Unmet service needs and profile of underserved communities.

Preventing substance misuse and improving access to high quality, affordable, and culturally and linguistically appropriate substance use disorder (SUD) services remains a stubborn and persistent challenge in Oregon. Oregon's SUD rate (19.4% in 2021) is significantly higher than the U.S. rate (16.5%), with about one in ten Oregonians having a drug use disorder (9.8%) (2021 NSDUH). Polysubstance use, involving more than one drug and/or alcohol, accounted for more than half (54.6%) of overdose deaths in 2021 (Oregon Death Certificate Data).

Communities experiencing the deepest health inequities 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
- Communities with high rates of poverty and economic disinvestment, including persons 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 (2.7 vs. 2.4 gallons of ethanol) (2020 NIAAA). Alcohol use is a risk factor in nearly 1 in 5 (18.9%) unintentional/undetermined drug overdose deaths (2022 SUDORS). While binge drinking among Oregon 8th and 11th graders has decreased, it has increased among Oregon adults from 15% in 2001 to 18% (2021 BRFSS), with binge drinking among young adults (ages 18-34) at 26%. One in five (20%) adults report binge or heavy drinking in the past month (2021), with more men (22%) than women (14%) binge drinking.

Equity Impacts (Alcohol) Non-Hispanic Blacks in Oregon have an alcohol-related death rate of 53.5 per 100,000, which is higher than non-Hispanic whites (47.8 per 100,000). Oregon Vital Records). The rate of alcohol-related deaths among AI/AN groups (99.8 per 100,000) is also higher than whites. These groups are disproportionately impacted by negative harms from excessive alcohol, despite consumption rates that are lower than whites. Alcohol is disproportionately available for sale in lower-income neighborhoods and systemic racism, discrimination, oppression, toxic stress, and trauma continue to perpetuate health inequities.

Opioids and other Drugs. Despite progress in reducing prescription opioid overdose, Oregon is seeing significant increases in overdoses from illicitly manufactured fentanyl (IMF) and non-opioid drugs such as methamphetamine. Unintentional and undetermined overdose deaths in Oregon increased from 701 in 2020 to 1,079 in 2021. Fentanyl overdose deaths more than doubled in this time, largely attributable to an increase in fentanyl in the illicit drug market. Preliminary 2022 data show this upward trend continuing, with fentanyl becoming the leading contributor for unintentional drug overdose deaths in Oregon. Amphetamine and fentanyl or fentanyl analogs, used alone or in combination with other drugs, accounted for 84% of all unintentional/undetermined overdose deaths in 2021 (SUDORS). Of all polysubstance deaths in 2021, 89% involved an opioid, 61% involved fentanyl, 62% involved an amphetamine, and 20% involved alcohol. The majority (89%) of overdose events in Oregon occur in urban counties, although rural and frontier counties are also affected by the crisis.

Equity Impacts (Overdose). In 2021, inequities in overdose death widened for Non-Hispanic-Black and AI/AN communities, which experienced overdoses at nearly double the rate of Whites (1.94 and 1.87 times higher, respectively). Black populations had the highest overdose death rate in Oregon (56.3 deaths per 100,000 people) with 90% occurring among persons 18 to 64 years old. Nearly 16% were reported as having an alcohol use problem, and one-third used alcohol when or prior to taking a drug. Alcohol contributed to nearly 15% of overdose deaths, and 17% had a blood alcohol level >= 0.08% on postmortem toxicology (July 2020-June 2022 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.

Over the last two years, the Oregon Legislature has invested over $1 billion into 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), making Oregon the first state in the U.S. to decriminalize personal possession of illegal drugs. Anticipated cost savings combined with marijuana sales fund 53 new Behavioral Health Resource Networks (BHRNs) covering all Oregon counties and 11 Tribes and tribal health organizations to provide outreach, referral, harm reduction, outpatient, and residential treatment services, but with no designated funding for prevention.

In 2022, the ADPC funded Oregon Health & Science University (OHSU) to conduct a SUD Inventory & Gaps Analysis which documented that Oregon's prevention, treatment, and recovery systems lack capacity to meet 50% of current demand, with the fewest resources dedicated to prevention. Subsequently, HB 5006 directs OHA to conduct a program and fiscal analysis of behavioral health services with recommendations for addressing funding, program, and infrastructure gaps across the SUD continuum, with a final report due back to the Oregon Legislature in March 2024.

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. Likewise, Oregon's Opioid Settlement Prevention, Treatment and Recovery (OSPTR) Advisory Board is overseeing distribution of an initial $146 million in new opioid settlement funds over the next 18 years, with additional funds expected pending future settlements.

TRIBAL PREVENTION NEEDS AND GAPS
Oregon Health & Sciences University's 2022 Oregon Substance Use Disorder Services Inventory and Gap Analysis highlighted the need for more Certified Prevention Specialists (CPS) working in the Substance Use Disorder Prevention field. The nine federally recognized Tribes of Oregon and the Native American Rehabilitation Association (NARA) of the Northwest prevention programs operate under Oregon Administrative Rules (OARs) 415-056-0045 which require those working in SUD prevention to become certified as CPS's within two years of being hired and working within the field.
The nine Tribes and NARA-NW, along with OHA staff, are working with the Mental Health & Addictions Certification Board of Oregon (MHACBO) to organize their Continuing Education Units (CEUs) to meet these requirements. OHA is developing infrastructure to help tribal programs meet certification requirements (e.g. providing CEU opportunities at quarterly meetings, setting up cohort style learning sessions, utilizing online resources provided by MHACBO, and partnering with community partners working in SUD prevention in Oregon Counties).
Tribal programs have also met with OHA staff to direct attention to a couple of needs pertaining to the Tribal Based Practices of Oregon, including: 1) Reviewing and approving all current tribal based

practices through review committee to ensure the current Tribal Based Practices list in Oregon is up-to-date and approved as written and, 2) Reviewing and approving any new interventions, through committee, for potential approval and inclusion of the Oregon Tribal Based Practices list (of which there are currently 21). The group responsible for maintaining this list has not met during the pandemic and is now reconvening; and OHA staff have been invited, by the tribal programs, to participate in this process.

PUBLIC HEALTH PREVENTION NEEDS AND GAPS

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

Excessive Alcohol Use Prevention:

- Policy strategies that 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 and retail environments and limiting exposure to and access to alcohol.
- Increasing funding for current ADPEP grantees through existing and new funding streams.
- Identifying new funding sources to fund CBOs serving communities disproportionately impacted by SUD.
- Expanding state infrastructure for data and surveillance, evaluation and 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, and Healthier Together Oregon.
- Integrated harm reduction approaches across the SUD continuum of care and increased culturally specific 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 state-wide coverage of overdose prevention coordinators (currently fund only 11 LPHAs covering 23 counties).
- Community-level prevention and harm reduction 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, including racism, stigma, and the many forms of trauma

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 a census-based survey of Oregon 6th, 8th and 11th-graders. 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 health, 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. Finally, OHA-PHD is aligning all data and evaluation activities with broader data sovereignty and equity initiatives underway at OHA, including Public Health and Behavioral Health Data modernization and new infrastructure for implementation of REALD and SOGI systems.

Veteran & Military Specific Unmet Needs & Gaps

While understanding the behavioral health needs of Service Members, Veterans, and their Families (SMVF) in Oregon has increased, workforce shortages, lack of military cultural awareness, and program eligibility requirements continue to create silos in the delivery of behavioral health services to the veteran and military population in Oregon.

Workforce shortages, especially in areas designated as Frontier or Rural, continue to limit service delivery. Information shared by contractors funded through OHA's Veteran Behavioral Health Peer Support Specialist (VBHPSS) program emphasize the importance of repeated outreach and engagement, particularly to those reluctant to come into a clinical setting. Billing, payment, system and referral coordination between the Veterans Health Administration, Department of Defense, and community health programs for Service Members, Veterans, and their Families (SMVF) may be individualized and time consuming for providers to understand. Not all healthcare providers have the means to allocate staff time and resources to navigating these complex systems. Additional burdens with reimbursement times and eligibility/coverage requirements have led to some providers closing their doors or limiting services otherwise available to SMVF. Traditional Health Workers (THWs) and continued workforce supports are essential in ensuring appropriate care is available to SMVF. Continued development of the Veteran Peer workforce, including training opportunities, as well as continued focus on increasing military culture awareness among service providers will remain an area of focus moving forward.

Many people who served in the military face additional requirements, including review of military discharge paperwork, when trying to access behavioral health services. Differences in language defining "veteran" exist at the federal, state, and local levels. These definitions and program eligibility requirements may exclude or dissuade some military veterans from accessing behavioral health services. This is particularly true for LGBTQ+ veterans, members of the National Guard who have not met active-duty service requirements, survivors of Military Sexual Trauma (MST), and others who have experienced trauma or received a military discharge status other than general or honorable. These requirements mean extra care and attention should be paid when engaging with community partners and in the development of new programming to ensure a treatment first approach is applied. A treatment first approach reduces delays in connecting SMVF in need with appropriate services. This is critically important in Oregon, where the state ranks one of the highest in the Veterans Administration's Western Region for rates of veteran suicide. Increased awareness of barriers to accessing and engaging in services has factored heavily into VBH programming. Areas not previously highlighted (e.g., social determinants of health, insurance gaps, challenges with the referral process, accessing care in the community, limited services for children, caregivers, or families, services to address culturally specific needs such as Traumatic Brain Injury) are now coming to the forefront of conversations within Oregon's SMVF community.

Lack of military cultural awareness often exacerbates challenges in destigmatizing behavioral health treatment, including substance use treatment, and communication around suicide. The common belief that someone who served in the military (including National Guard) has access to programs through the Veterans Health Administration (VHA) is incorrect and pervasive. This is particularly concerning given Oregon's high number of international and domestic National Guard deployments coupled with the existing veteran suicide rates. The need for providers and health systems to emphasize training in military culture was clearly communicated in the 2019 Oregon Veterans Behavioral Health Services Improvement Study and will remain an ongoing focus of the VBH program. Existing efforts are already producing a documented increase in community awareness and interest in continued learning.

Older Adults
Need for additional mental health and SUD services. Working to develop an OPAL-G (Options to Address Alternatives to Loneliness- Geriatric Program) to building this program.

State Opioid Response (SOR 3) Needs Assessment
The Recent Scope of OUD, SUD, and Overdose in Oregon

The 2020 NSDUH identifies Oregon as having the highest prevalence of methamphetamine and prescription opioid misuse in the United States.[1] Fentanyl in counterfeit pills and other drugs promotes continued increases in overdose rates. Oregon experienced a massive **40.7% increase in provisional overdose deaths in the 12 months ending September 2021**—the third greatest increase in the United States (compared to a 15.9% increase, nationally).[2] Most of the rise in overdose deaths can be attributed to increases in synthetic opioid and psychostimulant-involved deaths during the pandemic. Between March 2020 and September 2021, the 12-month-ending provisional number of overdose deaths involving synthetic opioids increased 358% (from 98 to 449), and those involving psychostimulants rose 90% (from 290 to 550)[3]. According to 2020 OHA SUDORS data, about half of overdose deaths involved more than one drug and 84.1% involved methamphetamine, heroin, or fentanyl used alone or in combination with other drugs. ***Only 2.7% of individuals who died of a drug overdose were being treated for a SUD at the time of death, and naloxone was only administered in 11.5% of opioid-involved deaths.***[4] Oregon also ranks second in the percentage of the population (12 and older) with past year IDUD (9.0%) and third in the prevalence of SUD (18.2%).[1] Among Oregonians continuously enrolled in Medicaid for at least nine months between October 1, 2020, and September 3, 2021, about 7% of individuals had an IDUD diagnosis, 2.6% had an OUD diagnosis, and 2.6% had a StimUD diagnosis.

Areas of Greatest Need

Examining 2021 OHA SUDORS data across eight geographic regions, drug overdose death rates were highest in the Southwest-Coast, Northwest Rural, and Portland Tri-County regions (Table 3). The highest rates of drug overdose death occurred among middle-aged people (aged 35-44 or 45-54), males, Black individuals, and people experiencing homelessness (13% of people who die of overdose in OR are homeless).[4]

Rates of non-fatal overdose ED visits show similar trends, except women have higher rates than men and rates are higher among young adults aged 18-24 or 25-34 and youth under age 18 (Table 3). In early 2022, suspected non-fatal overdoses reported by EDs rose 15% in Oregon with rates of suspected all-drug overdose among people ages 0-14 and 15-24 rising 20% and 24% respectively.[2] ED visits for drug overdose are highest in the Southwest, Mid-Valley,

and Eastern regions. Rates of stimulant overdose ED visits are highest among young adults (18-24), Black individuals, and in the Central and Eastern regions. Rates of opioid overdose ED visits are highest among those aged 25-34, ***AIAN,*** and Black individuals, and in the Southwest and Southwest-Coast regions. Data for opioid overdose-related EMS calls show an overall increase of 17% from 2020 to 2021. Increases in opioid overdose-related EMS calls were highest in the Northwest Rural (38%), Mid-Valley (38%), and Eastern (28%) regions.

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 45-54 (33.6), Age 35-44 (30.6), Age 55-64 (28.7), Male (26.9), Age 25-34 (25.8), Black (20.6)***	Southwest Coast (20.1), Northwest Rural (19.9), Portland Tri-County (19.2), *Central Gorge (24.3)*†	***Age 18-24 (436.2), Age 25-34 (327.0), Black (309.5), Age Under 18 (264.2), Rural (264.3), Female (249.6)***	Southwest (270.1) Mid-Valley (257.8), Eastern (254)
Opioids	***Age 35-44 (21.8), Age 25-34 (21.0), Age 45-54 (18.2), Male (18.1)***	***Southwest (13.6), Central Gorge (16.8)†, Northwest Rural (14.1)***†	***Age 25-34 (145.5), Age 35-44 (101.1), Age 18 – 24 (97.4), AIAN (83.9), Male (80.0)***	Southwest (108.1), Southwest-Coast (68.7)
Stimulants	***Age 45-54 (23.2), Age 55-64 (20.9), Age 35-44 (19.0), Male (16.9), Black (15.9)***	***Portland Tri-County (12.2), Southwest-Coast (12.2), Northwest Rural (14.1)***†	***Age 18-24 (21.9), Black (20.6), Age 25-34 (19.6), Male (12.7), Rural (12.6)***	Central (15.1), Eastern (14.1)

. Source: SUDORS, ED discharge data. AIAN=American Indian/Alaskan Native. †Rate is unstable due to counts less than 20.

Table 4 shows the prevalence of use disorders among Oregon Medicaid enrollees. The Northwest Rural, Southwest, and Southwest Coast regions have the highest prevalence of IDUD. OUD prevalence tends to be higher in urban areas such as the Portland Tri-County and Southwest (Medford) areas, whereas StimUD is higher in rural areas, such as Southwest-Coast, Northwest Rural, Eastern, and Central. The prevalence of use disorders is higher than the state average for all age groups between 25 and 65, with the highest rates among the 35-44 age group. ***The prevalence is exceptionally high among AIAN and White populations. Blacks have higher than state average prevalence of StimUD and IDUD, but not OUD. Hispanics tend to have low rates of diagnosed SUDs compared to non-Hispanics, and lower rates of treatment receipt.*** Males are more likely to have a use disorder.

Table 4. Populations with Highest Prevalence of Use Disorder among Medicaid Enrollees

	Demographics	***Regions***
Illicit Drug Use Disorder (State Avg 7.0%)	***Age 35-44 (12.2%), Age 45-54 (11.7%), AIAN (11.5%), Age 25-34 (11.4%), Age 55-64 (10.9%), Black (8.5%), White (8.8%), Male (7.6%), Rural (7.1%)***	***Southwest (8.2%), Southwest-Coast (8.1%), Northwest Rural (8.1%)***

Opioid Use Disorder (State Avg 2.6%)	***Age 35-44 (5.4%), Age 25-34 (5.1%), Age 45-54 (4.1%), AIAN (4.1%), Age 55–64 (3.8%), White (3.5%), Race Two or More (2.8%), Urban (2.8%), Male (2.7%)***	***Northwest Rural (3.4%), Southwest (3.2%), Portland Tri-County (2.9%)***
Stimulant Use Disorder (State Avg 2.6%)	***Age 35-44 (5.4%), AIAN (5.3%), Age 45-54 (5.1%), Age 25-34 (4.8%), Black (3.3%), White (3.3%), Male (3.0%), Rural (2.6%)***	***Southwest-Coast (3.2%), Northwest Rural (3.1%), Eastern (2.8%), Central (2.8%)***

Note: NHPI=Native Hawaiian/Pacific Islander, AIAN=American Indian/Alaskan Native.

[1] Substance Abuse and Mental Health Services Administration. 2019-2020 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia). https://www.samhsa.gov/data/report/2019-2020-nsduh-state-prevalence-estimates

[2] DOSE dashboard: Nonfatal Overdose Data. https://www.cdc.gov/drugoverdose/nonfatal/dashboard/index.html

[3] Ahmad FB, Rossen LM, Sutton P. Provisional drug overdose death counts, for 12 months ending September 2021, Updated February 6, 2022. Vital Statistics Rapid Release, National Center for Health Statistics. https://wwwcdcgov/nchs/nvss/vsrr/drug-overdose-datahtm#dashboard

[4] Shen, X. Characteristics of Unintentional Drug Overdose Deaths in Oregon, 2020. Oregon Health Authority. https://www.oregonpublichealth.org/assets/OPHA%20conference%20in%202021_XShen.pdf

Intensive Services for Adults

- housing
- residential treatment
- building out the continuum of care from inpatient, to php, to iop, to icm, to act, icc, outpatient, outreach
- Culturally appropriate care, ensuring that folks have access to treatment and care providers who speak the same language as they do and who understand unique cultural needs is critical
- Increased IOP programs could be useful, particularly if there was some sort of incentive tied to them to keep folks coming back, such as if you enroll in this IOP and attend x percentage of the treatment, you get a bus pass for the month or some kind of gift card. IOPs are so demanding but helping folks learn to build that kind of structure into their days can be helpful for the right people, especially if the IOP included groups and therapeutic activities that were tailored to a variety of levels of functioning
- Increased mental health peer services

988 & Crisis Services

Unmet needs for 988 & crisis services include:

- Lack of funding for construction of crisis receiving & stabilization centers
- Lack of funding for ongoing operation of crisis receiving & stabilization centers
- Insufficient workforce capacity to fully and appropriately staff the continuum of crisis services statewide
- Lack of funding for transportation vouchers / service to help people reach community resources - like medical care, food, family -- that could help them during times of crisis
- Lack of funding to support language access -- in-person interpreter services / interpreter-on-a-stick (teleinterpreters) for mobile crisis and crisis stabilization
- funding to further support Oregon's Nine Federally Recognized Tribes in any crisis system related services.

Gaps in Children/Family system

All of the service and support array is being impacted by the workforce shortage. This is leading to bottlenecks and slower access to many services. This can be especially true for rural and frontier communities. OHA is working to address this issue.
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
Children's System Advisory Council – Family Recommendations 2022 https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/Work-Plan-Recommendations-2022.pdf
System of Care Plan 2022 – 23, family and youth recommendations appendix - https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/SOC-Plan-2022-23.pdf

2022 Mental Health Statistics Improvement Program Surveyhttps://www.oregon.gov/oha/hpa/analytics/pages/mental-health-statistics-improvement-program-survey.aspx

2022 Intensive In-Home Behavioral Health Treatment services - https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/IIBHT-Annual-Report-2022.pdf

Youth Suicide Intervention Plan https://apps.state.or.us/Forms/Served/le8875.pdf

System gaps:

Promotion, prevention and early intervention
Mental health promotion activities – Oregon has limited investments in this area. This will probably be a legislative concept for the 2025 Oregon session.

Early intervention

- General – Needs further development
- Early childhood

School-based promotion, prevention, and early intervention – Oregon has made investments in this area. Expansion of this will probably be a legislative concept for the 2025 Oregon session.

Community
Screening: Early and Periodic Screening, Diagnostic and Treatment – This is in the implementation phase and will be tracked closely. It has previously been a gap in the State Plan
Parent/caregiver and youth peer support – Workforce shortages are impacting this development.

Outpatient
Access to assessment services has been limited. Oregon is working to implement interdisciplinary assessment teams to address the need for rapid assessment to inform interventions.
School-based mental health services - Oregon has made investments in this area. Expansion of this will probably be a legislative concept for the 2025 Oregon session.

Outpatient therapy - Individual, family, and group
Integrated mental health and substance use treatment – This continues to require intentional workforce development in order to meet the need for services

Trauma-specific treatments - Oregon has made investments in this area and further workforce development is needed.
Respite services, including crisis respite are requested by both youth and families. This is a system gap.

Therapeutic interventions
Therapeutic behavioral aide services – this is currently not available in Oregon
Behavior management skills training – the specific need around trainings for handing aggressive behaviors is a gap, especially for those outside in-patient settings
Therapeutic mentoring– this is currently not available in Oregon

Crisis Services
Mobile Response and Stabilization Services– this has been developed by OHA and is slowly being implemented by Oregon counties. It is a current implementation gap.

Intensive services
Intensive In-Home Behavioral Health Treatment– this has been developed by OHA and is slowly being implemented. It is a current implementation gap.

Multilevel care management
No gaps identified

Non-traditional / non-clinical
Social and recreational services, including after school programs, drop-in centers – Oregon has made investments in youth drop-in center pilot sites. Statewide this is a gap in the behavioral health continuum that is frequently filled with local services.

Hospital
No gaps identified

Residential
Capacity remains the largest gap in the mental health and substance use treatment array

Youth and young adults in transition
Supported housing – Specific development of housing options is a gap

Specialized care coordination, including focus on life and self-determination skills need development

Young Adult Residential Treatment Homes – Further capacity is needed to meet this need.

Non-traditional / non-clinical

Early childhood screening, assessment, and diagnosis – Further capacity is needed to meet this need.

Family navigation – Further capacity is needed to meet this need.

Parent-child therapies – Further capacity is needed to meet this need.

Parenting groups– Further capacity is needed to meet this need.