatment plans must be driven by the person and/or their authorized representative. The person or their representative must participate in a formal screening process and in formal treatment planning and the effort must be made to do so as thoroughly and extensively as possible.
Person-centered planning is based on Home and Community-Based Services 1915i processes and centrally facilitated through the Independent Qualified Agent (IQA) contractor, currently Comagine Health, and focusing on the Serious and Persistent Mentally Ill (SPMI) population. These plans on based on functional needs assessments, assuring that recipients have options to choose from among settings and services through active involvement by the participants themselves. In addition, the IQA facilitates medical appropriateness reviews, collaborates over transitions from one setting to another as well as monitoring that the participant is receiving needed services and supports from providers who are responding to their choices. Functional needs assessments are facilitated at least annually, though can be initiated by a change in functioning or setting, which then updates the service plan. Participants in the assessment is centrally the participant with supports by their guardian (if needing one), care coordinators from Community Mental Health Programs and Coordinated Care Organization agencies, providers (behavioral and physical health outpatient and residential), housing allies, personal supports, peers, family and any other person or agency the participant wants to join the process whether a formal paid service or not, such as ministers, community members or other participants of healthcare services.

4. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as A Practical Guide to Psychiatric Advance Directives)?

Oregon Administrative Rule directs County Mental Health Programs to provide education to all consumers at initial intake. Additionally, all individuals at risk of hospitalization due to mental health symptoms and behaviors, also directed to

CMHPs in rule, should be educated about and provided the opportunity to complete a psychiatric advanced directive at psychiatric hospitalization admission and/or discharge. While Oregon administrative rule provides direction to educate about the Declaration for Mental Health Treatment (as psychiatric advanced directives in Oregon are named), and the statute provides the template, providers across the state and across systems could improve how this task is integrated into practice. It is evident that guides and manuals reach some people, while others who struggle to understand the legal concepts of it, or who might have challenges with literacy, could likely benefit from higher touch, higher intensity support to utilize this tool.

5. Please indicate areas of technical assistance needs related to this section.

Oregon would be interested to talk through how this area relates to children's behavioral health and minor consent laws. Oregon would be interested to talk through how this area relates to children's behavioral health and minor consent laws.

4. **Program Integrity – Required for MHBG & SUPTRS BG – COMPLETED IN WebBGAS**

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's program integrity efforts are to promote the proper expenditure of Block Grant funds, improve Block Grant program compliance nationally, and demonstrate the effective use of Block Grant funds.

While some states have indicated an interest in using Block Grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 300x-31**, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under **42 U.S.C. § 300x-55(g)**, there are periodic site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. Guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing- assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services

that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid the covered mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?

   Yes ☒ **No** ☐

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

   Yes ☒ **No** ☐

3. Does the state have any activities related to this section that you would like to highlight?

All intermediaries, providers and entities that contract with Oregon Health Authority have clear language included in their contracts to adhere to Federal Block Grant consistent with the statutory and regulatory framework to ensure program integrity. Contract administrators are the first line in ensuring that the funds are spent in accordance with grant/program regulations and guidelines. This is operationalized through regularly scheduled site /audits/visits to monitor compliance. If provided adequate metrics or parameters, the Governance & Process Improvement compliance team can track and follow-up on any indicators. This will provide another level of quality assurance and completeness/compliance. Oregon Health Authority has developed a robust infrastructure for program integrity and compliance – including an organizational wide Program Integrity Unit and Internal Audits and Consulting, a shared service with OHA and the Department of Human Services.

• Contract Determination & Monitoring via CFAAs: Grant and contract administrators complete a determination checklist to classify agreements as either subrecipient or contractor before initiating contracts.

- If designated as a subrecipient, a risk assessment is conducted, followed by the development of a monitoring plan for the agreement.
- FFATA (Federal Funding Accountability and Transparency Act) and NOA (Notice of Award) documents are collected for contract record retention.
- Financial Tracking: The Statewide Financial Management Application (SFMA) tracks spending by category (e.g., prevention, treatment, administration).
- Monitoring Responsibilities: The Grant Administrator (named in the Grant Agreement or equivalent document) is responsible for conducting monitoring activities. OHA-PHD Grants Administration & Oversight of Program Elements and Service Agreements (SUPTRS BLOCK GRANT - 20% Prevention):
- 20% allocation of SUPTRS Block grant primarily funds OHA's Alcohol Drug Prevention and Education (ADPEP) Program, administered through the Public Health Division, Health Promotion and Chronic Disease Prevention (HCPDP) Section, and OHA's Tribal Affairs and Behavioral Health Division (BHD) for Tribal Alcohol and Drug programs.
- Approximately 80% of the prevention portion of SUPTRS is allocated to counties, community grantees, Nine Federally Recognized Tribes of Oregon, and Tribal serving organizations, with remaining funds supporting state level contract administration, data/evaluation, communications, and technical assistance and training (TTA) activities.
- Contract Determination
- Grant and contract administrators complete a determination checklist to classify agreements as either subrecipient or contractor before initiating contracts.
- FFATA (Federal Funding Accountability and Transparency Act) and NOA (Notice of Award) documents are collected for contract record retention. Program Element 36 and Intergovernmental Grant Agreements/Grant Agreements have been the contracting vehicles for ADPEP agreements, depending upon the agency type. Starting July 2025, OHA will transition most contract agreements to the LPHA.net (PE 36), an online Intergovernmental Agreement Management system.
- Financial Tracking: The LPHA.net is an online Intergovernmental Agreement Management system that combines payments to Counties, Tribes and other local subrecipients into monthly bulk payments. Contracting and payment occurs through discrete units called Program Elements (PE's) based on specific Scopes of Work (SOW) and funding source(s). Once contracts are approved, payments are made in equal monthly increments with quarterly reconciliation upon receipt of expense reports for each Program Element.
- Monitoring
- Detailed Funding & Program Guidance and expectations for contract compliance for PHD ADPEP grantees are described at https://www.oregon.gov/oha/ph/diseasesconditions/chronicdisease/hpcdpconnection/pages/rfas.aspx.
- PHD ADPEP grantees submit bi-annual reports and meet with their assigned Community Partner Liaison (CPL) regularly to monitor workplans, budgets, expenditures, program successes, and unmet needs. SAMHSA required program reporting data is routinely submitted to SAMSHA through the WebbGAS system where it is monitored by program officers for program compliance.
- OHA-PHD and SAMHSA funded regional TTA contractors offer a wide menu of

resources to advance evidence based, community informed prevention programs, practices, and policies. Local ADPEP prevention coordinators and any staff funded at 0.5 FTE or higher are required to complete specific training requirements as outlined in the ADPEP Funding & Program Guidance.

- ADPEP funds can also be used to support workforce development activities, including training that meets national standards for certified prevention specialists

4. Please indicate areas of technical assistance needs related to this section.
   No TA needed at this time.

5. **Primary Prevention – Required for SUPTRS BG – COMPLETED IN WebBGAS**

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals, families, and communities.
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities.
3. ***Alternative programs*** that provide for the participation of priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies

Assessment:

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)?

   Yes ☒ No ☐

2. Does your state collect the following types of data as a part of its primary prevention needs assessment process? (check all that apply)

   a. ☒ Data on consequences of substance-using behaviors

   b. ☒ Substance-using behaviors

   c. ☒ Intervening variables (including risk and protective factors)

   d. ☒ Other (Please list) Qualitative data as reported on funded sub-recipients activity reporting about prevention programs

3. Does your state collect assessment data that includes analysis of primary prevention needs for the following population groups? (check all that apply)

   a. ☒ Children (under age 12)

   b. ☒ Youth (ages 12-17)

   c. ☒ Young adults/college age (18-26)

   d. ☒ Adults (ages 27-54)

   e. ☒ Older adults (age 55 and above)

   f. ☒ Rural communities

   g. ☒ Other (please list)
      - Low socio-economic status
      - Self-report disability

4. Does your state use data from the following sources in its primary prevention needs assessment? (check all that apply)

   a. ☐ Archival indicators (please list) Click or tap here to enter text.

   b. ☒ National survey on Drug Use and Health (NSDUH)

   c. ☒ Behavioral Risk Factor Surveillance System (BRFSS)

   d. ☐ Youth Risk Behavioral Surveillance System (YRBS)

   e. ☐ Monitoring the Future

   f. ☐ Communities that Care

   g. ☒ State-developed survey instrument

   h. ☒ Other (please list)
      - Oregon Student Health Survey (youth survey based on YRBS)
      - Oregon Health Authority Vital Statistics reports
      - Fatal Accident Reporting System (FARS)
      - Emergency Medical Services (EMS)
      - Prescription Drug Monitoring Program (PDMP)
      - State Unintentional Drug Overdose Reporting System (SUDORS)

- Oregon Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE)

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds?

Yes ☒ No ☐

a. If yes, please explain.

Yes, the Oregon Health Authority - Public Health Division (OHA-PHD) uses the State Health Improvement Plan (SHIP) and State Health Assessment (SHA), and population-level data from youth and adult surveys to inform decisions about allocation of SUPTRS primary prevention funds. PHD's Health Promotion and Chronic Disease Prevention (HPCDP) Program uses data to inform development of primary prevention strategic plans and state-level initiatives, inclusive of alcohol, tobacco and cannabis. PHD's Injury & Violence Prevention Program (IVPP) uses a variety of surveillance systems to monitor fatal and nonfatal drug overdoses, identify trends, and inform overdose prevention and response strategies.

OHA allocates SUPTRS primary prevention resources to local communities and Nine Federally Recognized Tribes and designated Urban Indian Health Program (UIHP). County and tribal prevention programs allocate SUPTR funding based on local data collection and assessment activities, often coordinated through Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs) conducted by local and tribal public health and regional Coordinated Care Organization's (CCO).

Tribal prevention funds are consolidated into one, large behavioral health contract, through OHA's Behavioral Health Division (BHD) and Tribal Affairs. The Nine Federally Recognized Tribes and Oregon's designated UIHP all develop their plans under this single contract, with the help of OHA subject matter experts and tribal liaisons. Goals and objectives align with federal and state spending guidelines.

b. If no, please explain how SUPTRS BG funds are allocated.
Does the state have any activities related to this section that you would like to highlight?

Oregon's SEOW coordinates with a network of data analysts, evaluators, and researchers from OHA Behavioral Health Division, OHA Health Policy & Analytics Division, the Alcohol and Drug Policy Commission (ADPC), and other external organizations to promote high quality data and robust surveillance systems, guide planning for the implementation of prevention best practices and to inform strategic planning. The SEOW also enlists support from contractors to support specialized data collection and evaluation work. The SEOW leads and contributes to many data quality improvement efforts, such as development of the Student Health Survey and investigation of alternative methods to collect data from under-served and hard-to-reach populations in Oregon.

OHA-PHD's Health Promotion and Chronic Disease Prevention (HPCDP) Program's Surveillance, Evaluation and Epidemiology Team (SEET) includes 17 data analysts, evaluation specialists and epidemiologists supported by a 1.0 FTE Program Manager and 6 team leads. OHA-PHD's Injury and Violence Prevention Program (IVPP) includes 12 epidemiologists, data analysts, and program coordinators supported by an Information Systems Manager and an Overdose Prevention Program Manager. Both teams collaboratively examine data sources that describe alcohol, tobacco, other drugs, and injury among Oregonians. These systems inform

prevention strategies, interventions, and outcomes, including identification and prevention of morbidity and mortality among Oregonians.
The Alcohol and Drug Policy Commission (ADPC) and OHA's State Health Improvement Plan, Healthier Together Oregon, share and co-implement a behavioral health strategic priority area. The SEOW ensures that SUPTRS primary prevention funds align with the overall priorities of the ADPC, HTO, Oregon's Tribal Behavioral Health Plan, Oregon's Public Health Advisory Board (PHAB), and other state-level decision-makers, including the Governor's office. The SEOW also informs the ADPC, Tribal Affairs, and the PHAB regarding progress and needs related to substance use prevention.
IVPP utilizes these surveillance systems for monitoring and timely sharing with other divisions and agencies, local public health and behavioral health agencies, federally recognized tribes, medical providers, law enforcement, community-based organizations (CBOs), the public, and people who use drugs. These activities help increase awareness and focus efforts and interventions to save lives and prevent injuries, infections, disability, and disfigurement.

Narrative Question

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Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce?

Yes ☒ No ☐

If yes, please describe:

The Mental Health and Addiction Counselor Certification Board of Oregon (MHACCBO) supports Oregon's Certified Prevention Specialist (CPS) credentialing program. The training model is focused on the International Certification & Reciprocity Consortium (IC&RC) prevention domains and prepares participants for application and testing for the CPS credential. OHA-PHD does not require CPS certification requirements for SUPTRS primary prevention funded grantees. The Oregon Coalition of Prevention Professionals (OCPP) coordinates courses and training of trainers to provide CPS training resources. OHA-PHD documents participation in CPS eligible trainings to support prevention specialists in securing and maintaining training hours. OHA-PHD reviews prevention workforce capacity assessments as part of overall training and technical assistance (TTA) infrastructure to ensure a plan for sustainable prevention workforce. In 2024, the Oregon Opioid Settlement Prevention, Treatment, and Recovery Board allocated $450,000 to train and certify 100 new CPSs over the course of two years. The free training opportunity prioritizes SUPTRS primary prevention grantees and representatives from community-based organizations that serve populations disproportionately impacted by substance use and overdose. Infrastructure is being set up to assist the Tribal Alcohol and Other Drug Prevention Coordinators in receiving and maintaining their prevention certification, per the Oregon Administrative Rules (OARs) 415-056-0045, as Tribal Prevention programs are administered by Behavioral Health Division (BHD) and Tribal Affairs of Oregon Health Authority (OHA). Tribal prevention programs are encouraged to utilize MHACBOs online content in order to obtain CEUs, community partners have reached out to OHA staff to form partnerships around cohort style trainings and seminars that tribes are invited to participate in.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? **Yes ☒ No ☐**

If yes, please describe mechanism used:

OHA-PHD provides training and technical assistance (TTA) for alcohol, tobacco and other drug prevention grantees funded through SUPTRS. This includes TTA to support local communities to implement policy, systems and environmental change strategies to increase knowledge, facilitate partnerships and build community capacity to achieve local objectives aligned with statewide strategic goals.

OHA-PHD provides ongoing opportunities for mentoring, group coaching, training, collaboration with peers including sharing lessons learned and successful strategies. TTA opportunities include but are not limited to 1-on-1 technical assistance meetings, prevention cohort calls, Communities of Practice, Learning Institutes, Virtual Training Series, online resource hubs, monthly e-newsletters, and grantee support at other regional, state, and national conferences and training events, including those offered through SAMSHA TTA Centers.

Grantee participation is required at certain OHA-PHD-sponsored trainings, meetings, webinars, and conference calls. The Alcohol and other Drug Prevention and Education

Program Coordinators, the Overdose Prevention & Education Program Coordinators, and any staff working 0.50 FTE or more are required to complete all staff training requirements related to SUPTRS primary prevention funded work.
OHA-Tribal Affairs contracts with the Northwest Portland Area Indian Health Board (NPAIHB) to provide TTA for tribal commercial tobacco prevention programs. 1.0 FTE OHA-BHD position is dedicated to assisting tribal prevention programs with plans, reports, and contract administration. Tribal Quarterly Behavioral Health meetings, which prominently feature prevention programs, convene both tribal and state partners for updates and training. OHA-PHD staff continue to provide resources and offer TTA to tribal program partners. Local county programs also coordinated with tribes to share resources and training opportunities.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?

Yes ☒ **No** ☐

If yes, please describe mechanism used:
Oregon assesses community readiness to implement primary prevention strategies supported by the Public Health Division in numerous ways.
State Health Assessment (SHA) and State Health Improvement Plan (SHIP) – Oregon's State Health Assessment (SHA), used for public health accreditation, describes the health of the population, identifies areas for improvement, contributing factors that impact health outcomes, and assets and resources that can be mobilized to improve population health. Oregon's State Health Improvement Plan (SHIP) identifies population-wide priorities and strategies for improving the health of people in Oregon. The SHIP serves as the basis for taking collective action on key health issues in Oregon.
As stated previously, the Oregon Health Authority's 2024-2027 Strategic Plan includes the following five pillars: transforming behavioral health, strengthening access to affordable care for all, fostering healthy families and communities, achieving healthy tribal communities, and building OHA's internal capacity.

Narrative Question

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Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last 5 years? **Yes ☒ No ☐**

   If yes, please attach the plan in WebBGAS

   Please see attached reports**:** Health Promotion and Chronic Disease Prevention 2017-2025 Strategic Plan; Oregon Overdose Data to Action (OD2A) Work Plan; and the 2020-2025 Oregon Statewide Strategic Plan. All plans are inclusive of primary prevention interventions and programs. In close collaboration with the State Health Improvement Plan – Healthier Together Oregon, the Oregon Statewide Strategic Plan commission by the Alcohol and Drug Policy Commission (ADPC) is working to improve of the effectiveness and efficiency of state and County alcohol and drug prevention and treatment services. The Alcohol and Drug Policy Commission is currently developing a new Oregon Statewide Strategic Plan starting in 2026 and OHA-PHD HPCDP is also updating their strategic plan for 2026.
   Alcohol and Drug Policy Commission is working collaboratively with the System of Care Advisory Council to strategic plan goals, initiatives, and strategies to focus on youth substance use prevention, intervention and treatment.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?

   Yes ☒ No ☐ Not applicable (no prevention strategic plan) ☐

3. Does your state's prevention strategic plan include the following components? (check all that apply)
   a. ☒ Based on needs assessment datasets, the priorities that guide the allocation of SUPTRS BG primary prevention funds
   b. ☒ Timelines
   c. ☒ Roles and Responsibilities
   d. ☒ Process indicators
   e. ☒ Outcome indicators
   f. ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? **Yes** ☒ **No** ☐
If yes, does the composition of the Advisory Council represent the demographics of the state? **Yes** ☒ **No** ☐

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? **Yes** ☒ **No** ☐
If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based.
OHA's Public Health Division (PHD) uses best practice standards from the Centers for Disease Control, Guide to Community Preventive Services. The Community Preventive Services Task Force, an independent, non-federal, volunteer body of public health and prevention experts, recommends several evidence-based community strategies to reduce harmful alcohol use. The Guide to Community Preventive Services systematically reviews the effectiveness of population-based interventions to prevent excessive alcohol consumption and related health outcomes. The task force conducts a comprehensive meta-analysis of studies to determine recommended evidence-based population-level interventions. These evidence-based strategies are included in HPCDP's eight-year strategic plan to address excessive drinking and tobacco use. OHA continues to fund Counties and Tribes to implement evidence-informed practices and strategies supported by SAMHSA's evidence-based practices resource center and Oregon's Tribal Based Practices, which are practices based on evidence for Native American communities. Oregon's Tribal Behavioral Prevention Program funds Oregon's Nine Federally Recognized Tribes and designated Urban Area Indian Health Program to address and prevent substance use. Tribes use a variety of strategies and Tribal Based Practices. Community coalitions and programs mobilize communities to prevent substance misuse by addressing risk and promoting protective factors in youth, families, and communities. Some tribal prevention programs implement Tribal-Based Practices to provide culturally relevant education, skills, and opportunities, uniting through a "culture of prevention" framework of support, to protect and build resilient communities. OHA enlists support from the Behavioral Health Prevention and Promotion (BHPP) Sub-Committee of the Addictions and Mental Health Planning and Advisory Council (AMHPAC) to advise and the Conference of Local Health Officials provide feedback on SUPTRS primary prevention funds.

Narrative Question

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Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. (check all that apply)
   a. ☒ SSA staff directly implements primary prevention programs and strategies.
   b. ☒ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract,
      statewide media campaign contract.)
   c. ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
   d. ☐ The SSA funds regional entities that provide training and technical assistance.
   e. ☐ The SSA funds regional entities to provide prevention services.
   f. ☒ The SSA funds county, city, or tribal governments to provide prevention services.
   g. ☐ The SSA funds community coalitions to provide prevention services.
   h. ☐ The SSA funds individual programs that are not part of a larger community effort.
   i. ☐ The SSA directly funds other state agency prevention programs.
   j. ☒ Other (please describe) funds non-profits providing prevention programs

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
   a. Information Dissemination:
      Local interventions: Funds Counties, Nine Federally Recognized Tribes and non-profits to lead coordination and program management of local efforts to reduce the harms associated with alcohol, tobacco and other drugs, including overdoses, in all 36 Oregon Counties and Nine Federally Recognized Tribes.

Current strategies include: Awareness raising campaigns and activities about alcohol and drug risks, problems and solutions. Tribal Based Practices: Cultural Camp, Tribal Family Activities, Tribal Youth Conference
Mass Reach Health Communications: Campaign brand and strategic messaging for communicating to Oregonians about risks, problems and solutions about excessive alcohol use and related harms.

b. Education:
Local interventions: Funds Counties, Nine Federally Recognized Tribes and non-profits to lead coordination and program management of local efforts to reduce the harms associated with alcohol, tobacco and other drugs in all 36 Oregon Counties and Nine Federally Recognized Tribes.
Current strategies include: local prevention campaign and education efforts, multi-session prevention education. Tribal Based Practices: Baby Doll Cradle, Ceremonies & Rituals, Cradle Boards, Family Unity, Healthy Relationships Curriculum, Native American Storytelling, Positive Indian Parenting, Talking Circles, Tribal Crafts.

c. Alternatives:
Local interventions: Funds Counties, Nine Federally Recognized Tribes and non-profits to lead coordination and program management of local efforts to reduce the harms associated with alcohol, tobacco and other drugs in all 36 Oregon Counties and Nine Federally Recognized Tribes.

Current strategies include: Youth development and engagement and advocacy programs. Tribal Based Practices: Adventure Based, BAAD Tournaments, Canoe Journey, Horse Program, Powwow, Round Dance, Sweat Lodge.

d. Problem Identification and Referral:
Local interventions: Funds Counties, Nine Federally Recognized Tribes and non-profits to lead coordination and program management of local efforts to reduce the harms associated with alcohol, tobacco and other drugs in all 36 Oregon Counties and Nine Federally Recognized Tribes.

Current strategies include: student assistance programs and youth focused problem identification and referral services. Tribal Based Practices: Funds the coordination and program management of local efforts to reduce the harms associated with alcohol, tobacco and other drugs across all 36 counties and Nine Federally Recognized Tribes of Oregon

e. Community-Based processes:
Local interventions: Funds Counties, Nine Federally Recognized Tribes and non-profits to lead coordination and program management of local efforts to reduce the harms associated with alcohol, tobacco and other drugs, including overdoses, in all 36 Oregon Counties and Nine Federally Recognized Tribes.

Current strategies include: Prevention coalition engagement; local/regional multisector stakeholder group engagement; community awareness raising activities; collaboration with community partners and stakeholders. Tribal Based Practices: Native American Community Mobilization.

f. Environmental:
Local Interventions: Funds Counties, Nine Federally Recognized Tribes and non-profits to lead coordination and program management of local efforts to reduce the harms

associated with alcohol, tobacco and other drugs, including overdose, in all 36 Oregon Counties and Nine Federally Recognized Tribes.

Current strategies include: Community event policies; alcohol and tobacco retail and point of sale policies; Indoor Clean Air Act policy expansion; raising the price of alcohol and tobacco; restrictions on alcohol marketing, promotion and retail environments; maintenance of a controlled state; mapping and limiting alcohol density; anti-stigma messaging and training. Tribal Based Practices: Ceremonies & Rituals (Protocols, Appropriate Behaviors, Informal Policy, Community Norms, etc.)

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? **Yes** ☒ **No** ☐

If yes please describe:

The planning and implementation of SUPTRS funded primary prevention strategies are supported through an integrated program structure within OHA-PHD. OHA-PHD supports local grantees in a community programs model with operational and strategic support teams made up of program liaisons, policy specialists, health promotion specialists and research analysts. The community programs model establishes a system and process for grantee guidance and review of biennial alcohol, tobacco and other drug prevention implementation plans. OHA-BHD supports tribal behavioral health with Tribal Behavioral Health specialists.

Each biennium, counties and Tribes complete and submit prevention implementation plans for approval and are awarded funding. These plans include the specific alcohol, tobacco and drug prevention programs, practices and strategies that the county or Tribe intends to implement or build capacity for and must be justified through the prevention plan activities.

A wide variety of strategies are conducted throughout Oregon's prevention system. Local prevention programs generally include a number of approaches used simultaneously, including: Coalition work; multi-media campaigns; awareness and social norm campaigns; information and data collection; youth development to promote protective factors and reduce risk factors; partnerships with enforcement for sustainable resources to reduce youth access to alcohol and tobacco; multi-session prevention education programs; alcohol and tobacco policy work such as creation of local ordinances to reduce youth access and exposure to advertising; and ongoing collaboration with community partners.

OHA-PHD coordinates with Addictions and Mental Health Planning and Advisory Council (AMHPAC) and the Conference of Local Health Officials (CLHO) to advise on SUPTRS funded primary prevention strategies are not used for other means.

Narrative Question

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Evaluation:

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last 5 years?

Yes ☐ No ☒

If yes, please attach the plan in WebBGAS

The state has several evaluations relating to specific components of its substance use primary prevention work. The state is working to identify funds and capacity for specific evaluation related to local primary prevention work across the state. Current substance use primary prevention evaluation components include: SAMHSA SPF-PFS evaluation plan, Tobacco Prevention and Education Program (TPEP) Evaluation, state substance use prevention indicators monitoring, and local prevention program biennial work plan monitoring and state media campaign evaluation.

2. Does your state's prevention evaluation plan include the following components? (check all that apply)

a. ☒ Establishes methods for monitoring progress towards outcomes, such as prioritized benchmarks
b. ☒ Includes evaluation information from sub-recipients
c. ☒ Includes National Outcome Measurement (NOMs) requirements
d. ☐ Establishes a process for providing timely evaluation information to stakeholders

e. ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
f. ☐ Other (please describe): Click or tap here to enter text.

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services.
   a. ☒ Numbers served
   b. ☐ Implementation fidelity
   c. ☐ Participant satisfaction
   d. ☒ Number of evidence-based programs/practices/policies implemented
   e. ☐ Attendance
   f. ☐ Demographic information
   g. ☒ Other (please describe): Program successes and challenges

4. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services.
   a. ☒ 30-day use of alcohol, tobacco, prescription drugs, etc.
   b. ☒ Heavy alcohol use
   c. ☒ Binge alcohol use
   d. ☒ Perception of harm
   e. ☒ Disapproval of use
   f. ☒ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

   ☒ Other (please describe):
   The state collects and tracks the above outcome measures with population level surveys (Oregon Student Health Survey and Behavioral Health Risk Factor Surveillance System), with data reports available at the County and school district level. Funded prevention program strategies at the state and County/Tribal prevention programs regularly utilize outcome measurement data for planning and prioritizing prevention programs, strategies and practices.

6 Statutory Criterion for MHBG – Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based mental Health Service Systems
Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of impatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items:
Criterion 1

1. **Describe available services and resources to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.**
   Oregon has established a comprehensive, community-based mental health service system that supports individuals with mental illness, including those with co-occurring mental and substance use disorders, in achieving the highest level of independence possible outside of

inpatient or residential institutions. Services are delivered along a continuum of care, beginning with the Oregon State Hospital and transitioning through adult foster homes—the first step down from institutional care—followed by varying levels of community-based and outpatient services. These include partial hospitalization programs, intensive outpatient programs, intensive case management, and outpatient therapy.

The Oregon Health Authority (OHA) leads the Integrated Co-Occurring Disorders (COD) Initiative, which includes over thirty provider organizations across the state. These programs deliver outpatient behavioral health treatment using the Integrated Dual Disorder Treatment (IDDT) model, an evidence-based approach. Practitioners receive over twenty hours of specialized training to support integrated treatment for individuals with co-occurring substance use and mental health disorders. Some of these programs maintain formal referral pathways with the Oregon State Hospital to support individuals stepping down in level of care. In addition, community-based peer support is available through organizations like Dual Diagnosis Anonymous.

Oregon coordinates a wide array of services—physical and mental health care, rehabilitation, employment, housing, education, substance use disorder treatment, and support services—through Certified Community Behavioral Health Clinics (CCBHCs) and Coordinated Care Organizations (CCOs), which are guided by local advisory councils to address service gaps. The Medicaid Division in OHA administers services for over one million Oregonians, primarily through the Oregon Health Plan, and emphasizes prevention, early intervention, and culturally responsive care. For youth, Oregon employs cross-system collaboration through programs like Wraparound, which provide individualized, team-based planning. Case management services are tailored to each individual's needs and include support for transitions between care settings, access to health and social services, and assistance with safety net programs.

To reduce hospitalizations and lengths of stay, Oregon utilizes residential treatment, Assertive Community Treatment (ACT), and intensive case management strategies. This integrated and coordinated approach ensures that individuals with mental health and substance use challenges receive the support they need to thrive in their communities.

2. **Does your state coordinate with following services under comprehensive community - based mental health service systems?**

a. Physical Health Yes ☒ No ☐

b. Mental Health Yes ☒ No ☐

c. Rehabilitation services Yes ☒ No ☐

d. Employment services Yes ☒ No ☐

e. Housing services Yes ☒ No ☐

f. Educational services Yes ☒ No ☐

g. Substance use prevention and SUD treatment services Yes ☒ No ☐

h. Medical and dental services Yes ☒ No ☐

Commented [JB5R4]: @Piering Stephanie D. can you add this please?

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Commented [PD8R4]: Okay, I will see what I can do.

Commented [PD9R4]: Okay, copied and pasted in. I highlighted "Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)". Sam should be able to just click below and enter the information. :)

Commented [JB10R4]: Thank you!

i. Recovery Support services Yes ☒ No ☐

j. Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) Yes ☒ No ☐

k. Services for persons with co-occurring M/SUDs Yes ☒ No ☒

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

In many regions of the state CCBHC's exist that coordinate all mentioned services. Oregon has funded community mental health programs to offer supported employment services, housing services, educational coordination services, SUD services and other support services. In each county the CCO's are required to have local community advisory councils that identify the gaps or programs to offer supported employment services, housing services, educational coordination services, SUD services and other support services; the local community advisory councils identify the gaps or inability to access services and these councils create local solutions.

Oregon's health care transformation has changed how health care is conceptualized, managed, delivered and financed in Oregon. There has been a significant increase in the number of people eligible for Medicaid funded health services with about 300,000 new members enrolled. Oregon's Health System Division administers state and federal funds to deliver and pay for health care services to over 1 million people in Oregon, primarily through the Oregon Health Plan (OHP) with 43 percent of them being children. Enrollment in OHP contributes to Oregon achieving one of the lowest uninsured rates in the nation.

Prevention, treatment, and recovery services have a solid evidence base on which to build a system that promises better outcomes for people who have been diagnosed with or who are at risk for mental illness, substance use, gambling disorders and co-occurring disorders. Preventing the need for behavioral health services through evidence based primary prevention and environmental interventions at the population level are also critically needed.

The Behavioral Health Division (BHD) of the Oregon Health Authority (OHA) coordinates a statewide system of integrated physical, behavioral, and oral health care that supports the triple aim of better health, better care, and lower costs by increasing access to preventive, coordinated care for Oregon's medical assistant program members and behavioral health consumers. BHD's mission is to build and advance a system of care that serves and respects the diversity, cultures and languages spoken in Oregon's communities and population. BHD administers community mental health and addiction programs statewide. These services are delivered through Tribal programs, community mental health programs, local public health departments, individual health care provider agreements, coordinated care organizations (CCOs), other managed care plans, and funding opportunities to support additional housing for individuals with severe and persistent mental illness.

In addition, the mission of the Behavioral Health Division is to assist Oregonians to achieve physical, mental and social well being by providing access to health, mental health and addiction services and supports to meet the needs of adults and children to live, be educated, work and participate in their communities. The mission is accomplished by working in partnership with individuals and their families, counties, other state agencies, providers, advocates and communities. For example, Wraparound is a collaborative, team-based,

principles-driven planning process. Through the Wraparound process, teams create one individualized plan of care to meet the needs, and improve the lives, of multi-system involved youth and their families.

3. **Describe your states case management services:**

Case management services are offered at the Oregon State Hospital, CMHP level and the CCO level. These include: case management, intensive case management, care coordination, navigation of services and cross sector care coordination. Basic HIE (health information exchange) promotes care coordination in real time across care settings. OHA has created a role called ENCC (Enhanced Care Coordinators) that is enacted through the Coordinated Care Organization contract for Medicaid administration. ENCCs are available in each region in Oregon.

4. **Describe activities intended to reduce hospitalizations and hospital stays:**

Oregon has robust ACT teams; licensed residential settings, care transitions navigation, expanded guardianship program; Exceptional Needs Care Coordinators; electronic bed registry (OHSU) and weekly mental health residential capacity report; 1915i HCBS (home and community based services); ECMU (Extended Care Management Unit) which facilities discharges from Oregon State Hospital; Capacity Restoration services offered in the community; deflection program; PATH offers case management for homeless individuals.

5. **Please indicate areas of technical assistance needs related to this section.**

Technical assistance around standardizing expectations and best practice standards for care coordination across system and health settings.

Narrative question
Criterion 2: Mental Health System Data Epidemiology
Contains an estimate of the incidence and prevalence in the state of SMI amount adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

1. **In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health or other federal/state data that describes the population so focus.**

Column C required that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED.

Priority Population (A)	OHP prevalence (B)	OHP Incidence (C)
1. Adults with SMI	23.36	8.78

2. Children with SED	16.83	6.82

2. **Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If you state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.**

Our team calculated prevalence and incidence using Medicaid claims data for children ages 0-17 with SED and adults 18 years and over with SMI.

- **Prevalence:** Number of unique Medicaid members with an SED/SMI diagnosis in 2024, divided by the total Medicaid-enrolled population in the same age group, expressed per 100 members.

- **Incidence:** Number of unique Medicaid members *newly* diagnosed with an SED/SMI in 2024, with a one-year look back to 2023 to ensure no prior diagnosis, divided by the total Medicaid-enrolled population, expressed per 100 members.

Why we used Medicaid / Oregon Health Plan (OHP) population?

Although Medicaid data does not capture the full statewide population, it provides the most complete and timely information available within the required timeframe.

3. **Please indicate areas of technical assistance needs related to the section.**

Discussion around how other states are using this data to inform, drive or impact policy or investments.

Criterion 3

1. **Does your state integrate the following services into a comprehensive system of care?**

a. Social Services x☐ Yes ☐ No

b. Educational services, including services provided under IDEA x ☐Yes ☐No

c. Juvenile justice services x☐Yes ☐No

d. Substance use prevention and SUD treatment services x☐Yes ☐No

e. Health and mental health services x☐Yes ☐No

f. Establishes defined geographic area for the provision of the services of such systems

☐ xYes ☐ No

2. **Please indicate areas of technical assistance needs related to this section.**

Metabolic screening for SMI in CMHP and robust uptake of Tobacco Cessation and Integrated – IMR)

Narrative Question

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults
Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community -based services to older adults.

Criterion 4

1. **Describe your state's tailored services to rural population with SMI/SED. See SAMHSA's Rural Behavioral Health page for program resources**
   Majority of services are offered through the CMHP or LMHA in rural counties and or through the FQHC. ACT teams are available in rural counties; Telehealth /tele-mental health services are also available; there are specific grant funded programs offered by OHA specifically for rural areas;

2. **Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal for program resources.**

OHA's 1115 Medicaid Waiver offers housing assistance and supports to eligible older adults as a Medicaid benefit; PATH funds street outreach and case management in 3 large populous counties.

3. **Describe your state's tailored services to the older adult population with SMI. See the federal Resources for Older Adults webpage for resources.**

Oregon invests in the Older Adult Behavioral Health Initiative. The goal of this Initiative is to serve older adults and people with physical disabilities by improving timely access to care from qualified providers (workforce) who work together to provide coordinated, quality and culturally responsive behavioral health and health and wellness promotion. We do this by funding staff positions – older adult behavioral health specialists – who cover all 36 counties in Oregon. This Initiative I now in its 10th year and is considered a national templar program. These specialists provide the following deliverables: enhance multi agency and multi sector collaboration and coordination, provide workforce development trainings, promote emotional health and wellness activities, and provide complex care consultations by bringing community partners and key state partners together to find solutions for older adults with complex care needs. Focus areas are scaling depression care, building resilient communities through mitigating social isolation and loneliness, end of life planning, busting ageism and moving the needle on equity, suicide prevention, health and wellness promotion and mental health prevention, dementia education and awareness; developing geriatric behavioral health core competencies in the workforce; providing multidisciplinary teams to coordinate care for older adults with complex care needs.
Oregon has invested in a statewide Senior Loneliness Line (SLL). This is a warm line where seniors and their caregivers or family members can call for support and connection to resources. This line averages about 1200 calls/month.
Through a CDC multi-year comprehensive suicide prevention grant, one of the priority populations is Older Adults. Through this grant we have trained 24 of the older adult BH specialists in PEARLS (Program to Encourage Active, Rewarding Lives) a treatment program designed to reduce symptoms of depression from the University of Washington – as PEARLS Coaches. These 24 specialists deliver this 6-week program to older adults in community setting such as senior centers, churches and public housing – low barrier, easy access to evidence-based depression program. We are starting the third year for this program. Through this same CDC Suicide Prevention Grant, we offer the ROAM Grant (Rural Older Adults Mini Grant) to promote social connection as a protective factor for upstream suicide prevention.
We have developed specific curriculum/modules on responding to older adults in crisis for our mobile

crisis workforce as part of their core competencies.
We have contributed to curriculum development re: older adults for our integrated co-occurring treatment providers core competencies.
We held our third annual Older Adult, Veterans and Problem Gambling conference in October 2024
We hold an annual geriatric Behavioral Health Conference each highlighting national subject matter experts as keynote speakers.
Some of our CMHP have dedicated older adult programs and teams.
Enhanced Care Facilities/Enhanced Care Outreach Services (ECF & ECOS) These programs are a collaborative partnership between OHA Behavioral Health Division and DHS Aging and People with Disabilities (APD). Services are designed to support individuals with complex mental health and complex physical health needs that require a higher level of support than typically provided in a standard care setting.
Programs emphasize person-centered rehabilitative mental health treatment while continuing to work towards transitioning individuals into the most integrated community setting possible. OHA is responsible for collaborating with APD on managing program referrals, and for working with local providers regarding program administration and strengthening coordination between systems. There are 9 Enhanced Care Facilities that are either APD licensed residential care facilities or units within intermediate care facilities dedicated to serving individuals who qualify for this service. These programs have higher staffing ratios than traditional APD licensed settings, and mental health staff on-site 7 days a week. Mental health staff work closely with APD in developing strategies to support individuals in meeting their goals. Enhanced Care Outreach Services provides intensive mental health services to individuals living in standard APD licensed settings.
Services, for the most part, are delivered in the community in an outreach model. Treatment services for both ECF and ECOS programs are delivered by designated local mental health providers who have a knowledge and competencies in working with the aging population and have an understanding of the interplay between physical and mental health.

Complex Case Consultation and Care Transitions
The older adult team within OHA works closely with Oregon State Hospital staff and Aging and People with Disabilities to discharge and or divert complex BH clients to the most appropriate level of care in the community

Oregon also has the statutory Pre-Admission Screening and Resident Review (PASRR) program where individuals identified with SMI indicators on a screener before being admitted to a licensed nursing facility receive a comprehensive mental health evaluation and person-centered recommendations.

4. **Please indicate areas of technical assistance needs related to this section.**

Narrative Question
Criterion 5 Management Systems
States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

1. **Describe your state's management systems.**

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention

itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client- provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out- of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.

2. **Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.**

Telehealth was expanded during the COVID pandemic to manage outbreaks and access. Oregon learned that there was a benefit to Telehealth in that there was a decrease in no-show rates (this is anecdotal we don't have data), increasing access.

Oregon is in the midst of Medicaid rule changes allowing Telehealth providers nationally, as long as they have an Oregon license.

Oregon does not have funds specifically allotted to telehealth for behavioral health services. We do however, have the BH fee schedule which informs our policy. We allow telehealth as indicated with the GT modifier for BH services.

These are paid in parity with in-person services. Evidence from the pandemic has shown telehealth is an appropriate modality to provide some services, as chosen and directed by the individual accessing.

These telehealth services have especially been helpful in serving SPMI populations (when they can separate delusions from technology). From care coordination to crisis intervention, this modality has increased access to services when and where a client may present themselves. **https://www.oregon.gov/oha/hsd/ohp/pages/fee-schedule.aspx?wp6426=l:100** . Residential services are not approved for telehealth; outpatient services in support of residential treatment is allowed and helpful for client access to services.

3. **Please indicate areas of technical assistance needs related to this section**

It would be helpful to learn about strategies others have used to help SMI clients to keep technology interfaces separate from delusional content, interventions for clients who sometimes misappropriate electronic communication from delusional content, and indications

when to stop electronic communications beyond the obvious symptoms.

7 **Substance Use Disorder Treatment – Required for SUPTRS BG** **Narrative Question**

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a. A full continuum of services (with medications for addiction treatment included in v-x):

i) Screening **Yes** ☒ **No** ☐

ii) Education **Yes** ☒ **No** ☐

iii) Brief Intervention **Yes** ☒ **No** ☐

iv) Assessment **Yes** ☒ **No** ☐

v) Withdrawal Management (inpatient/residential) **Yes** ☒ **No** ☐

vi) Outpatient **Yes** ☒ **No** ☐

vii) Intensive Outpatient **Yes** ☒ **No** ☐

viii) Inpatient/Residential **Yes** ☒ **No** ☐

ix) Aftercare/Continuing Care **Yes** ☒ **No** ☐

x) Recovery Support **Yes** ☒ **No** ☐

b. Services for special populations:

i) Prioritized services for veterans **Yes** ☒ **No** ☐

ii) Adolescents **Yes** ☒ **No** ☐

iii) Older adults **Yes** ☒ **No** ☐

Narrative Question

Criterion 2: Improving Access and Addressing Primary Prevention – **see Section 8**

Criterion 2

Narrative Question

Criterion 3: Pregnant Women and Women with Dependent Children (PWWDC)

Criterion 3

1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability?

   Yes ☒ No ☐

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?

   Yes ☒ No ☐

3. Does your state have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?

   Yes ☒ No ☐

4. Does your state have an arrangement for ensuring the provision of required supportive services?

   Yes ☒ No ☐

5. Has your state identified a need for any of the following:

   a. Open assessment and intake scheduling **Yes ☒ No ☐**

   b. Establishment of an electronic system to identify available treatment slots **Yes ☒ No ☐**

   c. Expanded community network for supportive services and healthcare **Yes ☒ No ☐**

   d. Inclusion of recovery support services **Yes ☒ No ☐**

   e. Health navigators to assist clients with community linkages **Yes ☒ No ☐**

   f. Expanded capability for family services, relationship restoration, and custody issues **Yes ☒ No ☐**

   g. Providing employment assistance **Yes ☒ No ☐**

   h. Providing transportation to and from services **Yes ☒ No ☐**

   i. Educational assistance **Yes ☒ No ☐**

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   Oregon Health Authority (OHA) Compliance Specialists complete regular site reviews to ensure that programs meet requirements as described in the administrative standards, including those corresponding to women's treatment services. OHA revised the addiction and mental health administrative rules governing these services. The rule requirements for women's treatment services were developed by an advisory committee comprised of clients, partners from various regions of the state, and policy analysts. The rules are based on best practice guidelines that aim to address the holistic recovery

needs of women and their families within an integrated and trauma-informed framework. The administrative rules strive to promote family-centered treatment through the endorsement of collaborative care principles and culturally competent practices. Contracts between OHA and the counties, tribes, and direct contractors require that pregnant women and women with children must be prioritized. Oregon conducts onsite reviews of each licensed residential program at a minimum of every two years, and approved outpatient programs at a minimum of every three years. The reviews evaluate each program's compliance with administrative rules that require specific programming applicable for this population. Services must include gender specific treatment, including care for issues such as social isolation, self-reliance, parenting, family/relationship difficulties, domestic violence, housing and financial problems and prenatal care. Programs are reviewed to evaluate compliance with administrative rule requirements to provide or coordinate services that meet special access needs such as childcare, mental health services, and transportation. Providers are required to submit enrollment and status update data on all clients served in publicly funded treatment programs licensed or certified by OHA. In addition to general demographic information at enrollment (drug use, level of impairment, income, employment status, living arrangements, and arrest history) the system collects whether or not the client is pregnant at admission and the number of dependent children in the household.

In addition to on-site reviews and capacity reporting requirements, OHA's Women's Services Coordinator conducts technical assistance events, quarterly meetings, frequent check-ins with programs and community partners, and coordinates with Child Welfare to ensure PWWDC have priority access to treatment and wrap around services.

Oregon uses standard contract language in all contracts with counties and sub-contractors to assure compliance through the A-133 audit requirement and also through routine audits of state licensed facilities. OHA has updated boiler plate contract language for policies and procedures around corrective action plans as described in the administrative standards, including those corresponding to women's treatment services. OHA revised the addiction and mental health administrative rules governing these services. The rule requirements for women's treatment services were developed by an advisory committee comprised of clients, partners from various regions of the state, and policy analysts. The rules are based on best practice guidelines that aim to address the holistic recovery needs of women and their families within an integrated and trauma-informed framework. The administrative rules strive to promote family-centered treatment through the endorsement of collaborative care principles and culturally competent practices. Contracts between OHA and the counties, tribes, and direct contractors require that pregnant women and women with children must be prioritized. Oregon conducts onsite reviews of each licensed residential program at a minimum of every two years, and approved outpatient programs at a minimum of every three years. The reviews evaluate each program's compliance with administrative rules that require specific programming applicable for this population. Services must include gender specific treatment, including care for issues such as social isolation, self-reliance, parenting, family/relationship difficulties, domestic violence, housing and financial problems and prenatal care. Programs are reviewed to evaluate compliance with administrative rule requirements to provide or coordinate services that meet special access needs such as childcare, mental

health services, and transportation. Providers are required to submit enrollment and status update data on all clients served in publicly funded treatment programs licensed or certified by OHA. In addition to general demographic information at enrollment (drug use, level of impairment, income, employment status, living arrangements, and arrest history) the system collects whether or not the client is pregnant at admission and the number of dependent children in the household. In addition to on-site reviews and capacity reporting requirements, OHA's Women's Services Coordinator conducts technical assistance events, quarterly meetings, frequent check-ins with programs and community partners, and coordinates with Child Welfare to ensure PWWDC have priority access to treatment and wrap around services. Oregon uses standard contract language in all contracts with counties and sub-contractors to assure compliance through the A-133 audit requirement and also through routine audits of state licensed facilities. OHA has updated boiler plate contract language for policies and procedures around corrective action plans.

Narrative Question

Criterion 4, 5 and 6: Persons Who Inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), and Hypodermic Needle Prohibition

Criterion 4, 5 & 6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:
   a. 90 percent capacity reporting requirement **Yes ☒ No ☐**
   b. 14-120 day performance requirement with provision of interim services **Yes ☒ No ☐**
   c. Outreach activities **Yes ☒ No ☐**
   d. Monitoring requirements as outlined in the authorizing **statute** and implementing **regulation** **Yes ☒ No ☐**

2. Has your state identified a need for any of the following:
   a. Electronic system with alert when 90 percent capacity is reached **Yes ☒ No ☐**
   b. Automatic reminder system associated with 14-120 day performance requirement **Yes ☒ No ☐**
   c. Use of peer recovery supports to maintain contact and support **Yes ☒ No ☐**
   d. Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults) **Yes ☒ No ☐**

3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The BHD Licensing and Certification Unit complete onsite compliance reviews in accordance with OAR 309-008-0700, OAR 415-012-0050, and OAR 415-050-0110. The purpose of the reviews is to verify that state approved providers are fulfilling the requirements set forth in applicable administrative rules and statutes. During the onsite reviews, compliance specialists use the following sources of information to determine whether the provider is complying with regulations that govern activities and services to PWID and tuberculosis services.

The purpose of the reviews is to verify that state approved providers are fulfilling the requirements set forth in applicable administrative rules and statutes. During the onsite reviews, compliance specialists use the following sources of information to determine whether the provider is complying with regulations that govern activities and services to PWID and tuberculosis services:

- Review of policies and procedures that are related to activities and services to PWID.
- Review of policies and procedures related to tuberculosis screening and referral services.
- Review of the medical protocols that are approved by the agency's Medical Director.
- Interview with the agency's Medical Director.
- Interview with agency's director and program managers.
- Interview with SUDs treatment staff.
- Interview with line staff.
- Interview with clients.
- Review of screening protocol to ensure that priority populations are given advanced admission.
- Review of Service Records, including Assessments, Service Plans, Service Notes, and Transfer Plans.
- Review of forms used to complete infectious disease risk screening.
- Review of written educational and referral materials that SUDs treatment staff provide to PWID and those at risk of tuberculosis exposure.

Corrective actions required to address identified problems: Behavioral Health Division (BHD) compliance specialists complete summary reports within 30 days of the onsite review and submit these to the agency's director. The compliance reports contain detailed descriptions of findings of noncompliance with administrative standards and include specific instructions on corrective action requirements. The agency's director is required to submit to the BHD compliance specialist a plan of correction (POC) within 30 days from receiving the report.

The POC must include a detailed summary of the activities that will be completed, timeline for corrections, and the name of all staff who are responsible for implementing and monitoring each corrective activity of the onsite review and submit these to the agency's director. The compliance reports contain detailed descriptions of findings of noncompliance with administrative standards and include specific instructions on corrective action requirements. The agency's director is required to submit to the BHD compliance specialist a plan of correction (POC) within 30 days from receiving the report. The POC must include a detailed summary of the activities that will be completed, timeline for corrections, and the name of all staff who are responsible for implementing and monitoring each corrective activity.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through

arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?

Yes ☒ No ☐

2. Has your state identified a need for any of the following:

   a. Business agreement/MOU with primary healthcare providers **Yes ☐ No ☒**

   b. Cooperative agreement/MOU with public health entity for testing and treatment **Yes ☐ No ☒**

   c. Established co-located SUD professionals within FQHCs **Yes ☒ No ☐**

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

BHD compliance specialists may also require the director to include with the POC documents to fulfill corrective action requirements. Such documents may include: requirements. Such documents may include:

- Updated policies and procedures that are related to activities and services to PWID.
- Updated policies and procedures related to tuberculosis screening and referral services.
- Records to show that staff have received training on services to PWID.
- Records to show that staff have received training on tuberculosis screening and referral services.
- Revised forms that will be used to complete infectious disease risk screening.
- Agendas and minutes from the quality improvement committee meetings to ensure that activities and services to PWID and tuberculosis screening and referral are being carried out in accordance with the agency's policies, medical protocol, and OAR

  Requirements, tuberculosis screening and referral are being carried out in accordance with the agency's policies, medical protocol, and OAR requirements.
- A written list of resources that SUDs treatment and support staff will provide to clients.

Early Intervention Services for HIV (for "Designated States" Only) N/A for Oregon

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery? **Yes ☐ No ☐**
2. Has your state identified a need for any of the following:

   a. Establishment of EIS-HIV service hubs in rural areas **Yes ☐ No ☐**

   b. Establishment or expansion of tele-health and social media support services **Yes ☐ No ☐**

   c. Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS **Yes ☐ No ☐**

Hypodermic Needle Prohibition

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are

NOT expended to provide individuals with hypodermic needles or syringes for the purpose of injecting illicit substances **(42 U.S.C.§ 300x-31(a)(1)(F))** **Yes ☒ No ☐**

Narrative Question

Criterion 8, 9 and 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independent Peer Review

Criterion 8, 9 & 10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement? **Yes ☒ No ☐**
2. Has your state identified a need for any of the following:
   a. Workforce development efforts to expand service access **Yes ☒ No ☐**
   b. Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services? **Yes ☒ No ☐**
   c. Establish a peer recovery support network to assist in filling in the gaps **Yes ☒ No ☐**
   d. Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, person experiencing homelessness) **Yes ☒ No ☐**
   e. Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations **Yes ☒ No ☐**

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered care? **Yes ☒ No ☐**

2. Has your state identified a need for any of the following:
   a. Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services **Yes ☐ No ☒**
   b. Establish a program to provide trauma-informed care **Yes ☐ No ☒**
   c. Identify current and prospective partners to be included in buiding a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice system, adult criminal justice system, and education **Yes ☐ No ☒**

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (**42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449**)? **Yes ☒ No ☐**
2. Does your state provide any of the following

a. Notice to Program Beneficiaries **Yes** ☒ **No** ☐

b. An organized referral system to identify alternative providers **Yes** ☐ **No** ☒

c. A system to maintain a list of referrals made by religious organizations

Yes ☐ **No** ☒

Referrals

1. Does your state have an agreement to improve the process for referring individual to the treatment modality that is most appropriate for their needs? **Yes** ☒ **No** ☐

2. Has your state identified a need for any of the following:

a. Review and update of screening and assessment instruments **Yes** ☐ **No** ☒

b. Review of current levels of care to determine changes or additions **Yes** ☒ **No** ☐

c. Identify workforce needs to expand service capabilities **Yes** ☒ **No** ☐

Patient Records

1. Does your state have an agreement to ensure the protection of client records

Yes ☒ **No** ☐

Narrative Question

Criterion 7 and 11: Group Homes for Persons In Recovery and Professional Development

Criterion 7 & 11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?

Yes ☒ **No** ☐

2. Has your state identified a need for any of the following:

a. Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service

Yes ☒ **No** ☐

b. Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing

Yes ☐ **No** ☒

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment, and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a. Recent trends in substance use disorders in the state **Yes** ☒ **No** ☐

b. Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services **Yes** ☒ **No** ☐

c. Performance-based accountability **Yes** ☒ **No** ☐

d. Data collection and reporting requirements **Yes** ☒ **No** ☐

If the answer is No to any of the above, please explain:

2. Has your state identified a need for any of the following:

a. A comprehensive review of the current training schedule and identification of additional training needs **Yes** ☒ **No** ☐

b. Addition of training sessions designed to increase employee understanding of recovery services **Yes** ☒ **No** ☐

c. Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services **Yes** ☒ **No** ☐

d. State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort **Yes** ☒ **No** ☐

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers [1](TTCs):

a. Prevention TTC **Yes** ☒ **No** ☐

b. SMI Advisor **Yes** ☒ **No** ☐

c. Addiction TTC **Yes** ☒ **No** ☐

d. State Opioid Response Network **Yes** ☒ **No** ☐

e. Strategic Prevention Technical Assistance Center (SPTAC) **Yes** ☒ **No** ☐

Waivers

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections **42 U.S.C.§ 300x-22(b),300x-23,300x-24 and 300x-28 (42 U.S.C.§ 300x-32(e)**.*

1. Is your state considering requesting a waiver of any requirements related to:

a. Allocations regarding women (300x-22(b)) **Yes** ☐ **No** ☒

b. Intravenous substance use (300x-23) **Yes** ☐ **No** ☒

2. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a. Tuberculosis **Yes** ☐ **No** ☒

b. Early Intervention Services Regarding HIV **Yes** ☐ **No** ☒

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements (**42 U.S.C. § 300x-28**):

a. Improvement of Process for Appropriate Referrals for Treatment **Yes** ☐ **No** ☒

b. Professional Development **Yes** ☐ **No** ☒

c. Coordination of Various Activities and Services **Yes** ☐ **No** ☒

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://www.oregon.gov/oha/ph/ProviderPartnerResources/HealthcareProvidersFacilities/HealthcareHealthCareRegulationQualityImprovement/Pages/index.aspx

8 Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data sets (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. Title XIX, Part B, Subpart III of the Public Health Services Act (42 U.S.C. §300x-52(a)), mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in

accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH- CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process.

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

1. Briefly describe the SMHA 's data collection and reporting system and what level of data are reported currently (e.g., at the client, program, provider, and/or other levels).

The Resilience Outcomes Analysis and Data Submission (ROADS) System collects treatment enrollment status (active/inactive client status), Non-Medicaid Service, and program data from Oregon's behavioral health providers. As the primary data collection tool for services, ROADS allows OHA to have a more complete picture of behavioral health treatment and outcomes at the client level. The ROADS system is not designed to collect program level data.

The Certification and Licensing Information System (CLICS) serves as Oregon's official system of record for detailed behavioral health provider licensing and certification. CLICS streamlines and supports the functions of the regulatory units charged with administering and enforcing licensing and certification processes under state law.

Oregon's reporting system provides reports such as URS, CLD, and TEDS reports which contain client-level data. These reports use a combination of data sources such as Medicaid

claims, fiscal information, and data on non-Medicaid funded behavioral health services. Data from the Oregon State Hospital are also utilized.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, Child Welfare, etc.).

Data collection is specific to mental health and substance use disorder services through ROADS, as described above. A suite of smaller systems is used to collect information on:

- Acute care hospital provider data, commitment admissions, and discharge data
- Behavioral health program and facility licensing and certification
- 988 call center data
- Gambling treatment data
- Child residential treatment referral and facility capacity information

Data collected in other systems such as Medicaid and child welfare may be used in combination when reporting as noted above.

Oregon has collaborated with other child serving state agencies related to SB 1 (2019) and created an integrated dashboard between Oregon Health Authority, Oregon Department of Human Services and Oregon Youth Authority. This outward facing and interactive dashboard is overseen and supported by state agencies and the System of Care Advisory Council and can be found here.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

OHA does not currently have a master data management solution. An initial proof of concept demonstrated successful client indexing between Medicaid and other data sources including behavioral health treatment data, gambling treatment data, Oregon State Hospital records, and circuit court records. OHA is currently exploring options for indexing client and provider data that would expand our capacity to link data with other state agencies/entities.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

OHA reports on evidence-based practices (EBPs) and behavioral health crisis services (BHCS) based on client-level Medicaid claims data, as well as data collected directly from health programs. Using behavioral health diagnosis codes and Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes, we are able to track utilization of EBPs and BHCS by providing insight into service frequency, client diagnoses, and the types of interventions used. Through these analyses, we are able to investigate effectiveness of interventions and identify trends.

One example is Parent Child Interaction Therapy (PCIT), an evidence-based therapy for children which shows improvements in child behavior, positive communication, and positive parenting skills after attending four sessions. Data is collected at the client-level for each child and their caretaker, and improvement is monitored over each session. This data is also used by multiple universities to track early diagnoses for autism. See also: OHA Dashboard: Crisis Services, Self-Harm, and Suicide Ideation/Attempt among Medicaid Enrollees

5. Briefly describe the limitations of the SMHA 's existing data system.

The ROADS system replaced a legacy data collection system in March 2025 and the TEDS reports required redesign and development. An extension was requested in July 2025 for the

Oregon Quarterly submission due to the ongoing development and testing process.

As detailed in response to Question 3, OHA lacks a master data management solution this limits the extent to which information can be joined across available datasets.

6. What strategies are being employed by the SMHA to enhance data quality?

OHA uses field validations and business rules to ensure data quality and accuracy. As an example, data collection systems validate proprietary Medicaid IDs as part of provider data entry processes.

Providers receive reports of data anomalies based on their submissions. This supports them in confirming that the information submitted accurately represents the services they have rendered. Additionally, compliance reports and other system-generated reports are used to identify reporting gaps and assist the support team in addressing issues such as missing data or high error rates among providers.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

Restrictions and uncertainty around Federal funding is making planning and implementation difficult for critical IT projects supporting data collection and reporting for mental health and substance use disorder programs. Limitations described in Q5 and Q3 are unable to be resolved without Federal investment.

OHA does not have a comprehensive data catalog that could be used by behavioral health programs. Program staff lack a clear understanding of what is collected in the existing systems. This can lead to staff requesting data from providers in spreadsheets rather than using the modern tools available to them. Providers are duplicating effort and this increases the necessary lead time for analysts when attempting to produce new or modified reports.

8. Please indicate areas of technical assistance needs related to this section.

Technical assistance in data literacy and future federal requirements would be helpful to strengthen the behavioral health system at both administrative and service levels. For behavioral health professionals, technical assistance in this area would enhances the ability to use data for planning, policy, and performance monitoring, enabling informed decisions and improved outcomes.

For providers, data literacy assistance would support effective clinical decision-making, quality improvement, and outcome tracking. It also encourages compliance with reporting requirements and fosters a culture of accountability and continuous improvement.

9 Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *.....To support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*

CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some, or all of the core crises care service components, as applicable and appropriate, including the following:

- *Crisis call centers*
- *24/7 mobile crisis services*
- *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*

STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required, a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.

A crisis response system has the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.
Several resources exist to help states. These include Crisis Services: Meeting Needs, Saving Lives, which consists of the National Guidelines for Behavioral Health Coordinated System of Crisis Care as well as an Advisory: Peer Support Services in Crisis Care. There is also the National Guidelines for Child and Youth Behavioral Health Crisis Care which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving, and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911- based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand- off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to

coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

Please respond to the following items:

1. *Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.*

   Oregon's crisis system is a comprehensive, statewide network that operates 24/7 to support individuals of all ages, regardless of insurance status, across all geographic areas. The state is served by two 988 Suicide & Crisis Lifeline centers—one regional and one statewide—alongside individual crisis lines in each of Oregon's 36 counties, tailored to meet local needs. Every county also offers Mobile Crisis Intervention Services, which deploy a two-person, non-law enforcement team trained in suicide screening and naloxone administration. These teams provide immediate, on-site support and follow-up services for up to 72 hours. Youth and families benefit from specialized, developmentally appropriate crisis responses, with extended support available for up to 56 days. Services are coordinated by a Clinician and Family Support Specialist to ensure continuity of care. Additionally, Crisis Receiving and Stabilization Centers (CSCs) are emerging as a vital component of the system. CSCs are currently operational in Benton, Columbia, Deschutes, and Klamath counties, with others under development in Baker, Clackamas, Hood, and Lane counties—Clackamas is expected to open its CSC in November 2025. Oregon

Administrative Rules for CSCs are currently in the community engagement phase, reflecting the state's commitment to inclusive and responsive crisis care.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in:
   a. The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.
   b. The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.
   c. **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.
   d. **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.
   e. **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.

Check one box for each row indicating state's stage of implementation:

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to contact	☐	☐	☐	☐	☐	☒
Someone to respond	☐	☐	☐	☐	☒	☐
Safe place to be	☐	☐	☒	☐	☐	☐

3. Briefly explain your stages of implementation selections:
   As of July 16, 2022, Oregon has fully implemented its 988 Suicide & Crisis Lifeline Call Centers, which are now sustainably funded through a dedicated statewide telecommunications fee and trust fund. Mobile Crisis Intervention Services are fully operational across the state, while Mobile Response and Stabilization Services (MRSS) are in the process of scaling up to meet full staffing and service expectations. Crisis Receiving and Stabilization Centers (CSCs) currently operate in pilot formats in select counties; however, they lack a sustainable source of state funding. The Oregon Health Authority (OHA) is actively working with community partners and providers to develop Oregon Administrative Rules to support the future of CSCs.
4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

The Oregon Health Authority (OHA) is focused on ensuring seamless integration across all pillars of the state's crisis system to improve service outcomes and reduce inequities. For the 988 Suicide & Crisis Lifeline, OHA plans to pilot a software solution that enables direct dispatch to Mobile Crisis Intervention Services (MCIS), establish memoranda of understanding (MOUs) and quality improvement procedures between 988 centers, 911 Public Safety Answering Points (PSAPs), and MCIS providers, and unify data to identify areas with the greatest need for service development. For MCIS and Mobile Response and Stabilization Services (MRSS), OHA is ensuring that all programs have MOUs with their local 988 centers and that 988 staff are trained on when and how to engage mobile crisis teams, particularly for youth under age 21. Crisis Receiving and Stabilization Centers (CSCs), still in early implementation, are being planned for interoperability with 988 and MCIS, which will likely include formal agreements and coordination with local law enforcement to establish clear drop-off procedures.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state:
   i. In the 988 Suicide and Crisis lifeline network **2**
   ii. Not in the suicide lifeline network: **31**
b. Number of Crisis Call Centers with follow up protocols in place:
   i. In the 988 Suicide and Crisis lifeline network **2**
   ii. Not in the suicide lifeline network: **31**
c. Estimated percent of 911 calls that are coded out as BH related:
Unknown. Each of Oregon 43 911 centers uses a different coding structure, and some do not code BH related calls at all (they are coded along with "public disturbance" etc. OHA has recently collaborated with Oregon's Statewide 988 center to establish a fulltime 988-911 Coordinator position. Over the next 2 years this Coordinator will work individually with each of the 43 PSAPs to enhance service interoperability and estimate this number.

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the total number of communities):

a. Independent of public safety-first responder structures (police, paramedic, fire): Click or tap here to enter text. Unknown
b. Integrated with public safety-first responder structures (police, paramedic, fire): Click or tap here to enter text. Unknown
c. Number that utilizes peer recovery services as a core component of the model: Unknown
All 36 Oregon counties offer 24/7 mobile crisis service. However, the response type is in constant flux as counties are working to establish models independent of first responder structures and integrate peers.

Safe place to be:

a. Number of Emergency Departments: **59**
b. Number of Emergency Departments that operate a specialized behavioral health component: **15-20**
c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis: **4**

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response

systems, including any role in mobile crisis response and crisis follow-up. As part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

The planned activities for the 5% set aside go directly to CMHP's (some of which are CCBHCs) for Mobile Crisis Intervention Services.

7. Please indicate areas of technical assistance needs related to this section.

Implementation and change management led by the state but implemented at the local county level.

10 Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, there are 10 identified guiding principles of recovery:

- *Recovery emerges from hope*
- *Recovery is person-driven*
- *Recovery occurs via many pathways*
- *Recovery is holistic*
- *Recovery is supported by peers and allies*
- *Recovery is supported through relationship and social networks*
- *Recovery is culturally-based and influenced*
- *Recovery is supported by addressing trauma*
- *Recovery involves individuals, families, community strengths, and responsibility*
- *Recovery is based on respect*

*Please see **Working Definition of Recovery.***

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the ***Recovery Support Services Table***.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing, and monitoring the state behavioral health treatment system.

Please Respond to the following items:

1. Does the state support recovery through any of the following:
   a. Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care **Yes** ☒ **No** ☐
   b. Required peer accreditation or certification **Yes** ☒ **No** ☐
   c. Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health system **Yes** ☒ **No** ☐
2. Does the state measure the impact of your consumer and recovery community outreach activity? **Yes** ☐ **No** ☒
3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Oregon has some programs with recovery support services for adults with SMI and children with SED including our Intensive In-Home Behavioral Health Treatment, Fidelity Wraparound program, Assertive Community Treatment (ACT) teams, OSH Recovery Planning, Peers working within Aid and Assist (i.e. Community navigator pilot), Aid and Assist Peers within CMHPs and CBOs, EASA programs with Youth Peer Support Specialists. We also fund a variety of Mental Health Peer organizations that offer community support groups, 1:1 Peer support, and other services.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.

Oregon has a varied scope of recovery support services, including low-barrier recovery drop in centers for Peer support and connection to services, other standalone Peer support (not connected to outpatient/inpatient BH services) by Peer Run Organizations, and other clinical organizations and systems partners that provide Peer services. Recovery support services within Department of Corrections. Oregon also has culturally specific and linguistically appropriate recovery support services, but primarily through the I-5 corridor. These services need to be expanded, especially in rural and remote areas of Oregon. Community Counseling Solutions 24/7 peer run warmline (with bilingual Spanish speaking Peer support staff).

5. Does the state have any activities that it would like to highlight?

Peer Run Respite homes, Peer trainings (both MH and SUD) happening in Department of Corrections and Oregon Youth Authority, Office of Recovery and Resilience and work on a Peer Center of Excellence. Culturally grounded innovative BH recovery initiatives—i.e. **The Confess Project – Beyond the Shop Training**, weaves together Substance Use Disorder (SUD) awareness, mental health advocacy, and intentional outreach to marginalized communities. Rooted in the rich cultural tradition of the Black barbershop as a hub for trust, conversation, and community leadership, this movement began in Arkansas and grew into a national force, reaching Atlanta, Georgia, and beyond. Recognized and accredited by Harvard University, the training now thrives in multiple states, community-based organizations, and treatment programs. While originally designed for adults, the program is expanding to meet the needs of youth—ensuring that culturally affirming spaces continue to promote healing, connection, and resilience across generations.

6. Please indicate areas of technical assistance needs related to this section.

-More training for providers and systems partners about the role of peers in care.
-Need for more culturally specific SUD Recovery support services (especially in rural/remote areas of Oregon)
-Need for more Peer run organizations that provide standalone Peer support (especially in rural/remote areas of Oregon).
-Family and Youth Support Specialists: building workforce capacity. Increased trainings, training on legislative literacy.
-Need for more peer support services for youth and families with private insurance (solution would be funding more standalone Peer services).
-Need for TA around career ladders for Peers, ways to increase Peer worker retention if wages are not able to be increased.
-Investment into standalone Peer services for individuals with SMI encountering our court systems (i.e Aid and Assist, PSRB, Civil Commitment).
-Investment into standalone Peer "bridger" services for individuals leaving incarceration or the Oregon State Hospital.
-Investment into the exploration of virtual standalone Peer service programs, that could serve individuals across Oregon for short lengths of time (i.e. when an individual leaves incarceration, leaves the hospital after an overdose—if there are no in-person standalone Peer services in their area, need special support after calling into the CCS warmline, etcetera).
-Peer supports being integrated into primary care/physical health settings (not just into BH).
-Need for Peer supervision certification creation and state-approved trainings.
-Trainings for systems partners on Peer Delivered Services (i.e. trainings for court systems partners on the role of Peers for our Community Navigator program

11 Children and Adolescents M/SUD Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health disorder and one in 10 suffers from a

serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1] Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.[4]

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance use, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult- serving systems becomes even harder. To address the need for additional coordination, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to financing, workforce development, and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the functioning of children, youth and young adults in home, school, and community settings. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult, and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-

based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

1. *Improve emotional and behavioral outcomes for children and youth.*
2. *Enhance family outcomes such as decreased caregiver tasks.*
3. *Decreases suicidal ideation and gestures.*
4. *Expand the availability of effective supports and services; and*
5. *Save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.*

The expectation is that states will build on the well-documented, effective system of care approach. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources.

The array of services and supports in the system of care approach includes:

1. *Nonresidential services (e.g., wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response).*
2. *Supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and*
3. *Residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).*

[1] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[2] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3] Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4] The National Center on Addiction and Substance use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: America's #1 Public Health Problem.

[5] Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from ***https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM***

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
   a. The recovery of children and youth with SED **Yes ☒ No ☐**
   b. The resilience of children and youth with SED **Yes ☒ No ☐**
   c. The recovery of children and youth with SUD **Yes ☒ No ☐**
   d. The resilience of children and youth with SUD **Yes ☒ No ☐**

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
   a. Child welfare **Yes** ☒ **No** ☐
   b. Health Care **Yes** ☐ **No** ☒
   c. Juvenile Justice **Yes** X **No**
   d. Education **Yes** ☒ **No** ☐

3. Does the state monitor its progress and effectiveness, around:
   a. Service utilization **Yes** ☒ **No** ☐
   b. Costs **Yes** ☒ **No** ☐
   c. Outcomes for children and youth services **Yes** ☒ **No** ☐

4. Does the state provide training in evidence-based:
   a. Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families **Yes** **No** x
   b. Mental health treatment and recovery services for children/adolescents and their families **Yes** ☒ **No** ☐

5. Does the state have plans for transitioning children and youth receiving services:
   a. To the adult M/SUD system **Yes** ☐ **No** ☒
   b. For youth in foster care **Yes** ☒ **No** ☐
   c. Is the child serving system connected with the Early Serious Mental Illness (ESMI) services **Yes** ☒ **No** ☐
   d. Is the state providing trauma informed care **Yes** ☒ **No** ☐

6. Describe how the state provides integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.).

Oregon provides integrated services in our system of care primarily through Fidelity Wraparound, where care coordinators facilitate the child and family team and include other services outside of behavioral health that are involved with the child and family and chosen by them to participate on the team. In the case of Juvenile Justice involvement, or child welfare involvement, others may also attend child and family teams to integrate and coordinate care.Getting educational services and SUD services to the table for a child and family team is sometimes more challenging and is an area for further growth.

7. Does the state have any activities related to this section that you would like to highlight?

The state has a fully developed system of care governance structure both within Fidelity Wraparound, which is administered through the Coordinated Care Organizations, and within OHA and across other child serving systems. There is a governance structure that requires a Review Committee for entry into Wraparound, a Practice Level workgroup may be available to identify system issues locally, an Advisory/Executive council to provide barrier busting locally and if this progression does not address a system problem. Barriers can be taken to the State Agency Standing Committee which is a cross-system group. Oregon also has a legislatively created System of Care Advisory Council incorporating families and youth and system partners, to address statewide systemic barriers for youth and families.

8. Please indicate areas of technical assistance needs related to this section.
   Oregon would like to request technical assistance related to alternative funding models to be able to offer Wraparound services/supports to more youth regardless of where they've entered the system, and to capture younger children and their families' needs, and reduce barriers related to offering Wraparound to populations outside of Medicaid funding.

12 Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan since the FY2024-2025 Plan was submitted? **Yes ☒ No ☐**

2. Describe activities intended to reduce incidents of suicide in your state.

Youth Suicide Intervention and Prevention plan annual report for 2024:
https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le8874a_24.pdf
Our state plan includes activities related to coalition building, coordination between key partners, populations and sectors of focus (determined by disparate rates of suicide), training and education, workforce development and wellness, safe storage, and postvention response.

Adult Suicide Intervention Prevention Plan (ASIPP) Progress Report:
https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le-130274_24.pdf
OHA built ASIPP 2023–2027 based on strategic goals, strategic pillars, centering lens (equity, trauma informed, collaboration) and foundation (policy, funding, data, evaluation). These are the starting point for all suicide prevention work in Oregon. These terms are referenced in ASIPP 2023–2027 and are defined in its appendix.

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? **Yes ☒ No ☐**

4. Do you have any initiatives focused on improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments? **Yes ☒ No ☐**

If yes, please describe how barriers are eliminated.
Oregon has legislation requiring follow up communications for patients being discharged in both inpatient and ED settings. Our state plan includes the following strategy: 3.1.1.1 Policies

and legislation about care transitions and coordination will be monitored and assessed.

5. Have you begun any prioritized or statewide initiatives since the FY2024-2025 plan was submitted? **Yes ☒ No ☐**

If yes, please describe the population focus.
Our youth state plan focuses on youth ages 5-24 and our adult plan focuses on 18+. We focus on school suicide prevention (including postsecondary), veterans and other service members, older adults, and other populations with disparate rates of suicide.

6. Please indicate areas of technical assistance needs related to this section.
None at this time.

13 Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) - Required for MHBG

14 State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG
Advisory Council Members
Advisory Council Composition by Member Type

15 Public Comment on the State Plan

16 Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of