Child and Family Behavioral Health Performance Indicators

HEALTH SYSTEMS DIVISION
Child and Family Behavioral Health

April 2023

Table of contents

Executive summary

The Child and Family Behavioral Health unit (CFBH), within the Oregon Health Authority (OHA) Health Systems Division (HSD), developed this data report to create a useful data set to guide the work of the unit and report outcomes to youth, families, and children's behavioral health partners. The Child and Family Behavioral Health unit provides policy direction and service coordination for a range of programs serving young people ages 0-25 in Oregon through publicly funded programs

This report presents indicators for monitoring and evaluating the performance of Oregon's system of care for children and adolescents with mental health and/or alcohol or drug treatment need. Key performance indicators are presented from national reporting surveys as well as Oregon specific child and family behavioral health programs. National reporting includes:

- Mental Health National Outcome Measures (NOMS)
- Mental Health Statistics Improvement Program (MHSIP)
    - Youth Services Survey for Families (YSS-F)
    - Youth Services Survey
- National Survey on Drug Use and Health (NSDUH)
- Oregon Student Health Survey (SHS)

Oregon key performance indicators include our full continuum of care:

- Promotion and Prevention
- Community Based Treatment
- Crisis and Stabilization
- Facility Based Treatment
- Recovery and Stabilization

Background

The Child and Family Behavioral Health unit (CFBH), within the Oregon Health Authority (OHA) Health Systems Division (HSD), implements and manages Medicaid-funded and other publicly funded mental health, suicide prevention, and substance use disorder services and supports for children, youth, young adults, and their families. The children's behavioral health system in Oregon needs a full spectrum of effective supports from prevention to intensive acute care to be meaningfully responsive to the unique needs of each young person and their family. These services and supports are designed to address the needs of Oregonians from infancy through 25 years of age.

Based on discussions with youth and family with lived experience and the community, we have identified three fundamental philosophical pillars for our work: Health Equity, Youth and Family Voice, and Trauma-informed Principles. These are the foundation for everything within the four Strategic Pathways in our Roadmap:

1. Continuum of Care
   OHA's CFBH work addresses gaps and quality in the children's behavioral health continuum of care centering communities that have been disproportionally impacted by health inequity and systemic racism.
2. Youth and Family
   CFBH work continues to incorporate meaningful youth and family participation, with specific focus on centering communities of color, indigenous and Tribal communities, LGBTQIA2S+, and other historically marginalized populations.
3. Data
   CFBH work centers health equity by making policy and program decisions based on accurate and timely data and in seeking data that assists in understanding health inequities.
4. Cross System
   CFBH work supports and prioritizes cross system collaboration to improve the behavioral health continuum of care for youth and families.

The CFBH unit has worked to create a clearer and more useful data set to guide the direction and emphasis applied to the system. Work is managed through contracts with youth- and family-serving organizations, counties and private and public entities, non-profit providers, and other community groups within Oregon. Without accurate information about the services provided, it is functionally impossible to improve the direction of funds and treatment to areas with current health disparities.

This report serves to increase outward facing communication on children's behavioral health, including metrics, to youth and families and children's behavioral health partners. It gives an overview of key performance indicators for Oregon compared to national data, as well as Oregon specific programs, ranging from mental health promotion and prevention to intensive services. The strategies for implementing our data work are:

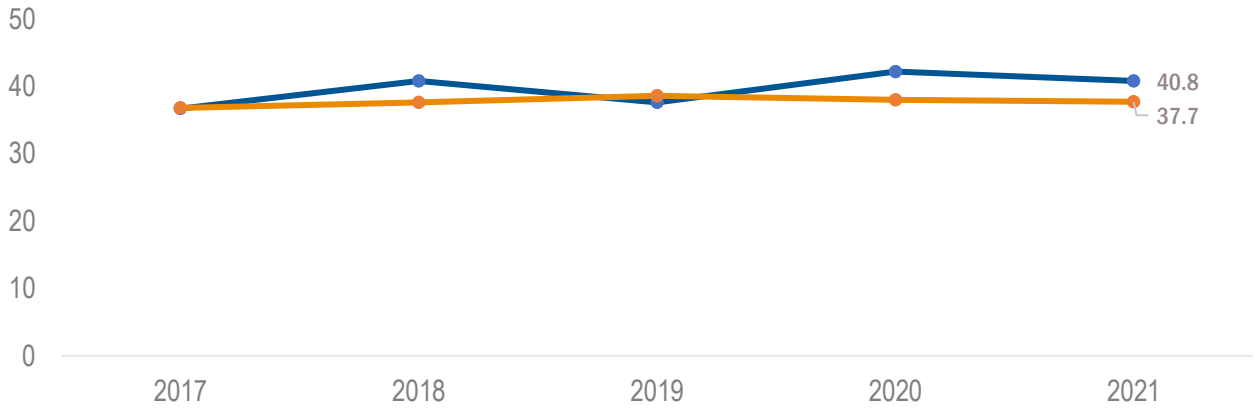
3.1 Structure data collection, evaluation and analysis.
3.2 Establish strategies and processes to address data gaps.
3.3 Develop and implement a CFBH system overview of data.
3.4 Develop and implement a communications strategy for CFBH data.
3.5 Address specific system issues and project needs via research and internal data

National Key Performance Indicators

Mental Health National Outcome Measures (NOMS)

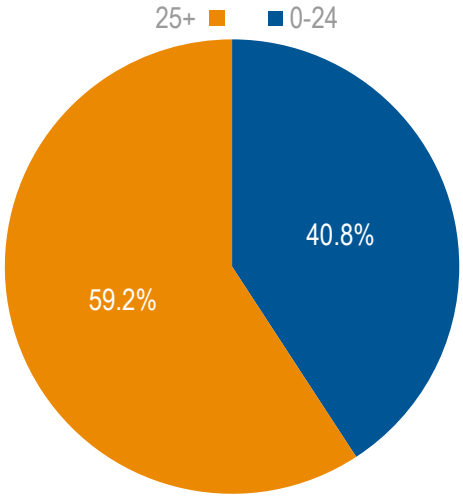
The Substance Abuse and Mental Health Services Administration (SAMHSA) has identified 10 domains for National Outcome Measures (NOMS). The domains represent meaningful, real-life outcomes for people who are working to achieve and sustain recovery, build resilience, and work, learn, live, and play a part in their communities. The annual Uniform Reporting System (URS), state and national reports collect data on evidence-based practices, and utilization measures, providing an overview of state mental health delivery systems.

Figure 1. Percentage of individuals (ages 0-24) served within the state mental health agency, Oregon and national



Source: 2021 Uniform Reporting Summary Output Tables

Figure 2. About 41 percent of individuals served by the state mental health agency in Oregon are youth (ages 0-24)



Source: 2021 Uniform Reporting Summary Output Tables

The percentage of individuals served by the state mental health agency (ages 0-24) in 2021 in Oregon was 40.8 percent, higher than the national percentage, 37.7.

Mental Health Statistics Improvement Program (MHSIP)

The MHSIP survey is a nationally used survey and measures concerns that are important to consumers of publicly funded mental health services. This survey is distributed annually in the spring. This is a voluntary survey which is collected by the Substance Abuse and Mental Health Services Administration (SAMHSA) and state departments monitoring mental health and substance use. The survey records data on consumers' perceptions of the mental health care they received from the community mental health system, and the results from this survey are reported annually to the Center for Mental Health Services (CMHS) as part of the requirements for the Mental Health Block Grant.

The outcomes of the MHSIP and Youth Services Survey for Families (YSS-F) function as a "report card" on how satisfied consumers are with community mental health services and provide insight for what is needed to enhance quality and continuity of care.

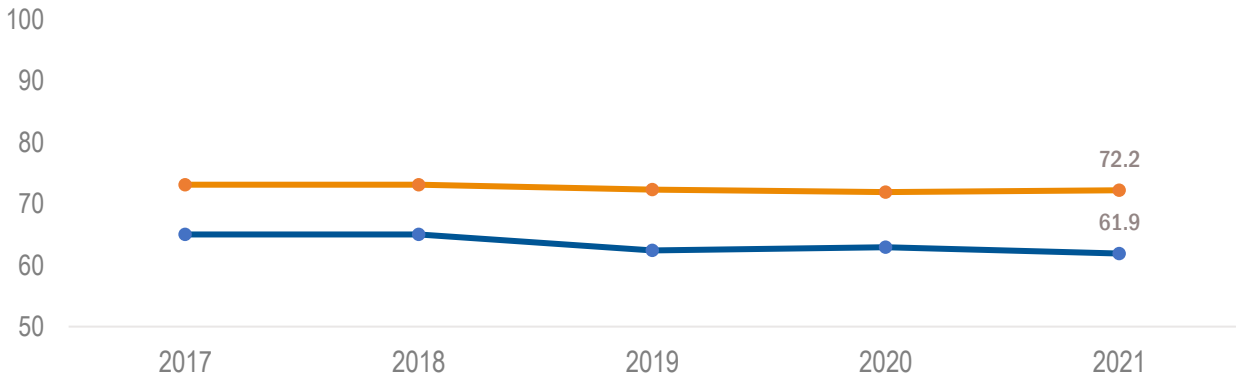
Youth Services Survey for Families

The Youth Services Survey for Families (YSS-F) is a part of the MHSIP and has been validated for caregivers of youth ages 0 to 17 who are receiving mental health services. The YSS-F survey asks parents or caregivers to report to what degree they agree or disagree on a set of seven domains: access, participation in treatment planning, cultural sensitivity, social connectedness, functioning, outcomes, and general satisfaction.

Survey Sample: Caregivers with youth under the age of 18 who have received Medicaid-funded mental health services in outpatient, psychiatric residential or psychiatric day treatment settings.

> *Slight sampling time frame differences between national and state reporting limits comparability of Oregon and national results.

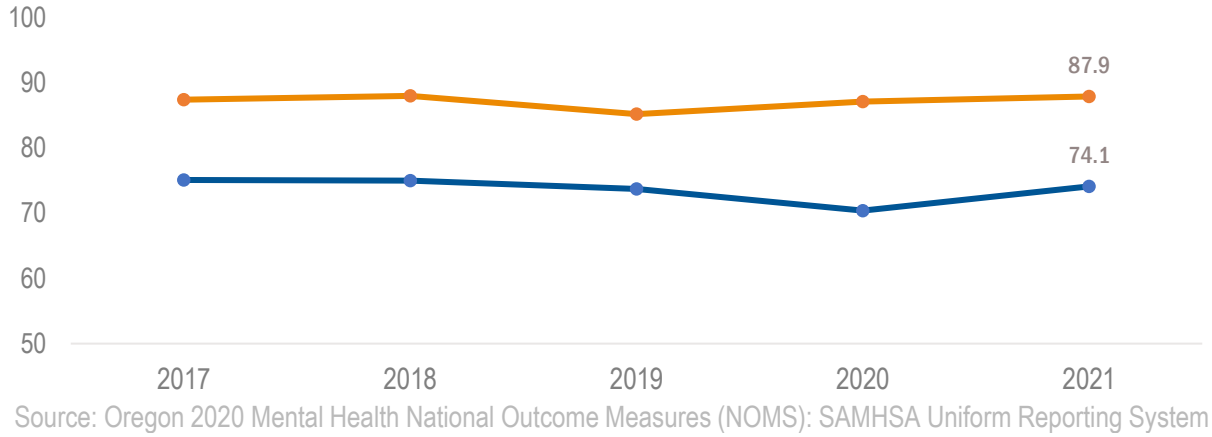
Figure 3. Percentage of caregivers with youth under age 18 who were satisfied with treatment outcomes, Oregon and national



Source: Oregon 2020 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System

Of sampled caregivers, 61.9 percent report satisfaction with treatment outcomes in 2021. Oregon is approximately 10 points below national satisfaction rates, with a downward trend over the past five years*.

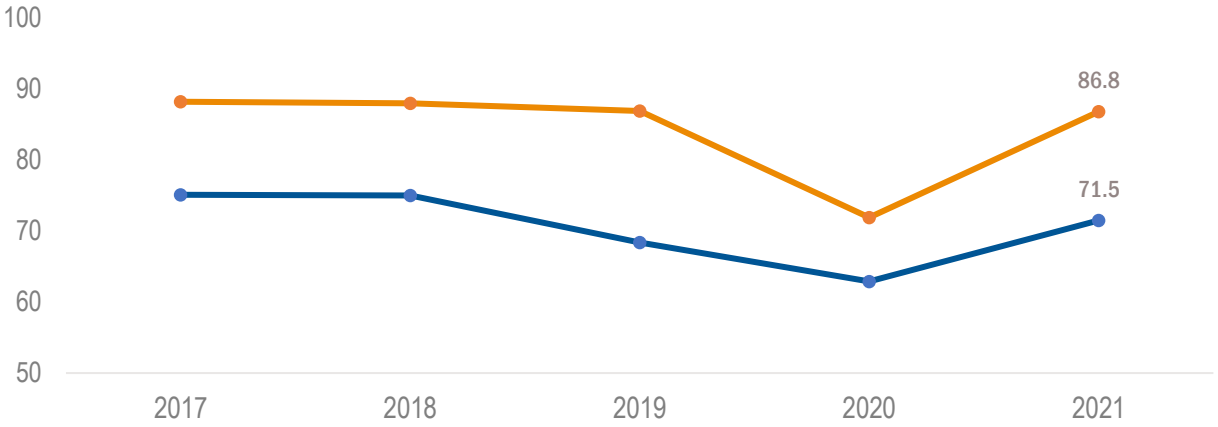
Figure 4. Percentage of caregivers reporting satisfaction with access to service, Oregon and national



Source: Oregon 2020 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System

In 2021 74.1 percent of sampled Oregon caregivers reported satisfaction with access to service, compared to 87.9 percent nationally*.

Figure 5. Percentage of caregivers reporting general satisfaction with services, Oregon and national

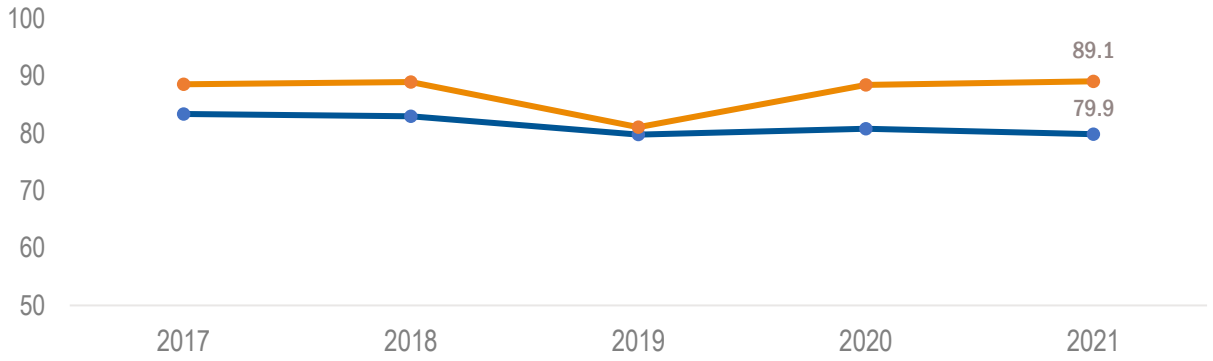


Source: Oregon 2020 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System

General satisfaction with services was reported by 71.5 percent of sampled Oregon caregivers in 2021, an 8.6 percent improvement from 2020*.

*Slight sampling time frame differences between national and state reporting limits comparability of OR and national results.

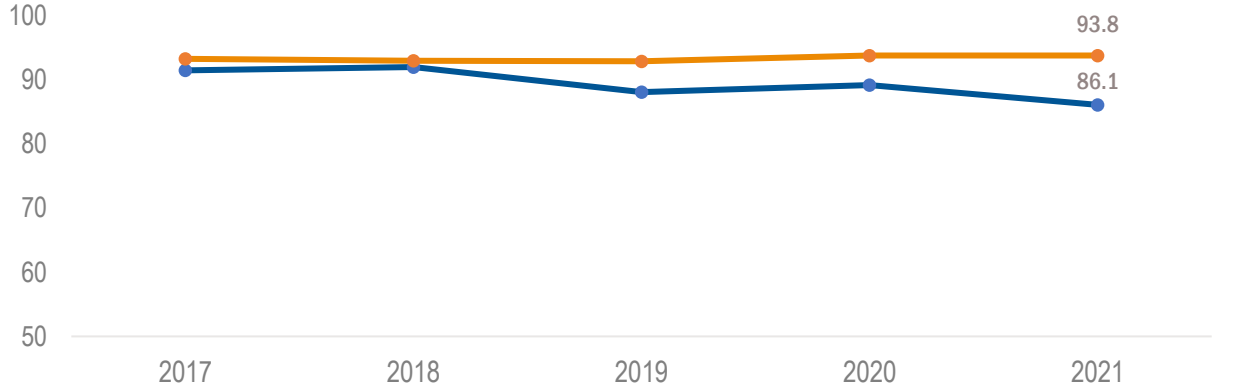
Figure 6. Percentage of caregivers reporting satisfaction in treatment planning, Oregon and national



Source: Oregon 2020 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System

Positive reporting of satisfaction with treatment planning has trended downward the past 5 years, Oregon is 9.2 percent below nationally reported percentages*.

Figure 7. Percentage of caregivers reporting high cultural sensitivity of staff, Oregon and national

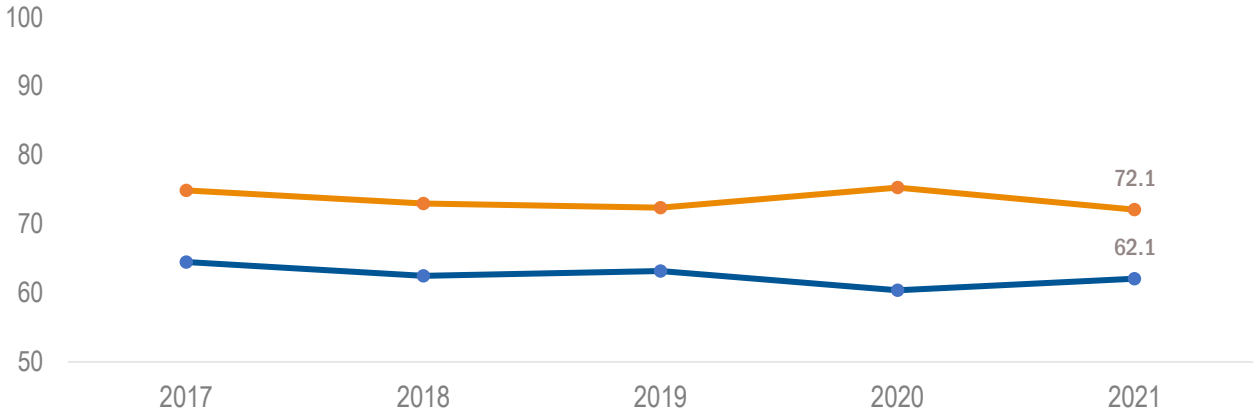


Source: Oregon 2020 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System

In 2021, sampled Oregon caregivers reported high cultural sensitivity of staff 86.1 percent of the time, compared to 93.8 percent nationally*.

*Slight sampling time frame differences between national and state reporting limits comparability of OR and national results.

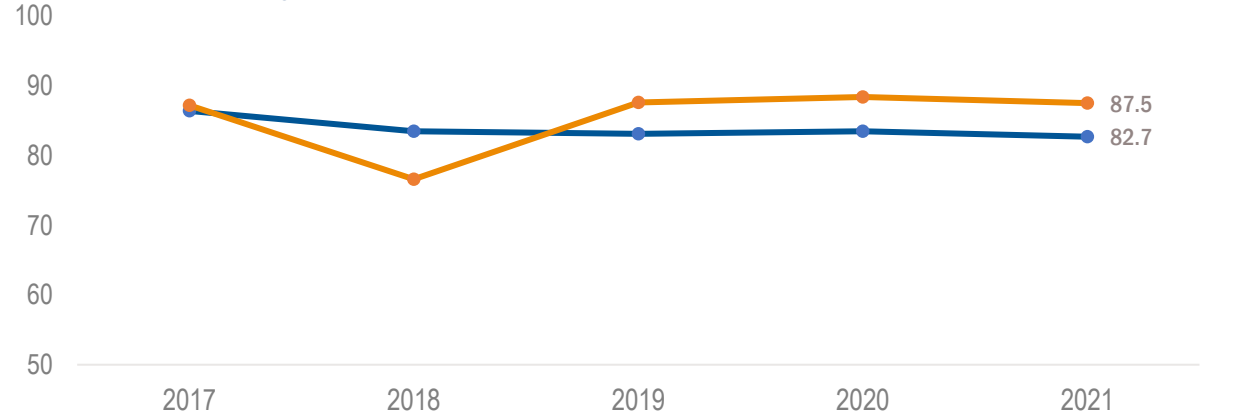
Figure 8. Percentage of caregivers with youth under 18 reporting improved functioning from services, Oregon and national



Source: Oregon 2020 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System

Improved functioning from services was reported by 62.1 percent of sampled caregivers in Oregon in 2021. Nationally 72.1 percent reported improved functioning*.

Figure 9. Percentage of caregivers reporting changes in social connectedness, Oregon and national

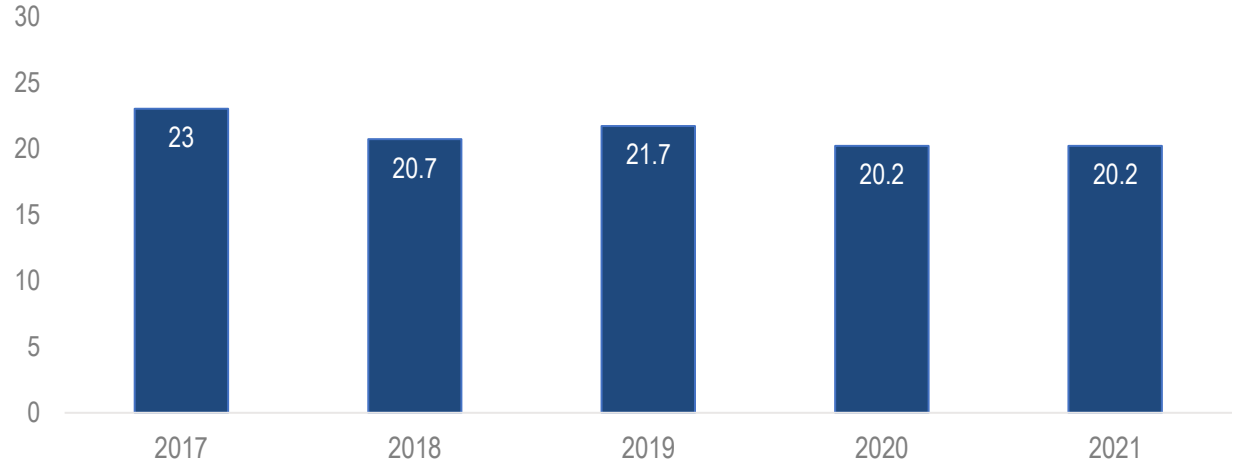


Source: Oregon 2020 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System

Positive change in social connectedness was reported by 82.7 percent of caregivers in 2021, 5.2 percent below the nationally reported 87.5 percent*.

Since 2017, Oregon caregivers' satisfaction with the social connectedness, cultural sensitivity and treatment outcomes have all trended significantly downward. Satisfaction with daily functioning has shown a significant downward trend as well.

Figure 10. One in five Oregon caregivers reported they or their child needed assistance as a result of a mental health crisis



Source: 2021 Youth Mental Health Survey Report

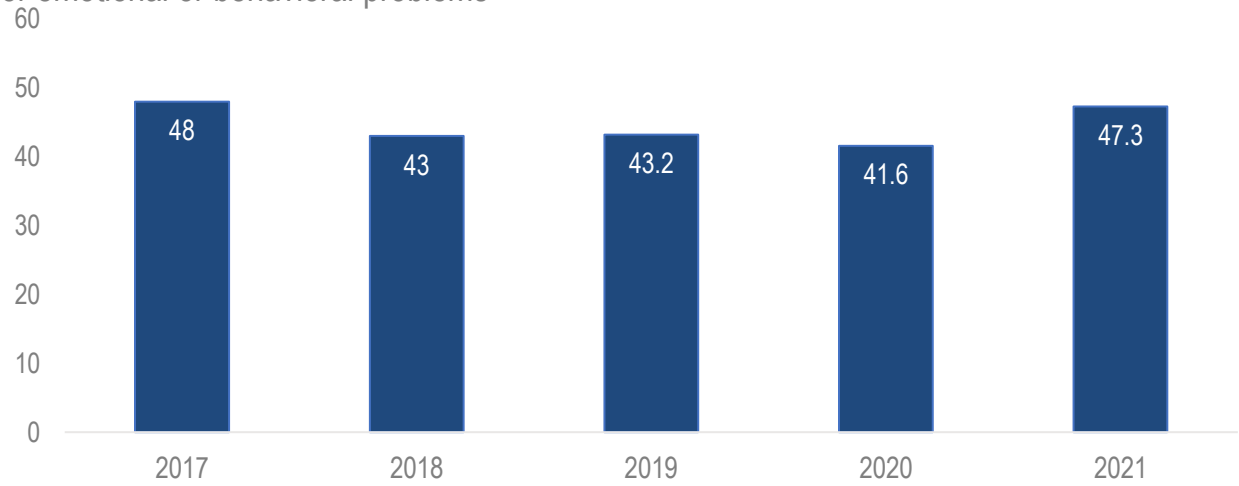
In 2021, 1 in 5 sampled caregivers report that they or their child needed assistance as a result of a mental health crisis.

Youth Services Survey

The Youth Services Survey (YSS) has been validated by the MHSIP for youth ages 14 to 17 who are receiving mental health services. The survey asks questions regarding the following domains: access to services, general satisfaction, cultural sensitivity, family participation in treatment, and treatment outcomes

Survey Sample: Youth in Oregon, ages 14 to 17, who have received Medicaid-funded mental health services in outpatient, psychiatric residential or psychiatric day treatment settings.

Almost half of youth in Oregon (ages 14 to 17) report taking a medication for emotional or behavioral problems



Source: 2021 Youth Mental Health Survey Report

Of sampled youth, 47.3 percent reporting taking medication for emotional or behavioral problems, up 5.7 percent from 2020.

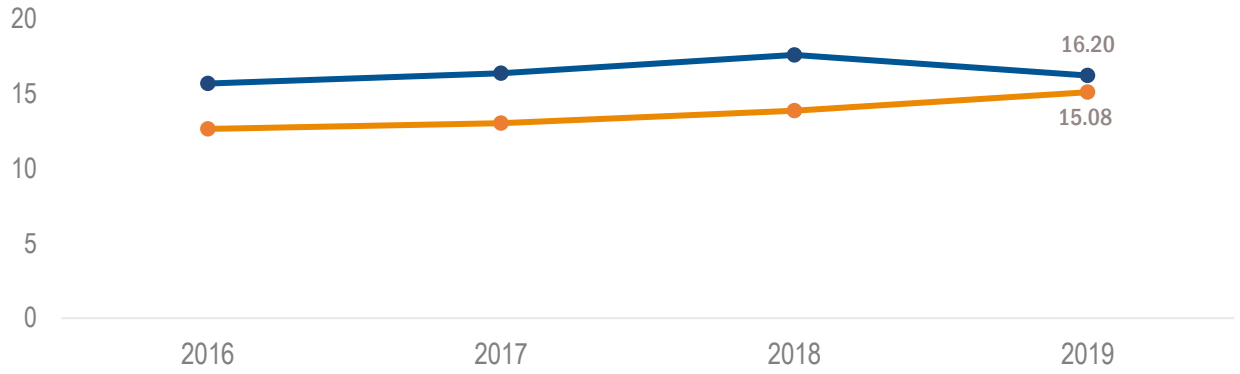
National Survey on Drug Use and Health (NSDUH)

The National Survey on Drug Use and Health (NSDUH), conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA), provides nationally representative data on the use of tobacco, alcohol, and illicit drugs; substance use disorders; receipt of substance use treatment; mental health issues; and the use of mental health services among the civilian, noninstitutionalized population ages 12 or older in the United States.

Survey Sample: Population ages 12 to 25 in the United States.

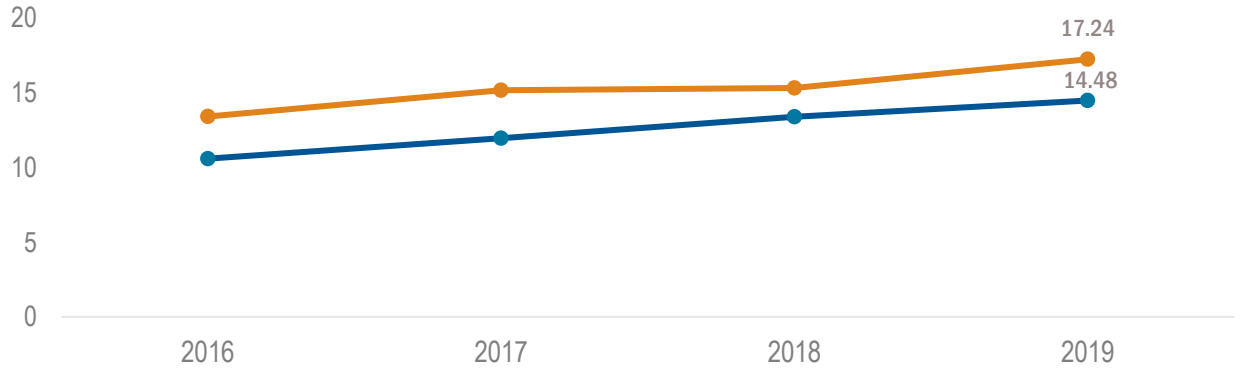
> *Differences in modes of collection due to the COVID-19 pandemic (in person to online), SAHMSA recommends data from 2020 and/or 2021 should not be pooled or compared with prior years and therefore have been left out of the following visuals.

Figure 11. Percentage of Youth (ages 12-17) experiencing a major depressive episode in the Past Year, Oregon compared to national



Source: Interactive NSDUH State Estimates SAMHDA

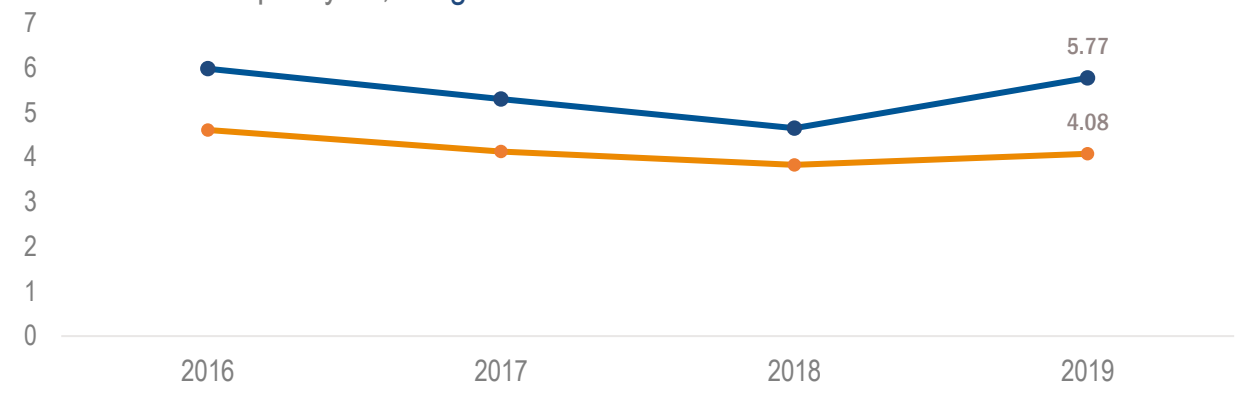
Figure 12. Percentage of youth (ages 18-25) experiencing a major depressive episode in the past year, Oregon compared to national



Source: Interactive NSDUH State Estimates SAMHDA

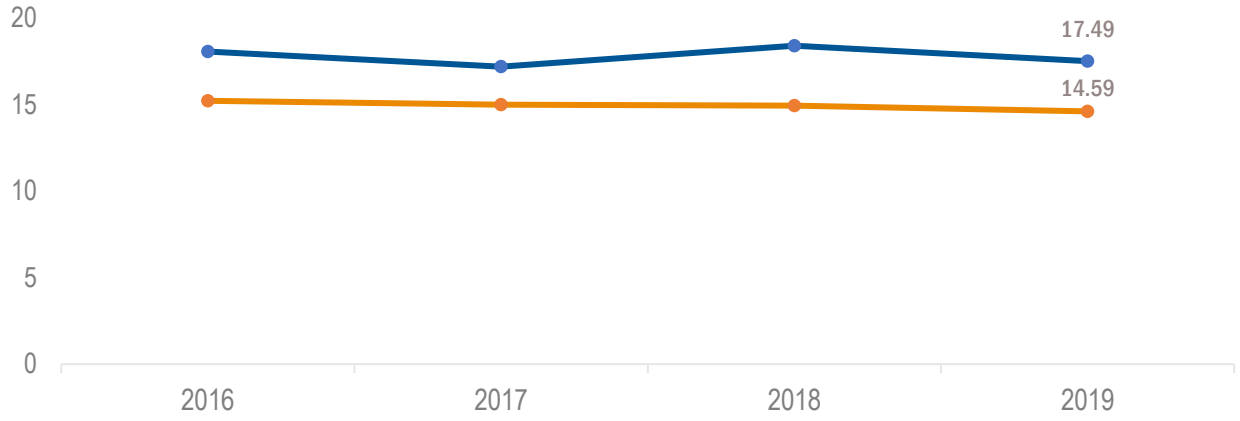
Percentage of youth, ages 12-25, reporting a major depressive episode in the past year increased in all categories except Oregon youth, ages 12-17, who saw a decrease from 17.57 to 16.2 in 2019.

Figure 13. Percentage of youth (ages 12-17) with a documented substance use disorder in the past year, Oregon and national



Source: Interactive NSDUH State Estimates SAMHDA

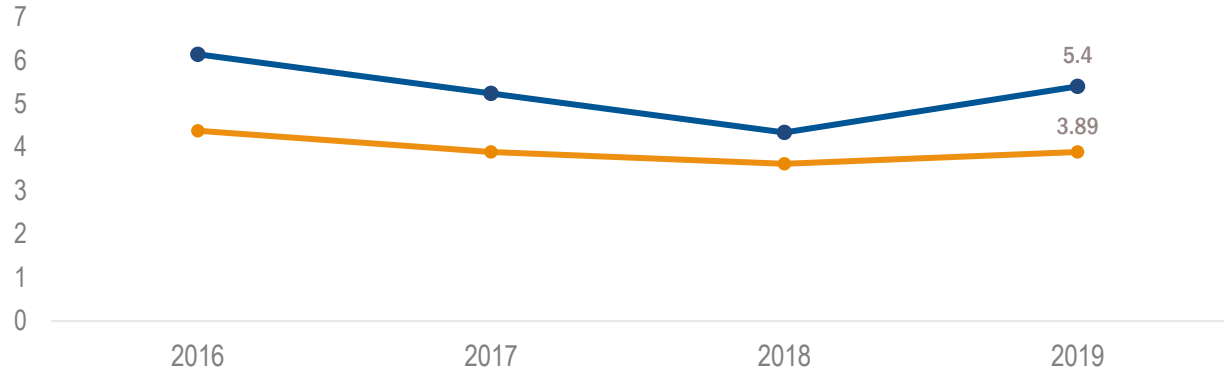
Figure 14. Percentage of youth (ages 18-25) with a documented substance use disorder in the past year, Oregon and national



Source: Interactive NSDUH State Estimates SAMHDA

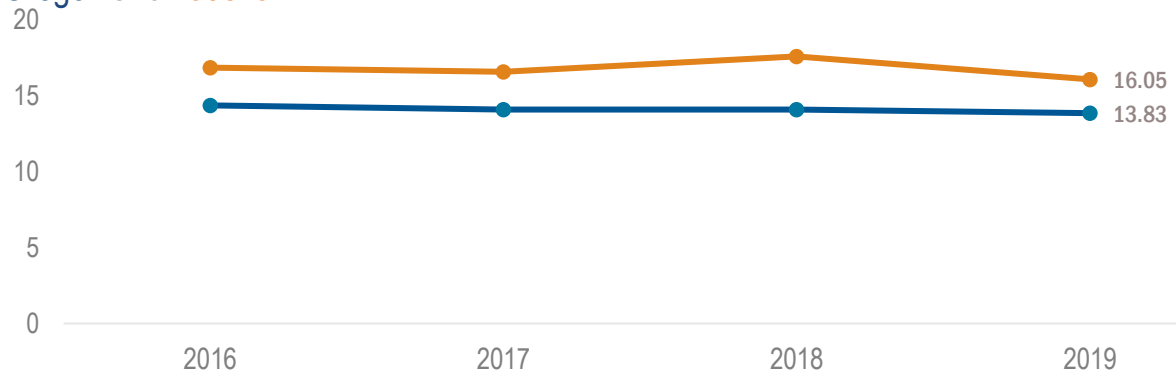
The percentage of youth, ages 12-17, with a documented substance use disorder in the past year increased nationally and in Oregon in 2019. The percentage of youth, ages 18-25, meeting the same criteria decreased nationally and in Oregon in 2019.

Figure 15. Percentage of youth (ages 12-17) needing but not receiving treatment for substance use at a specialty facility in the past year, Oregon and national



Source: Interactive NSDUH State Estimates SAMHDA

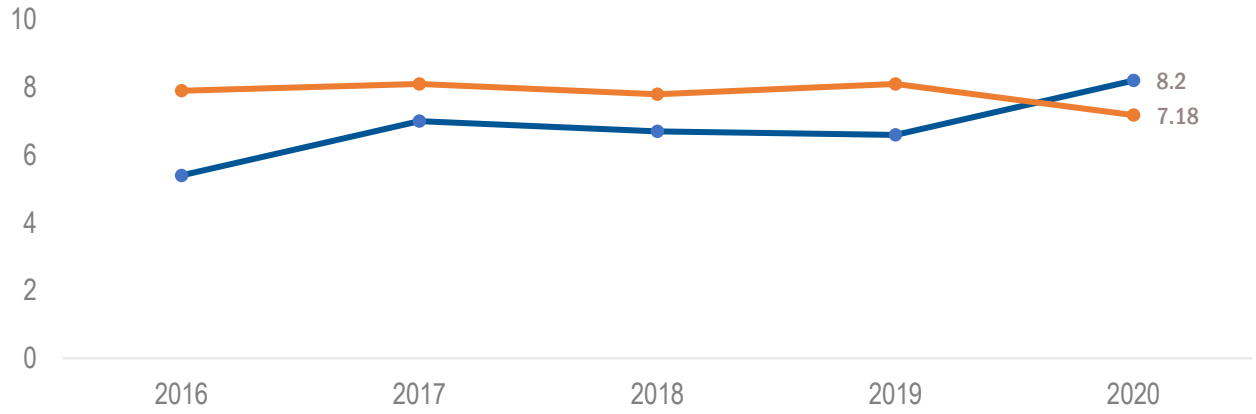
Figure 16. Percentage of youth (ages 18-25) needing but not receiving treatment for substance use at a specialty facility in the past year, Oregon and national



Source: Interactive NSDUH State Estimates SAMHDA

The percentage of youth, ages 12-17, needing but not receiving treatment for substance use at a specialty facility in the past year increased 1.06 percent in Oregon and 0.27 percent nationally since 2018. Youth, ages 18-25, saw a reduction in the percentage of youth needing but not receiving treatment for substance use at a specialty facility in the past year both nationally and in Oregon in 2019.

Figure 17. Percentage of youth (ages 12-17) with private insurance that did not cover treatment for mental or emotional problems, Oregon and national



Source: Interactive NSDUH State Estimates SAMHDA

In Oregon, the percentage of youth, ages 12-17, with private insurance that did not cover mental or emotional problems increased 1.6 percent in 2020, surpassing the national percent reported by 1.02 percent.

Oregon Student Health Survey (SHS)

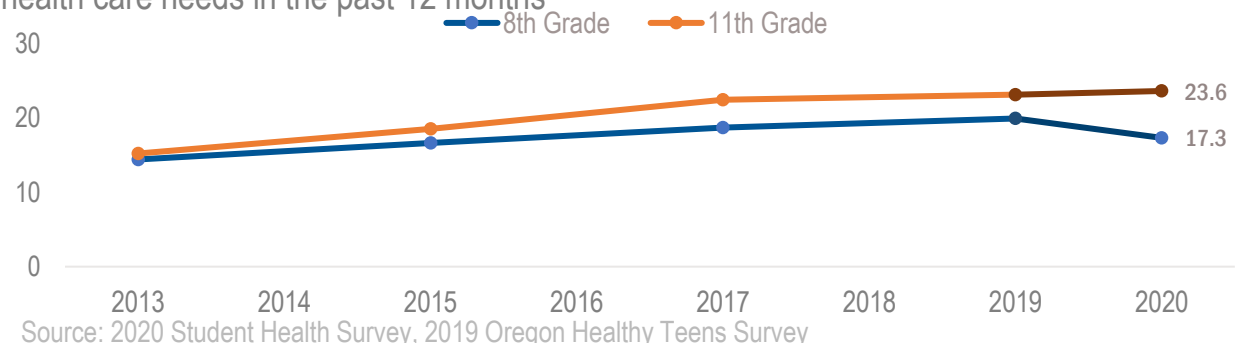
The 2020 Student Health Survey is a newly developed survey that integrates the Oregon Healthy Teens survey (2001-2019) to provide baseline measures of key youth health and risk behaviors. Darkened survey lines indicate adoption of SHS.

SHS data are not strictly comparable to prior Oregon Healthy Teen data and due to differences in methodology, grades surveyed, learning environment, data collection period and recruitment processes.

The 2020 survey results may be impacted by the general social and learning environment changes created by the COVID-19 pandemic during this data collection period.

SHS is now sampling 6th graders which will be include for some indicators in the 2020 survey and on.

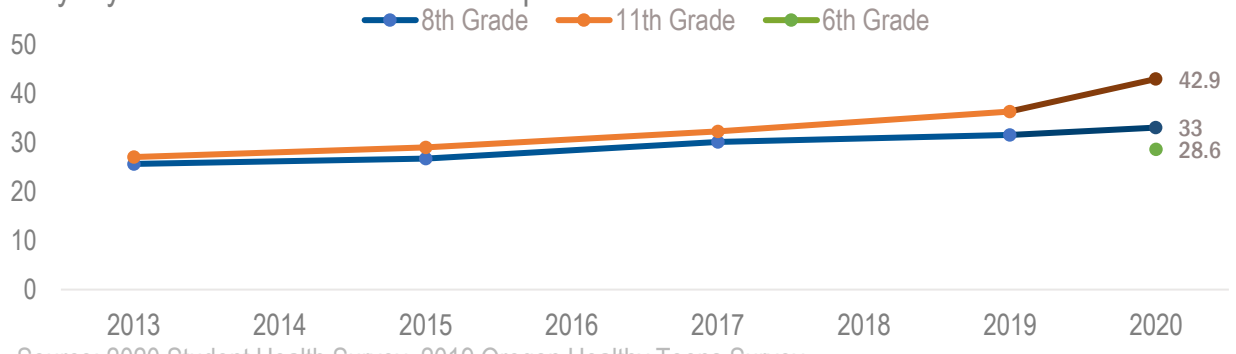
Figure 18. Percentage of student reporting unmet emotional or mental health care needs in the past 12 months



Source: 2020 Student Health Survey, 2019 Oregon Healthy Teens Survey

Darkened survey lines indicate adoption of SHS. The percentage of students reporting unmet emotional or mental health needs increased for students in 11th grade by 0.5 percent and decreased for 8th grade students by 2.6 percent in 2020. Overall, 6.3 percent more 11th graders report an unmet need.

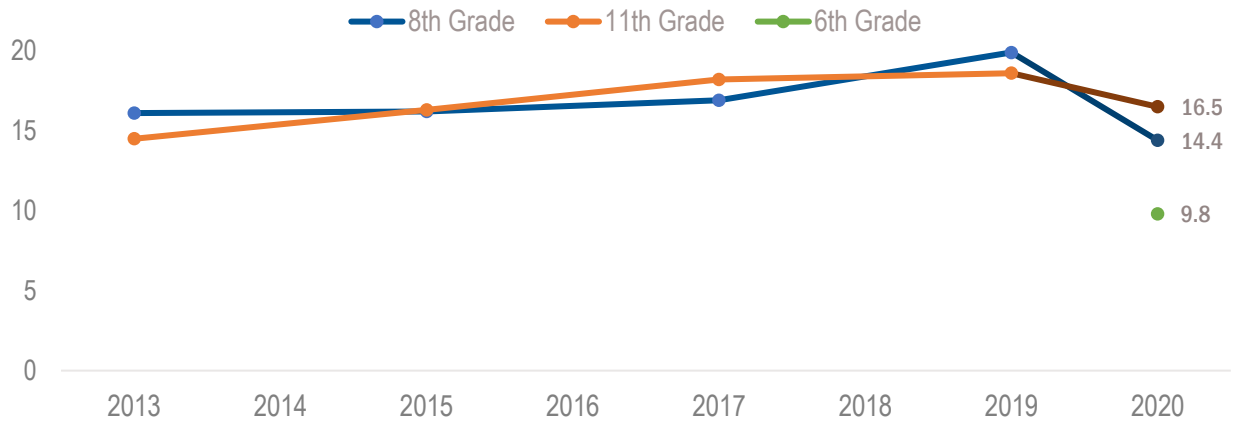
Figure 19. Percentage of students reporting feeling sad or hopeless almost everyday for two weeks or more in the past 12 months



Source: 2020 Student Health Survey, 2019 Oregon Healthy Teens Survey

The percentage of students in the past 12 months, reporting feeling so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities, has increased since 2013 for 8th and 11th graders. In 2020, the first time this group was measured, 28.6 percent of 6th graders reported feeling so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities.

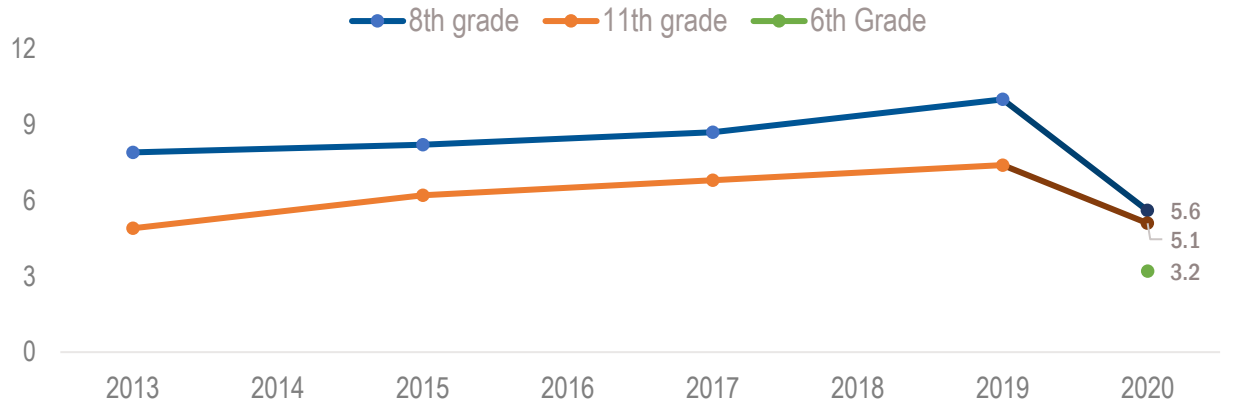
Figure 20. Percentage of students reporting seriously considering attempting suicide in the past 12 months



Source: 2020 Student Health Survey, 2019 Oregon Healthy Teens Survey

The percentage of 8th and 11th grade students seriously considering attempting suicide decreased in 2020 for the first time during the years in the reporting period. In 2020, 9.8 percent of 6th graders reported seriously considering attempting suicide, this was the first year this group was measured.

Figure 21. Percentage of students reporting actually attempting suicide in the past 12 months

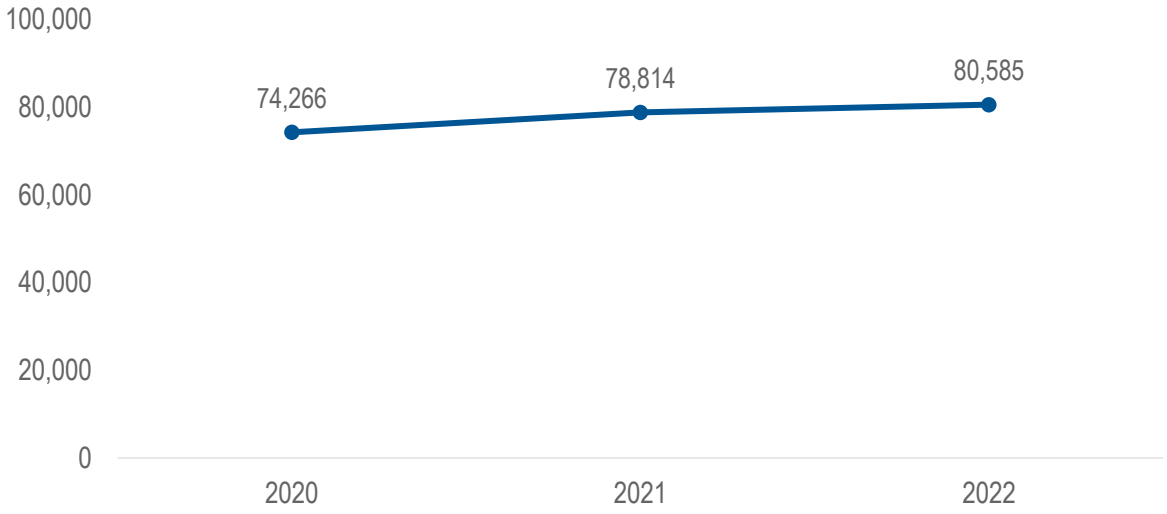


Source: 2020 Student Health Survey, 2019 Oregon Healthy Teens Survey

The percentage of 8th and 11th grade students actually attempting suicide decreased in 2020 for the first time during the years in the reporting period. In 2020, 3.2 percent of 6th graders reported actually attempting suicide, the first year this group was measured.

All Child and Youth Behavioral Health (BH) programs serving Oregon Health Plan members, ages 0-25

Figure 22. Youth served by behavioral health increases every year



Source: Children's System of Care Data Dashboard, 2020-2022, Medicaid Management Information System (MMIS) data source

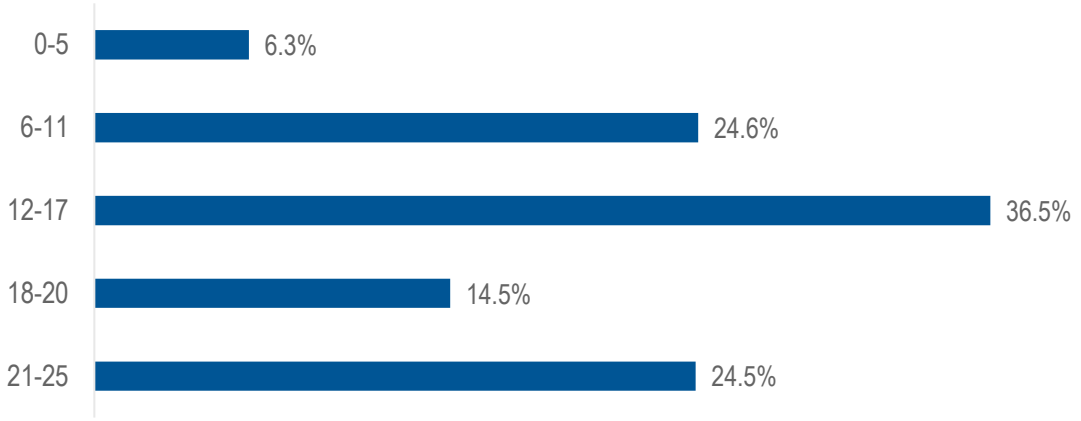
Youth served by behavioral health programs serving Oregon Health Plan members, ages 0 through 25, increases every year with 80,585 being served in 2022.

Figure 23. Youth (ages 0-25) served by behavioral health in 2022 by gender

Source: Children's System of Care Data Dashboard, 2020-2022, Medicaid Management Information System (MMIS) data source

In 2022, 58.4 percent of OHP members, ages 0-25, served by behavioral health were female, while 41.6 percent were male.

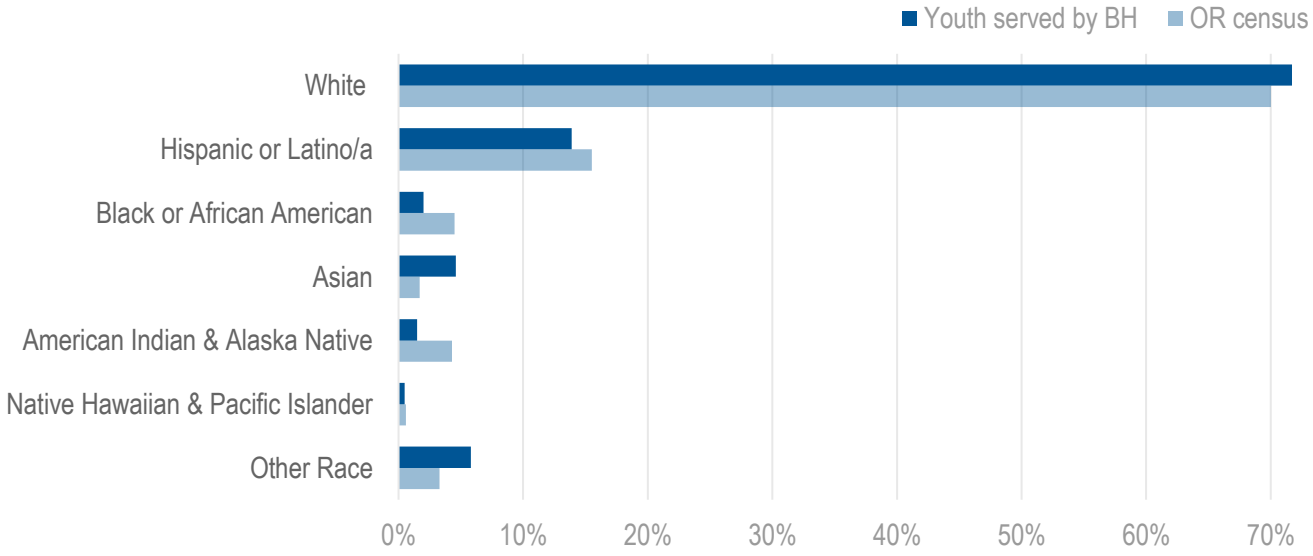
Figure 24. Youth (ages 0-25) served by behavioral health in 2022 by age group



Source: Children's System of Care Data Dashboard, 2020-2022, Medicaid Management Information System (MMIS) data source

Oregon Health Plan members, ages 0-25 served by behavioral health in 2022 were 6.3 percent ages 0-5, 24.6 percent ages 6-11, 36.5 percent ages 12-17, 14.6 percent ages 18-20, and 24.5 percent ages 21-25.

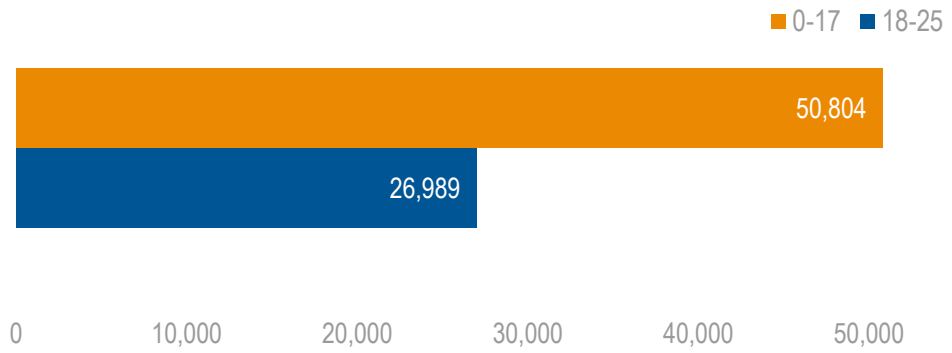
Figure 25. Percent of youth (ages 0-25) served by behavioral health in 2022 by race/ethnicity compared to 2020 census data



Source: Children's System of Care Data Dashboard, 2020-2022, Medicaid Management Information System (MMIS) data source

Oregon Health Plan members, ages 0-25, served by behavioral health in 2022 were overrepresented in some race categories and underrepresented in others when compared to 2020 census data. Native Hawaiian and Pacific Islander were overrepresented by 0.1 percent, Hispanic or Latino/a by 1.6 percent, Black or African American by 2.5 percent, and American Indian and Alaska Native by 2.8 percent. White was underrepresented by 1.7 percent, Asian by 2.9 percent, and other race by 2.5 percent.

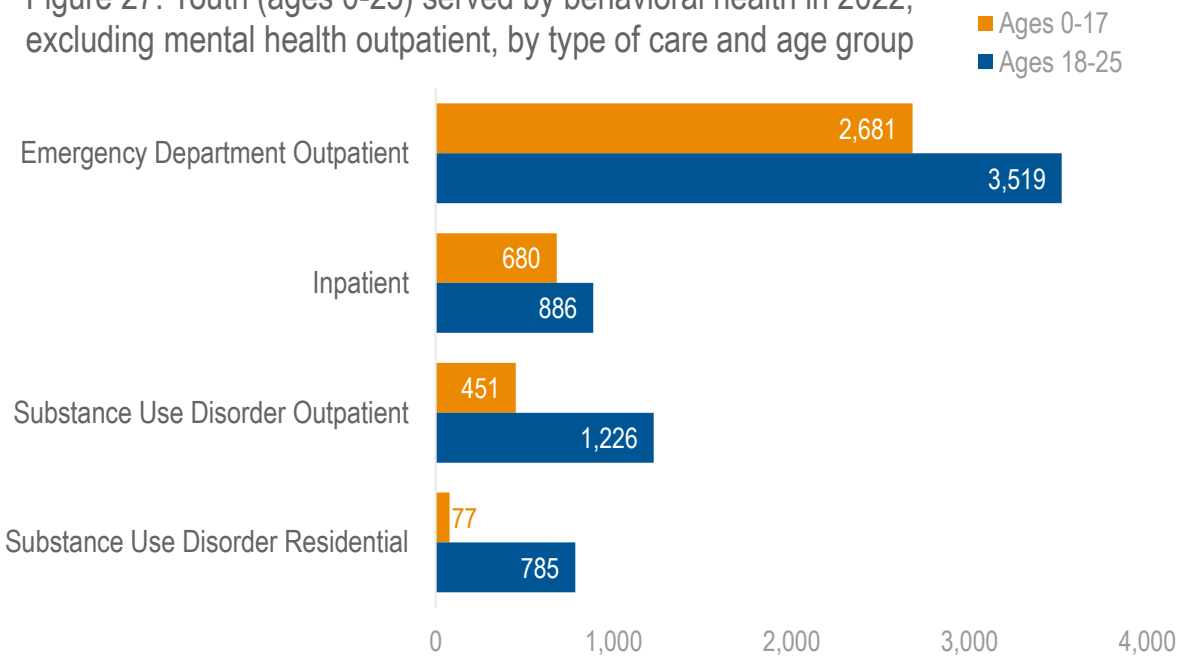
Figure 26. Youth (ages 0-25) receiving mental health outpatient services in 2022, by age group



Source: Children's System of Care Data Dashboard, 2020-2022, Medicaid Management Information System (MMIS) data source

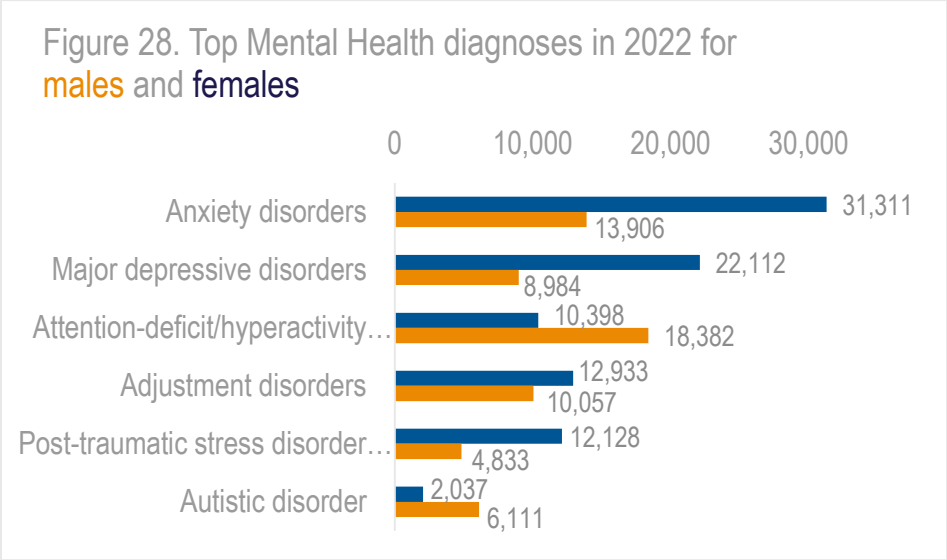
More youth, ages 0-25, OHP members received mental health outpatient services than any other type of behavioral service in 2022. Youth receiving mental health outpatient services in 2022 totaled 50,804 for ages 0-17 and 26,989 for ages 18-25.

Figure 27. Youth (ages 0-25) served by behavioral health in 2022, excluding mental health outpatient, by type of care and age group



Source: Children's System of Care Data Dashboard, 2020-2022, Medicaid Management Information System (MMIS) data source

Excluding mental health outpatient services, youth, ages 0-17, OHP members served by behavioral health in 2022 totaled 2,681 in emergency department outpatient, 680 in inpatient, 451 in substance use disorder outpatient, and 77 in substance use disorder residential. Excluding mental health outpatient services, youth, ages 18-25, served by behavioral health in 2022 totaled 3,519 in emergency department outpatient, 886 in inpatient, 1,226 in substance use disorder outpatient, and 785 in substance use disorder residential.



Source: Decision Support and Surveillance Utilization Review System (DDSURS)/Medicaid Management Information System (MMIS)

The top mental health diagnoses of youth, ages 0-25, in 2022 were: anxiety disorders (45,217); major depressive disorders (30,870); attention-deficit/hyperactivity disorder (ADHD) (28,780); adjustment disorders (22,990); post-traumatic stress disorder (PTSD) (16,961); autistic disorder (8,148); other depressive disorders (7,357); severe stress (6,856); bipolar disorder (5,219); and other disorders of psychological development (2,456). Male and female counts per diagnosis vary, with more females receiving treatment in all diagnoses except for attention-deficit disorder and autistic disorder. Note that individuals could have multiple claims with one or more mental health diagnosis and thus numbers are not unique individuals.

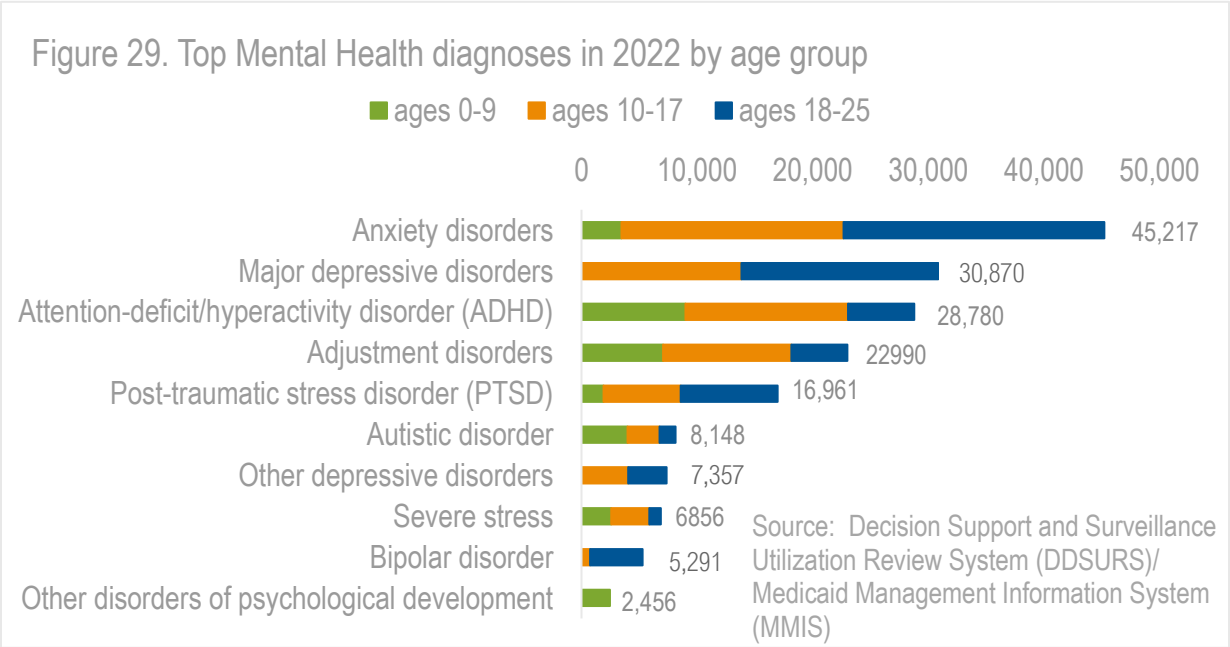
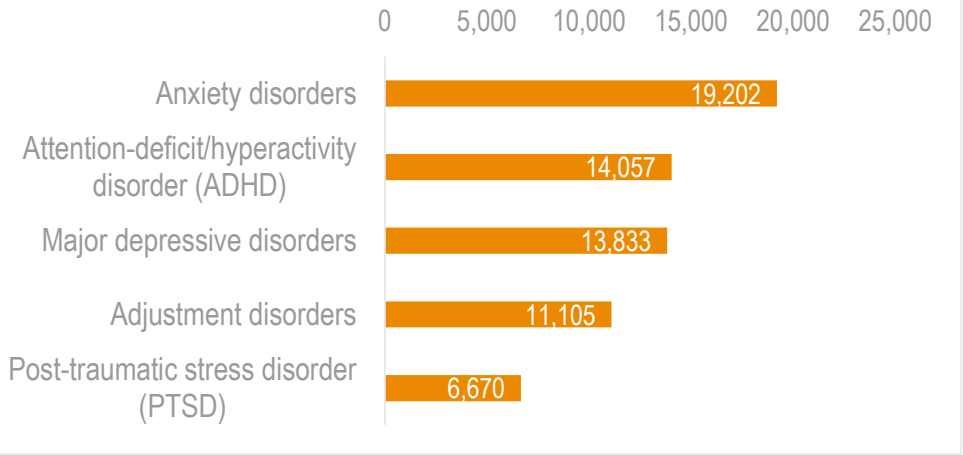


Figure 30. Top Mental Health diagnoses in 2022 for children (ages 0-9)

Source: Decision Support and Surveillance Utilization Review System (DDSURS)/ Medicaid Management Information System (MMIS)

The top mental health diagnoses of children, ages 0-9, in 2022 were: attention-deficit hyperactivity disorder (8,985); adjustment disorders (7,063); autistic disorder (3,985); anxiety disorders (3,470), and severe stress (2,568). Note that individuals could have multiple claims with one or more mental health diagnosis and thus numbers are not unique individuals.

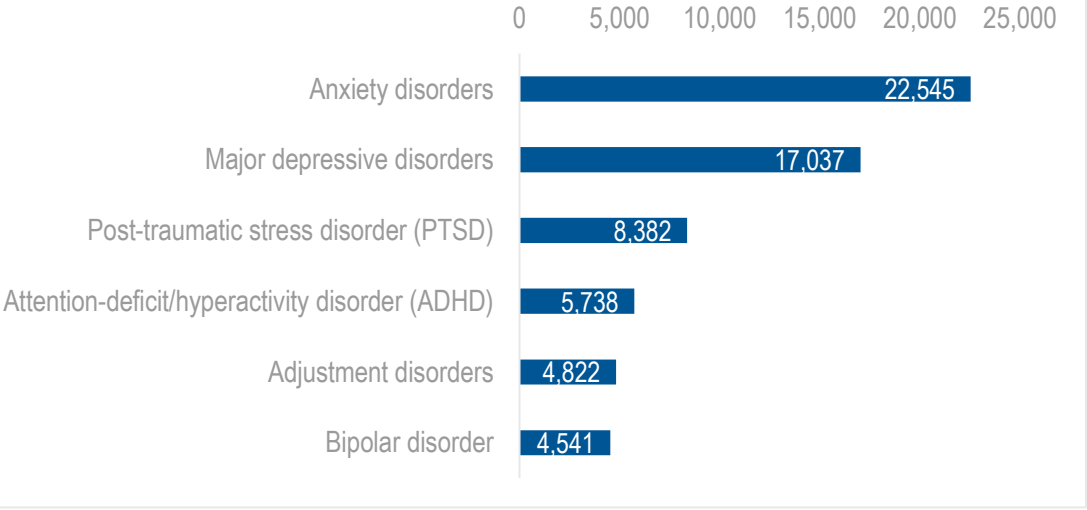
Figure 31. Top Mental Health diagnoses for youth (ages 10-17)



Source: Decision Support and Surveillance Utilization Review System (DDSURS)/ Medicaid Management Information System (MMIS)

The top mental health diagnoses of youth, ages 10-17, 2022 were: anxiety disorders (19,202); attention-deficit hyperactivity disorder (14,057); major depressive disorders (13,833); adjustment disorders (11,105); and post-traumatic stress disorder (6,670. Note that individuals could have multiple claims with one or more mental health diagnosis and thus numbers are not unique individuals.

Figure 32. Top Mental Health diagnoses in 2022 for young adults (ages 18-25)



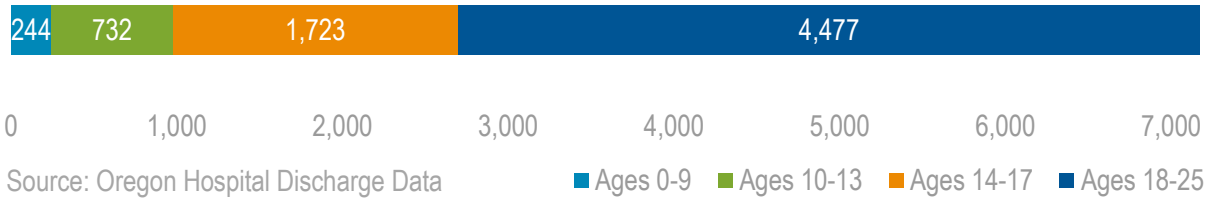
Source: Decision Support and Surveillance Utilization Review System (DDSURS)/ Medicaid Management Information System (MMIS)

The top mental health diagnoses of young adults, ages 18-25, in 2022 were: anxiety disorders (22,545); major depressive disorders (17,037); post-traumatic stress disorder (8,382); attention-deficit/hyperactivity disorder (5,738); adjustment disorders (4,822); and bipolar disorder (4,541). Note that individuals could have multiple claims with one or more mental health diagnosis and thus numbers are not unique individuals.

Figure 33. Emergency Department **visits** for mental health in 2022, for all Oregonians, by age group for 0-25

Most visits by ages 18-25, followed by 14-17, and 10-13

Total = 7,176

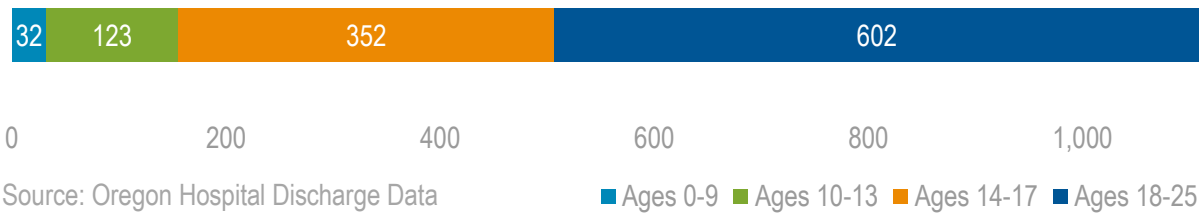


Emergency department visits for youth, ages 0-25, for mental health in 2022 totals 7,716. Of those, 4,477 were young adults, ages 18-25, 1,723 were youth, ages, 732 were youth, ages 10-13, and 244 were children, ages 0-9.

Figure 34. Emergency Department **boarding 24+ hours** for mental health in 2022, for all Oregonians, by age group for 0-25

Most visits by ages 18-25, followed by 14-17, and 10-13

Total = 1,109

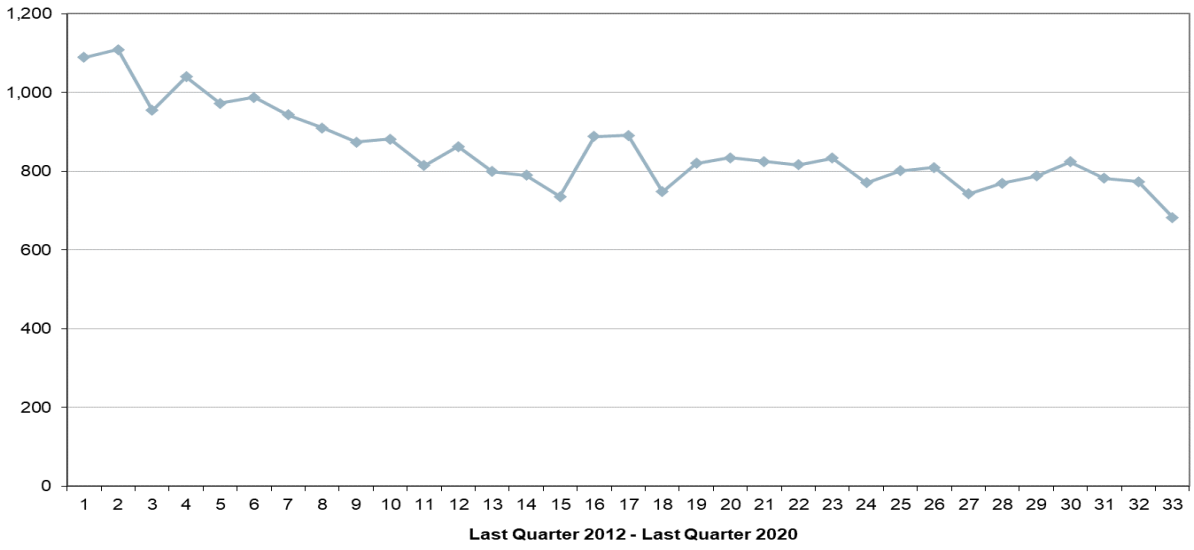


Emergency department boarding of 24+ hours for youth, ages 0-25, for mental health in 2022 totals 1,109. Of those, 602 were young adults, ages 18-25, 352 were youth, ages 14-17, 123 were youth, ages 10-13, and 32 were children, ages 0-9.

Figure 35. Prevalence of children (ages 0-17) receiving antipsychotics PMPM x100,000
Denominator = all eligible children <18 years of age
Numerator = children <18 years of age receiving an antipsychotic

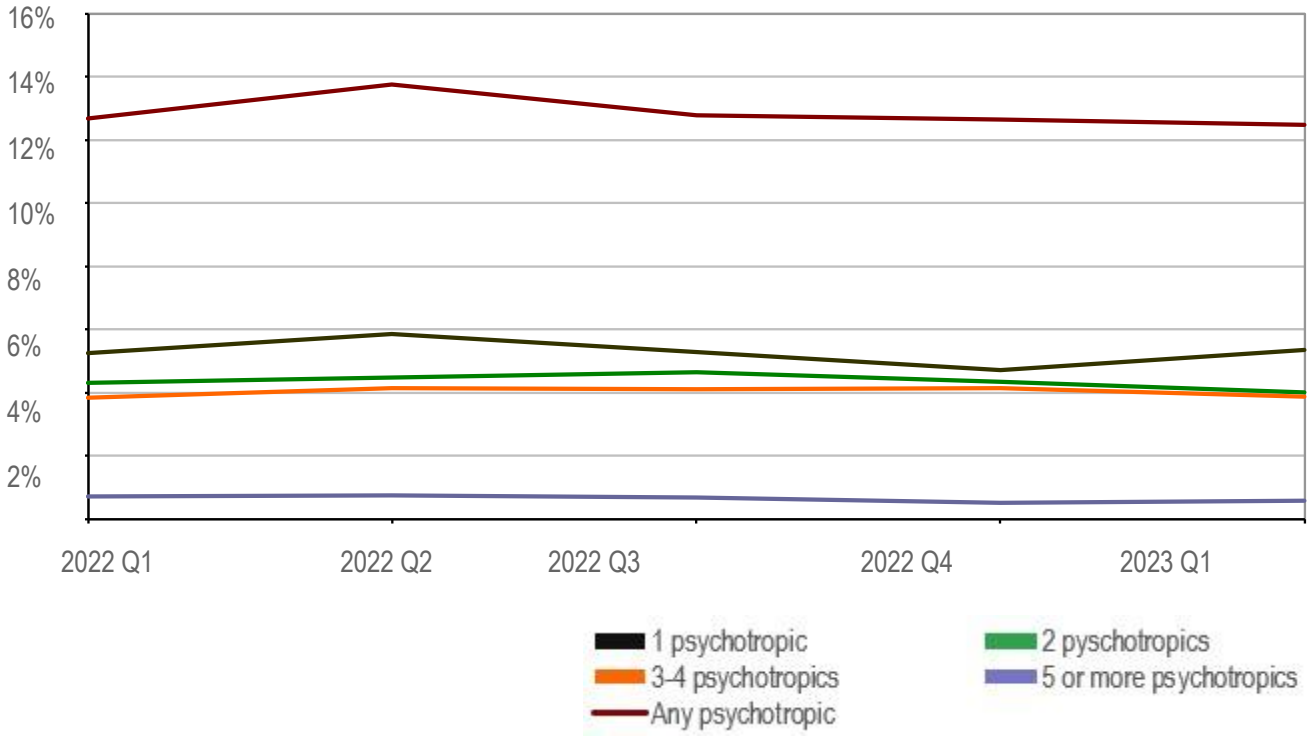
Oregon goals on antipsychotic use for children under the age of 18 include: improving the safety and effectiveness of psychotropic medication use through the application of best practices; and reduce the use of antipsychotic medications for unapproved indications.

Figure 36. Youth in foster care on any psychotropic medication



Every child in foster care receives, at minimum, an annual psychotropic medication review by the Psychotropic Oversight Registered Nurse. In addition, all new psychotropic medications require pre-authorization by the Psychotropic Oversight RN prior to administration for children in foster care.

Figure 37. Percent of Foster Children on Psychotropics
(Age 18 or under)



In the last 4 quarters (2022 quarter 2 through 2023 quarter 1), an average of 12.5% of youth under 18 in foster care were prescribed psychotropic medications compared to 19.7 % in 2011[1].

[1] Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions [Reissued on December 15, 2011] GAO-12-201. Published: Dec 14, 2011. Publicly Released: Dec 16, 2011

Mental Health Promotion and Prevention (MHPP)

Since 2014, the Oregon Health Authority (OHA) has funded local Mental Health Promotion and Prevention projects. Projects across Oregon build awareness of mental health, normalize help-seeking behaviors, and lift up communities. Activities are prioritized to support mental determinants of wellness, including social emotional competence, individual skill development, and healthy communities. These projects are implemented by local public health agencies, culturally specific community-based organizations and coordinated care organizations from 20 counties in Oregon.

Mental Health Promotion and Prevention activities are provided in various locations, with 30 percent taking place in communities, 24 percent in schools, 19 percent in businesses, 15 percent online, 7 percent in homes, and 5 percent in faith-based groups.

Figure 38. Mental Health Promotion and Prevention Service Locations in 2023

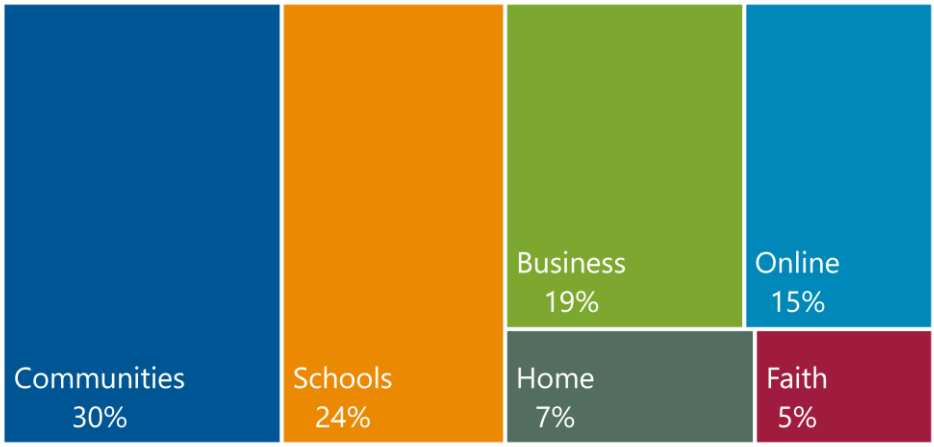
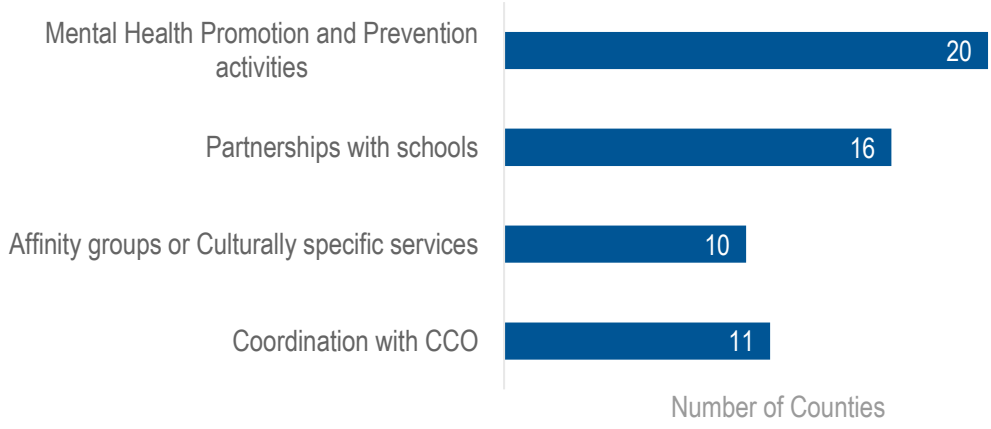


Figure 39. Mental Health Promotion and Prevention activities funded by OHA



OHA supports 19 programs, including two culturally specific organizations, six community-based mental health agencies, and 11 local public health agencies to provide mental health promotion and prevention activities across 20 counties in Oregon. Sixteen programs have partnerships with schools, 10 provide culturally specific services, and 11 coordinate with their Coordinated Care Organization (CCO).

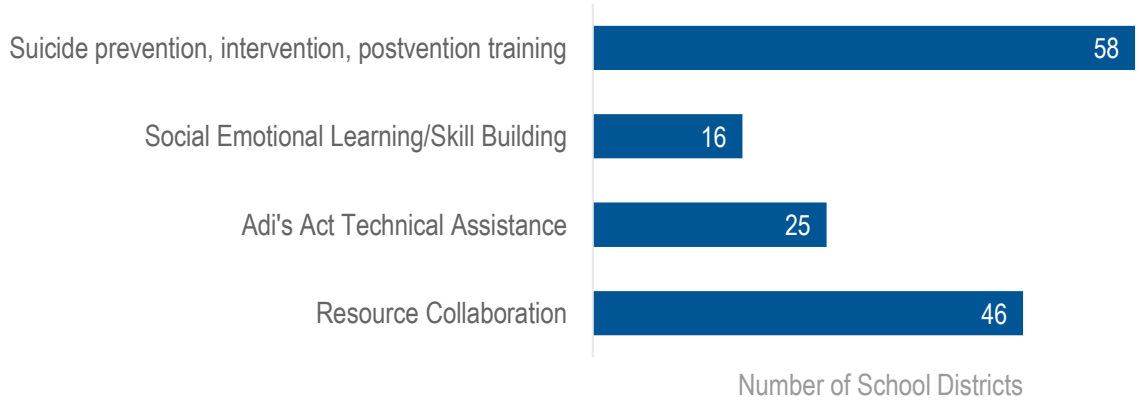
Mental health promotion and prevention activities are varied across programs and are prioritized through community engagement and thoughtful review and incorporation of national, state and local data. Some examples of activities include peer support specialists supporting youth to practice life skills and develop goals and plans for their future; mental health first aid training and suicide prevention training to all areas of a community including educators, parents, behavioral health providers, and faith communities. Workshops and trainings decrease stigma and build community safety around suicide and mental health and improve social support.

Affinity groups and culturally specific services offer community-based wellness promotion and prevention as well as advocacy for refugees and immigrant populations. They use strengths-based and culturally specific support groups and events. For example, the Asian Health and Service Center's promotion and outreach efforts aim to improve the overall wellbeing of Asian community members through an integration of resource building, psychoeducation, and maintenance of one's physical and emotional health.

An example of coordination with a CCO is the InterCommunity Health Network coordinated care organization (IHN-CCO). It supports three Community Mental Health Programs (Linn, Benton, and Lincoln) to provide trainings to community partners focused on suicide prevention and improved community mental health outcomes. Building on an established culture of collaboration, their goal is to increase the number of individuals who can provide trainings and thus the number of individuals served. This benefits the community by increasing the comfort levels of our providers in talking to those they serve about their mental health concerns and provides an early response to individuals who have suicidal thoughts.

For more information on partnership with schools, please see the table and explanations below.

Figure 40. Mental Health Promotion and Prevention services in 77 school districts in 2022



Oregon has 197 school districts, and overall, 77 partner with OHA sponsored programs to provide mental health promotion and prevention services. These OHA sponsored programs provide suicide prevention, intervention, and postvention training to 58 school districts. In addition, social emotional learning and skill building is incorporated in 16 districts, and Adi's Act, SB 52 (2019), technical assistance is delivered to 25 districts. Partnerships that include resources, collaboration, and training are offered in 46 districts.

Suicide prevention, intervention, and postvention training entails providing school-wide, all staff training, such as Mental Health First Aid (MHFA), Applied Suicide Intervention Skills Training (ASIST), and Question, Persuade, Refer (QPR) on a regular basis.

Social Emotional Learning curriculum and skill-building groups focus on helping students develop individual skills to improve social connection, problem solving and self-regulation. Some MHPP programs provide Adi's Act, SB 52 (2019), technical assistance to their local school districts by helping review and create the district's required suicide prevention, intervention, and postvention plans.

Resource Collaboration may include consulting on mental health curriculum for the district or connecting families and students to community or agency resources for support.

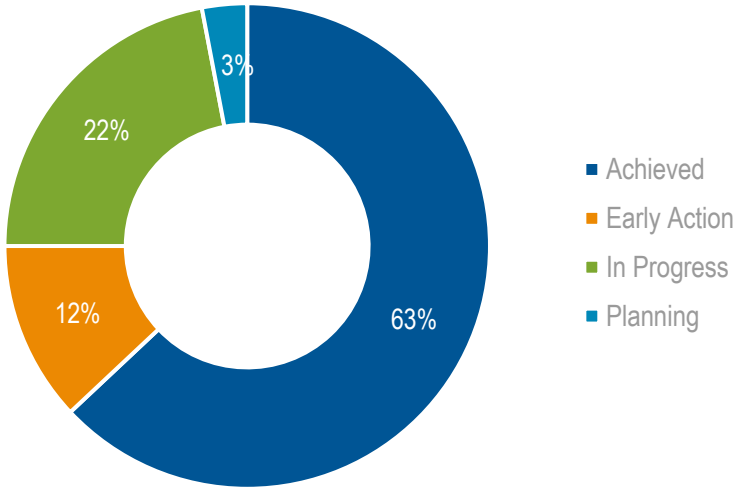
Youth Suicide Prevention

Youth suicide is a persistent problem nationwide. In Oregon, the rate of youth suicide deaths increased steadily from 2011 to 2018. Oregon experienced a three-year decrease in youth suicide in 2019, 2020, and 2021. Despite this promising decrease, Oregon ranks above the national average for youth suicide. Collaborative, innovative work is being done to create a state that is safer against suicide for young people in Oregon. In 2021, Oregon made significant progress in youth suicide prevention. This progress included:

- Developing a suicide prevention framework,
- Publishing an updated five-year plan for youth suicide prevention, and
- Starting the work outlined in the YSIPP 21–22 initiatives.

The Oregon Health Authority (OHA) is working with partners to build out the strategic pathways in Oregon's suicide prevention framework. This work advances the Youth Suicide Intervention and Prevention Plan (YSIPP), which OHA updates every five years.

Figure 41. YSIPP 2021-2022 Status of All Initiatives (117 count)



Among the 117 initiatives for the Youth Suicide Intervention and Prevention Plan (YSIPP), 63 percent have been achieved, 12 percent have received early action, 22 percent are in progress, and 3 percent are in planning. For more information on YSIPP initiatives, please see this link.

Sources of Strength is a youth mental health promotion and suicide prevention program designed to harness the power of peer social networks to create healthy norms and culture, ultimately preventing suicide, violence, bullying, and substance misuse. The program empowers student peer leaders to connect with each other and with staff advisors. Sources of Strength promotes positive culture change in Oregon K-12 and post-secondary schools and does outreach to other youth-serving spaces. The mission of Sources of Strength is to prevent adverse outcomes by increasing wellbeing, help-seeking, resiliency, healthy coping, and belonging. In the 2021-2022 school year, estimated student reach was **20,575 elementary students** and **45,227 middle and high school students**.

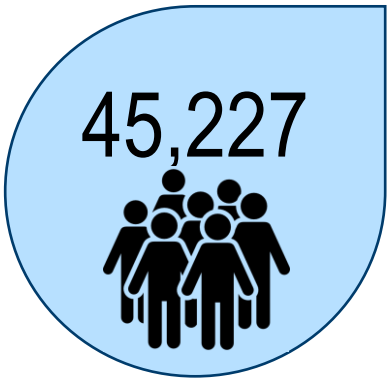
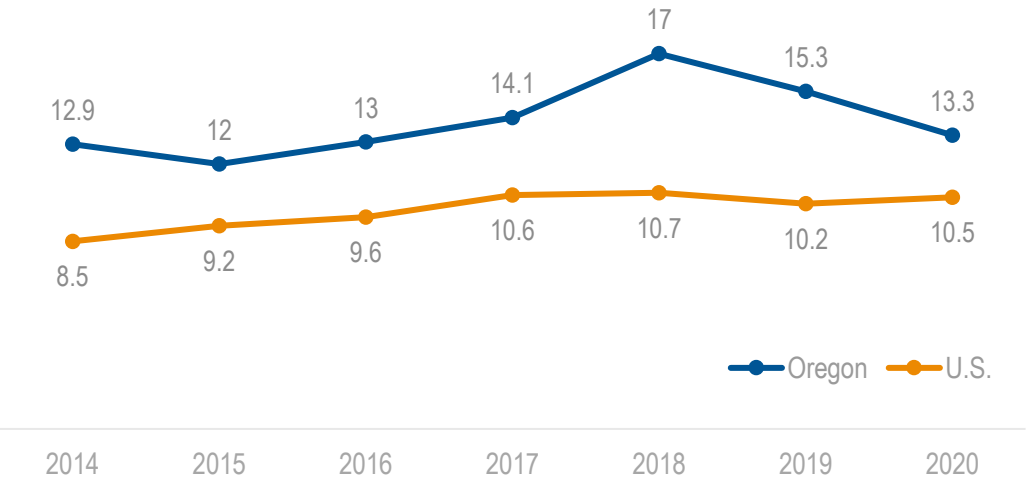


Figure 42. Sources of Strength student reach for 2021-2022 school year

	Elementary	Middle and High Schools
Schools implementing program	54	55
Number of Counties	10	15
People Trained	147 Coaches	355 Adult Advisors 1,070 Peer Leaders
Student Reach	20,575	45,227

Source: Sources of Strength Aug 2022 quarterly report

Figure 43. Death rate (per 100,000) for ages 10 to 24 for Oregon and the United States

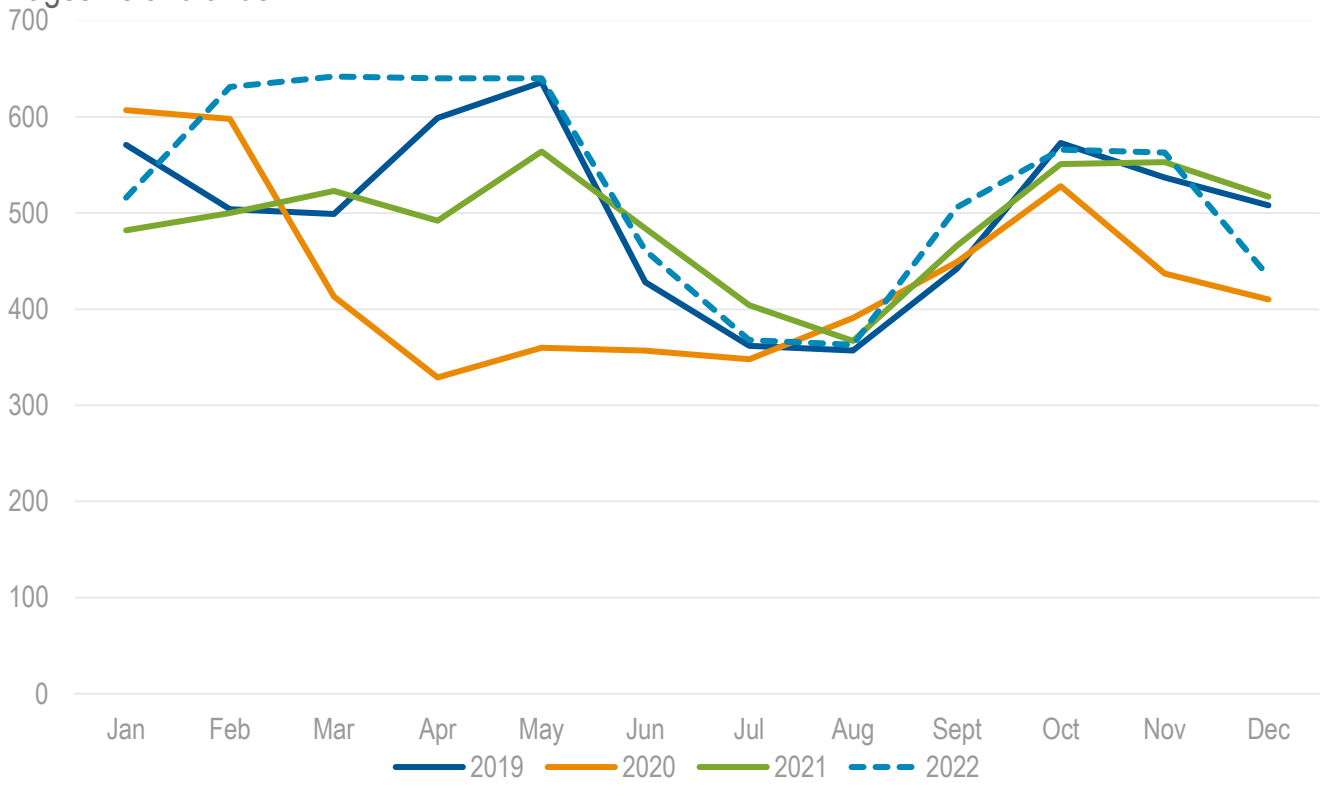


Source: CDC WISQARS

Preliminary data in Oregon indicate the following:

- For youth, age 17 and under, suicide numbers decreased in 2021 compared to 2020.
- For youth, age 18–24, suicide numbers in 2021 were similar to 2020.
- Suicide numbers decreased overall for youth, age 24 and under in 2021 compared to 2020.

Figure 44. Suicide related Emergency Department and Urgent Care visits, ages 18 and under



Source: ESSENCE syndromic surveillance suicide-related data, including visits for self-harm, suicide ideation and suicide attempt, from all nonfederal hospital EDs and select UCCs across Oregon

Suicide related Emergency Department and Urgent Care visits for ages 18 and under totaled 6,016 in 2019, 5,227 in 2020, 5,903 in 2021, and 6,330 in 2022.

Community Based Treatment

Early Childhood Mental Health

Early life experiences greatly influence a person's physical, social, emotional, adaptive, linguistic and cognitive health. In early childhood, responsive and nurturing relationships support social-emotional health and resiliency. Meanwhile, trauma or neglect may cause lifelong negative effects on psychological functioning, academic progress, and physical health. Infants and young children do experience serious social, emotional and behavioral problems. No matter a person's age, providing therapeutic services as soon as possible reduces long-term suffering and medical costs for children and families.

Parent-Child Interaction Therapy (PCIT) is a highly effective brief intervention for families of children 2-7 years old who have significant social-emotional and behavior problems. These problems can be related to anxiety, moderate to mild autism, hyperactivity, chronic trauma or neglect. Parents get direct coaching from a PCIT therapist in specific therapeutic skills to build or strengthen a secure relationship with their child, increase the child's social skills and positive behaviors, and decrease disruptive behaviors.

Child-Parent Psychotherapy (CPP) is for children aged birth through 6 years who have experienced trauma. Trauma can include maltreatment, sexual abuse, sudden loss of a loved one, or exposure to domestic violence. The central goal of CPP is to support and strengthen the child-parent relationship. In turn, the stronger relationship will restore and protect the child's mental health.

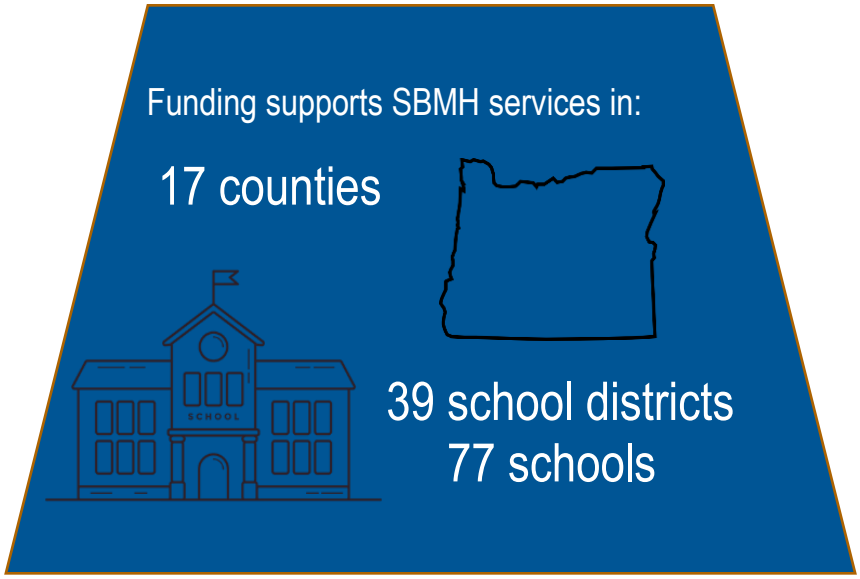
Generation PMTO (Parent Management Training, Oregon Model) is an evidence-based intervention. It helps parents strengthen families at all levels (children, youth, parents and couples). Based on more than 50 years of research, Generation PMTO promotes parenting and social skills; and prevents, reduces and reverses the development of moderate to severe conduct problems in children and youth.

Reporting for Early Childhood Mental Health programs has been on hold due to the impacts of the COVID-19 pandemic on the workforce.

School-Based Mental Health (SBMH)

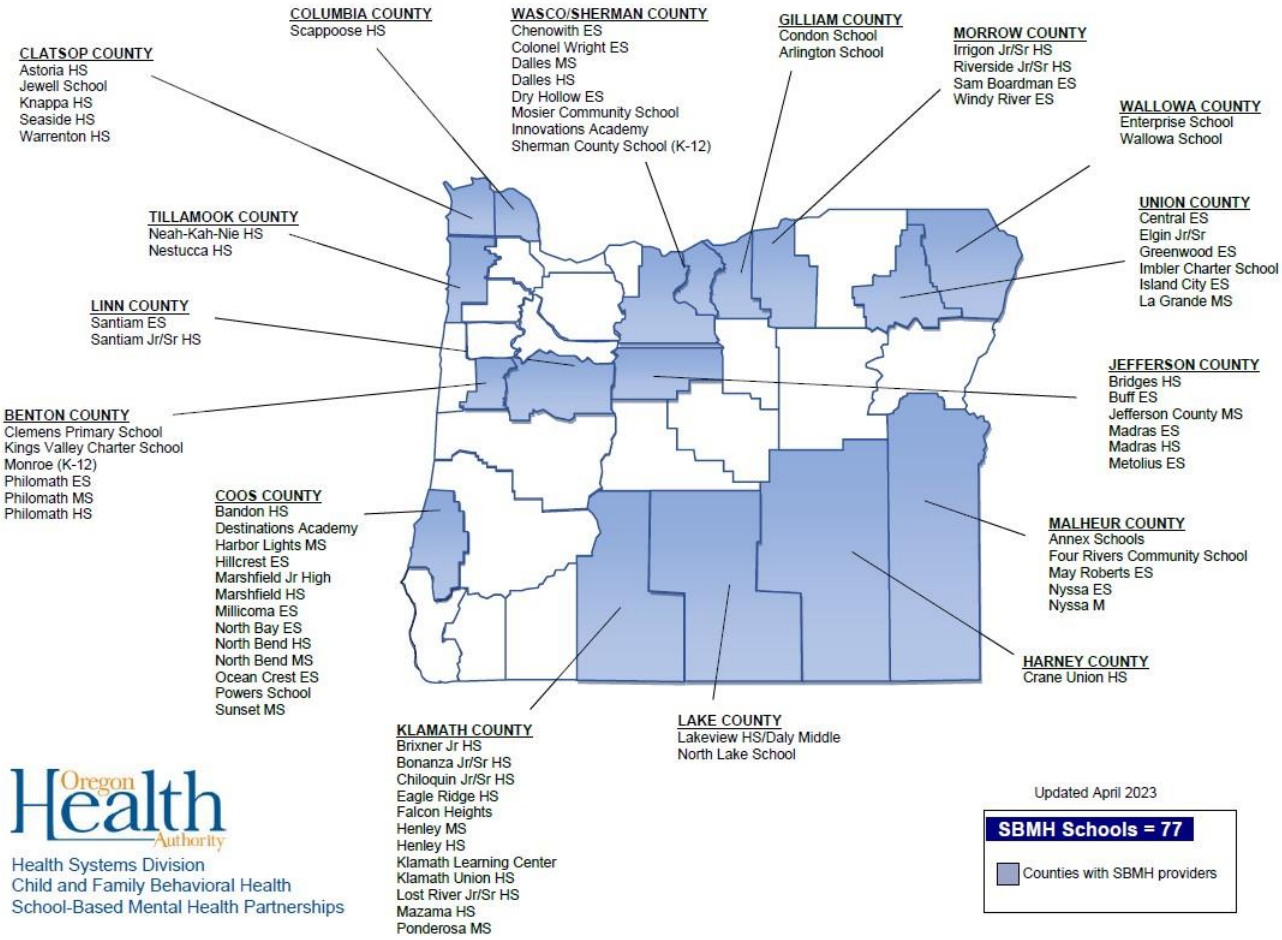
School-based mental health services are an essential component of our education system. Trauma, stress and conflict can interfere with almost every aspect of a child's learning. These services improve students' physical and psychological safety and are an immediate access point to a healing pathway that can help reduce exclusionary discipline events such as suspensions and expulsions. SBMH services also reduce and prevent costly negative outcomes such as mental health emergency department visits, dropping out, chronic absenteeism, substance misuse, suicidal thoughts, risky behaviors, and involvement with the criminal justice system.

The Health Systems Division provides direct funding to 17 counties in rural areas of Oregon with limited to no access to mental health services. The funds help these counties provide mental health services in 39 school districts which includes 77 schools. For schools served by this funding, view our provider map.



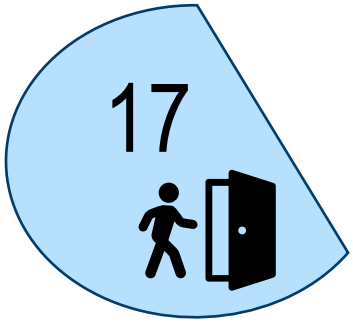
County mental health organizations that receive this funding partner with local schools and districts and place their mental health clinicians directly in local schools to provide person-centered, trauma-informed rapid crisis and clinical interventions directly to youth and families. SBMH providers maintain therapeutic relationships with students who need ongoing behavioral health support, covering concerns such as managing anxiety, depression and suicidal feelings, trauma, conflict resolution, navigating relationships, self-regulation and self-management skills. Services are available to any student, regardless of income or insurance status and are person-centered, strengths-based, trauma-informed, culturally responsive and linguistically attuned.

OHA SUPPORTED SCHOOL-BASED MENTAL HEALTH 2022-2023



Day Treatment

Sometimes referred to as “partial hospitalization,” this level of care offers:



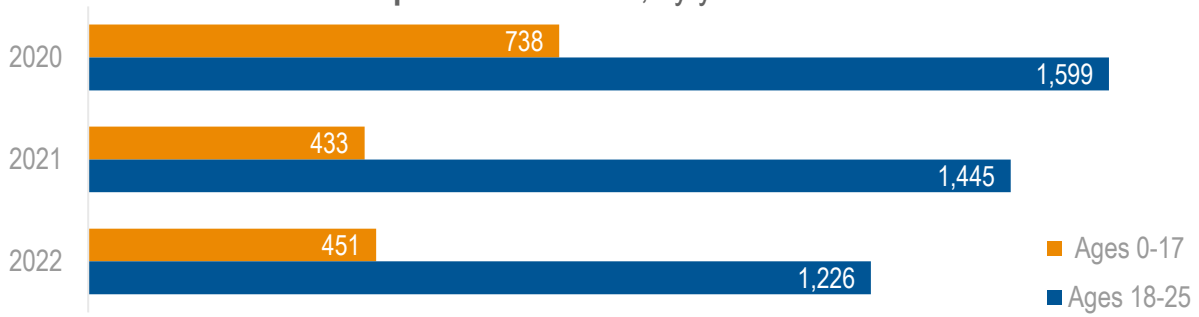
- Individualized therapeutic services,
- Social environment supervision,
- In the moment coaching of relationship skills,
- Groups, and
- Medication management.

There are **17 day treatment programs** in Oregon. Day treatment programs are usually provided during school hours. They offer education services in collaboration with the mental health treatment providers. These services offer support for significant mental health crises while youth live in their community. Day treatment is often useful in preventing an out of home placement, or to support youth as they step down from residential care.

Substance Use Disorder Treatment

New users of alcohol often start before age 18. Most people who develop substance use disorders begin using before age 25. Studies show adolescents, ages 12-17, and young adults, ages 18-25, frequent marijuana use is associated with concurrent or eventual opioid misuse, heavy alcohol use, and depression. The Oregon Health Authority is working to address factors contributing to early use of substances, including misuse and substance use disorders.

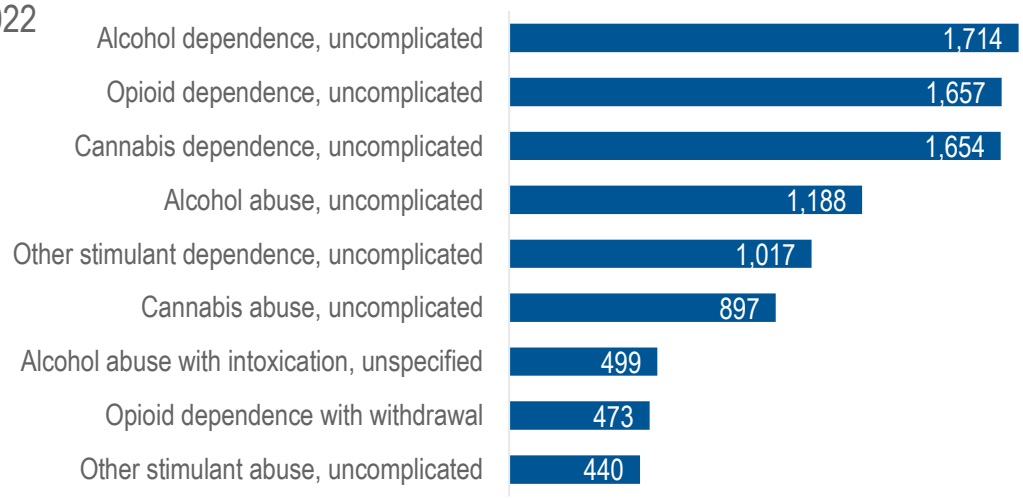
Figure 45. Number of youth (ages 0-17 and 18-25) receiving substance use disorder **outpatient** Treatment, by year



Source: Children's System of Care Data Dashboard, 2020-2022,

The number of youth, ages 0-25, who receive substance use disorder outpatient treatment decreased every year from 2020 to 2022. In every year, more young adults, ages 18-25, receive treatment than youth, ages 0-17.

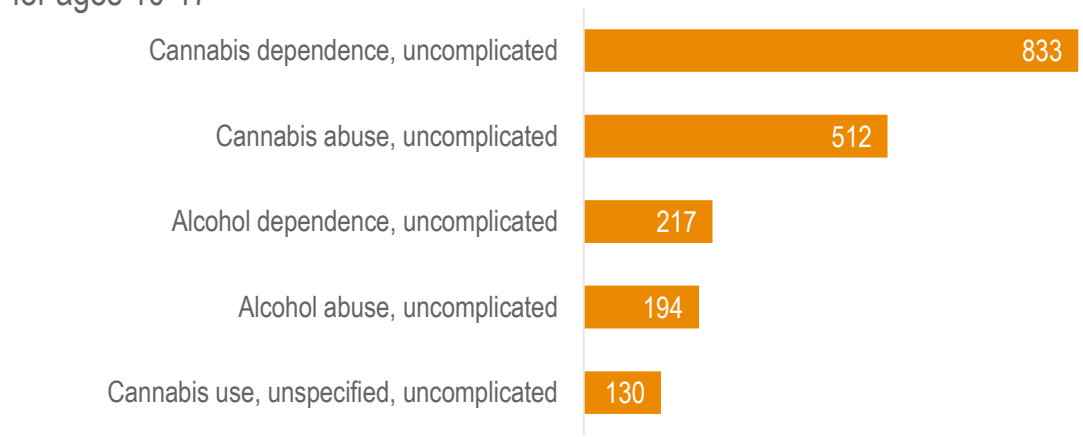
Figure 46. Top substance use disorder diagnoses for youth (ages 0-25) in 2022



Source: Decision Support and Surveillance Utilization Review System (DDSURS)/ Medicaid Management Information System (MMIS)

The top substance use disorder diagnoses of youth, ages 0-25, in 2022 were: alcohol dependence, uncomplicated (1,714); opioid dependence, uncomplicated (1,657); cannabis dependence, uncomplicated (1,654); alcohol abuse, uncomplicated (1,188); other stimulant dependence, uncomplicated (1,017); cannabis abuse, uncomplicated (897); alcohol abuse with intoxication, unspecified (499); opioid dependence with withdrawal (473); and other stimulant abuse, uncomplicated (440). Note that individuals could have multiple claims with one or more substance use disorder diagnosis and thus numbers are not unique individuals.

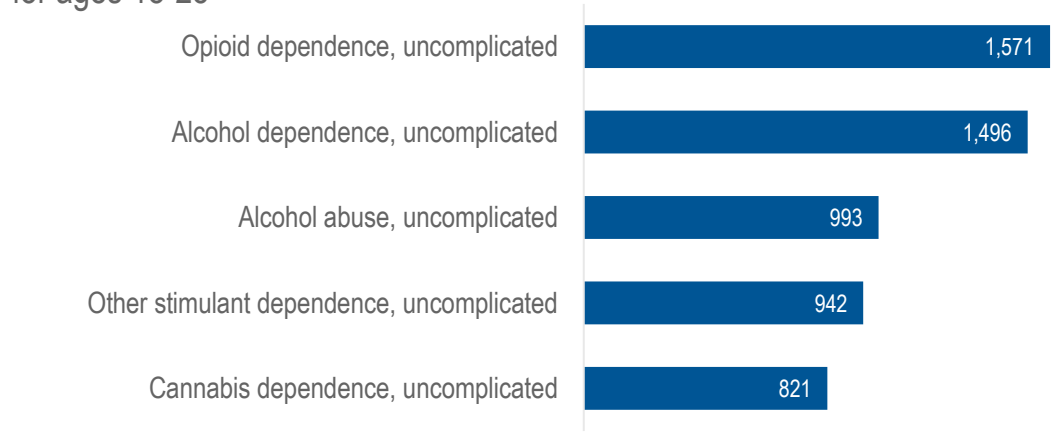
Figure 47. Top substance use disorder diagnoses in 2022 for ages 10-17



Source: Decision Support and Surveillance Utilization Review System (DDSURS)/ Medicaid Management Information System (MMIS)

The top substance use disorder diagnoses of youth, ages 10-17, in 2022 were: cannabis dependence, uncomplicated (833); cannabis abuse, uncomplicated (512); alcohol dependence, uncomplicated (217); alcohol abuse, uncomplicated (194); and cannabis use, unspecified, uncomplicated (130). Note that individuals could have multiple claims with one or more substance use disorder diagnosis and thus numbers are not unique individuals.

Figure 48. Top substance use disorder diagnoses in 2022 for ages 18-25



Source: Decision Support and Surveillance Utilization Review System (DDSURS)/ Medicaid Management Information System (MMIS)

The top substance use disorder diagnoses of young adults, ages 18-25, in 2022 were: opioid dependence, uncomplicated (1,571); alcohol dependence, uncomplicated (1,496); alcohol abuse, uncomplicated (993); other stimulant dependence, uncomplicated (942); and cannabis dependence, uncomplicated (821). Note that individuals could have multiple claims with one or more substance use disorder diagnosis and thus numbers are not unique individuals.

Figure 49. Emergency Department **visits** for substance use disorder in 2022, for all Oregonians, by age group for 0-25

Most visits by ages 18-25, followed by 14-17, and 10-13

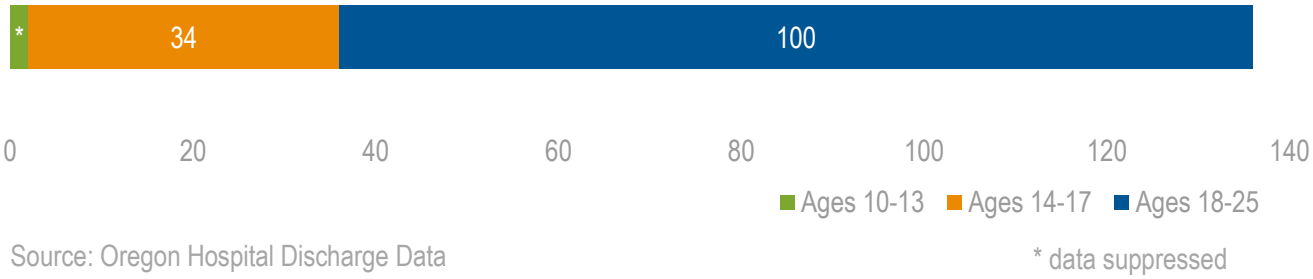
Total = 3,102

Emergency department visits for youth, ages 0-25, with substance use disorder in 2021 totals 918. Of those, 786 were young adults, ages 18-25, 124 were youth, ages 14-17, and seven were children, ages 10-13.

Figure 50. Emergency Department **boarding 24+ hours** for substance use disorder in 2022, for all Oregonians, by age group for 0-25

Most visits by ages 18-25, followed by 14-17, and 10-13

Total =136



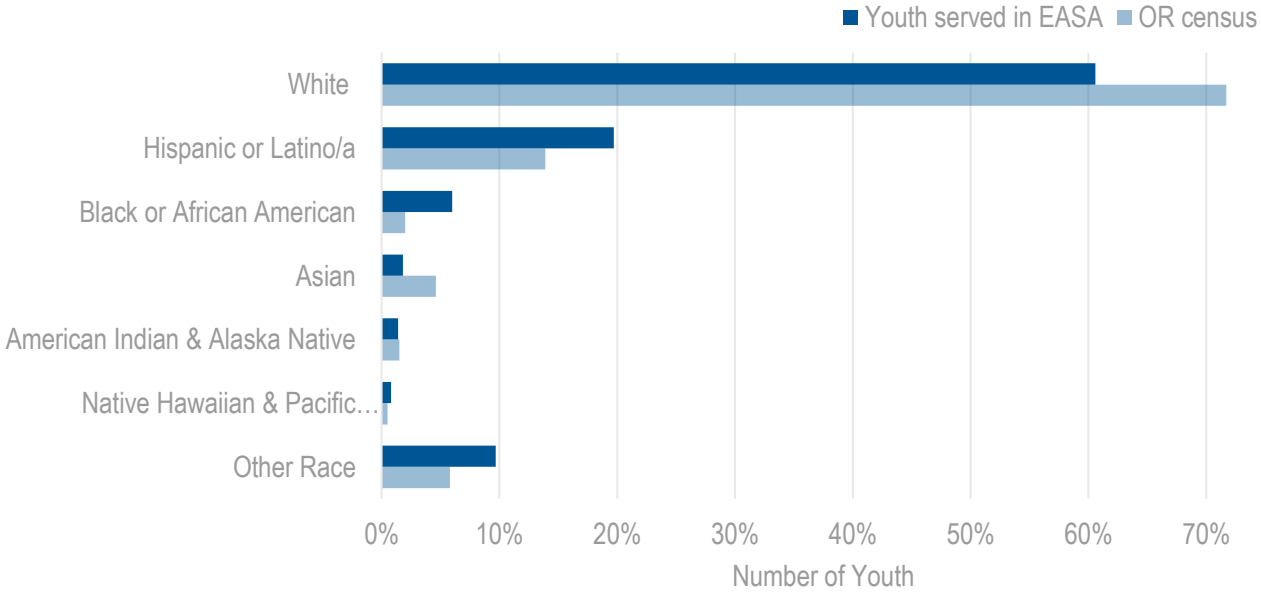
Emergency department boarding of 24+ hours for youth, ages 0-25, with substance use disorder in 2021 totals 134*. Of those, 100 were young adults, ages 18-25, 34 were youth, ages 14-17, and less than 5 were children, ages 10-13.

Early Psychosis and the Early Assessment and Support Alliance (EASA)

EASA is a statewide network of programs which identify youth, ages 12-25, with symptoms of psychosis as early as possible, and provide support and treatment based on current research. EASA serves people for up to two years. EASA teams include counselors, case managers, medical staff, occupational and supported employment/education specialists, and family education and mentorship.

There were 767 participants in EASA in 2022.

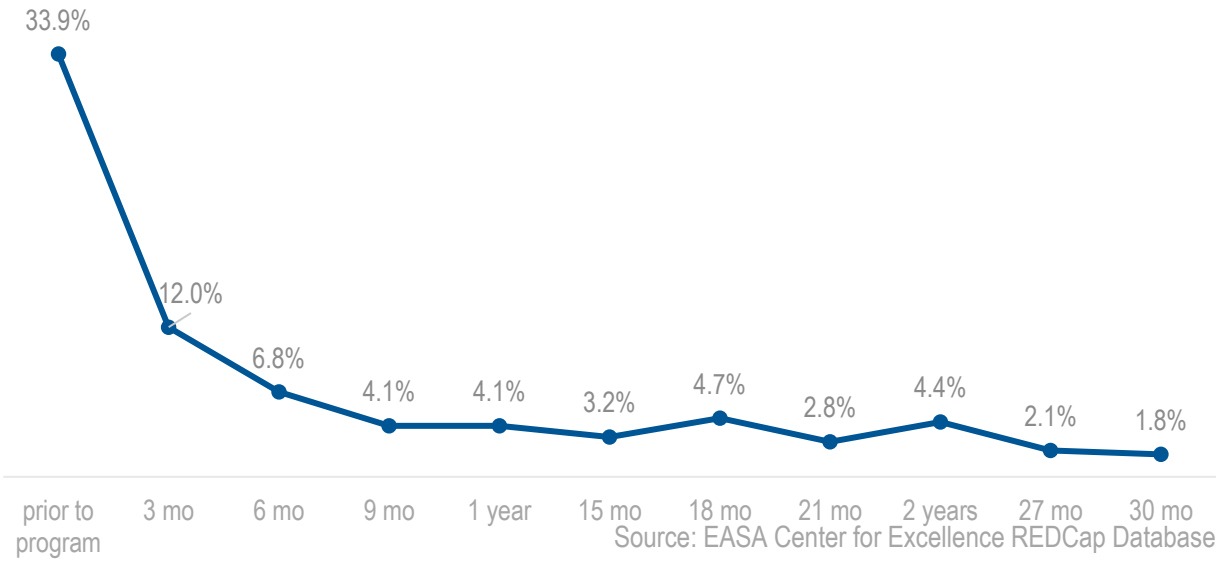
Figure 51. Percent of youth (ages 12-25) served by EASA in 2022 by race/ethnicity compared to 2020 census data



Source: EASA Center for Excellence REDCap Database

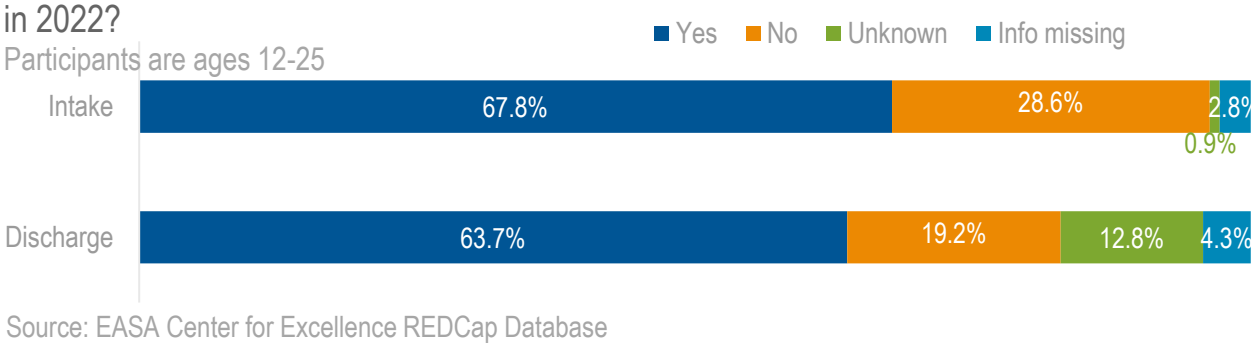
Youth, ages 12-25, participating in EASA in 2022 were overrepresented in some race categories and underrepresented in others when compared to 2020 census data. Hispanic or Latino/a was overrepresented by 5.8 percent, Black or African American by 4.0 percent, Native Hawaiian and Pacific Islander by 0.3 percent, and other race by 3.9 percent. White was underrepresented by 11.1 percent, Asians by 2.8 percent, and American Indians and Alaska Natives by 0.1 percent.

Figure 52. Percentage of participants admitted for psychiatric hospitalization by length of their participation in the EASA program in 2022



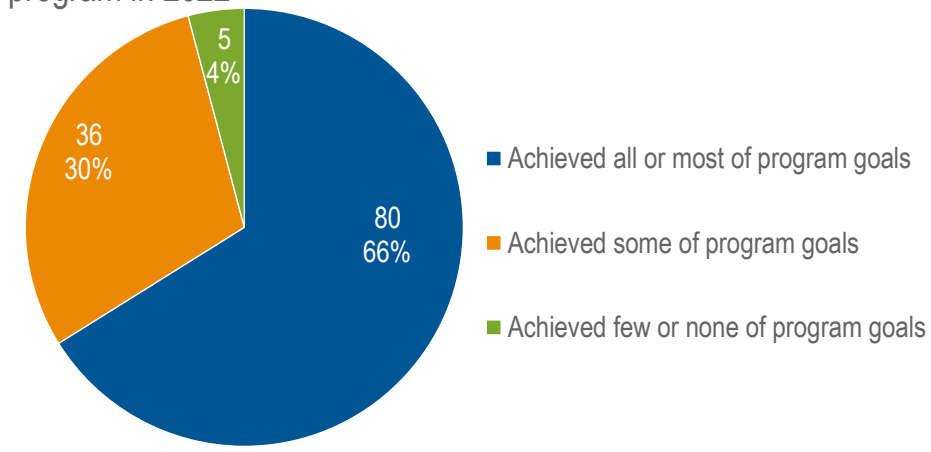
Hospitalization data from 2022 shows that the longer a participant is involved in the program, the less likely they are to report being admitted for psychiatric hospitalization in the previous three months.

Figure 53. Did youth participate in school or work in the previous 3 months in 2022?



In 2022, school or work participation in the previous three months decreased from intake to discharge, although 17.1 percent of participant data is unknown or missing.

Figure 54. 121 participants completed an EASA program in 2022

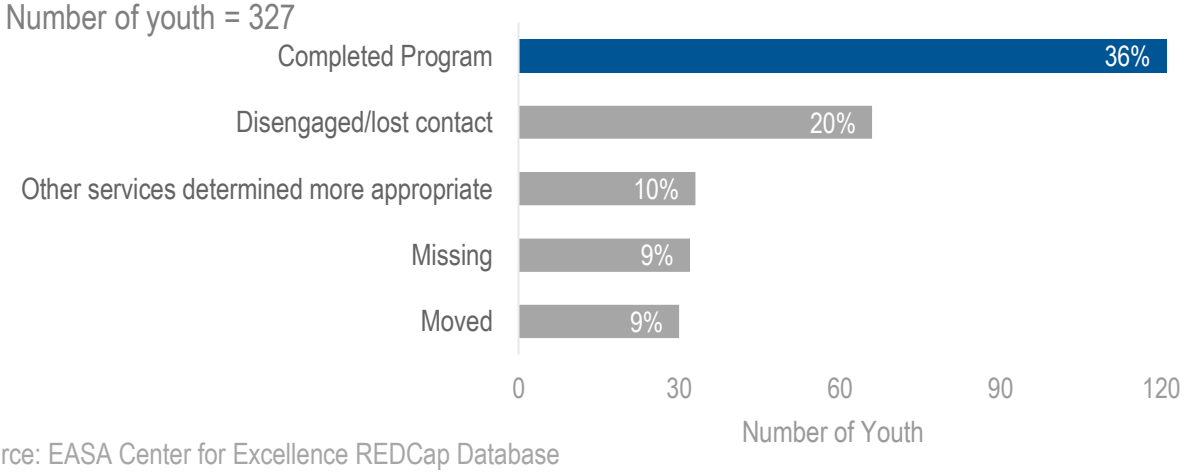


Source: EASA Center for Excellence REDCap Database

In 2022, 121 youth completed an EASA program, with 80 youth (66 percent) achieving all or most of the program goals, 36 youth (30 percent) achieving some of the program goals, and 5 youth (4 percent) achieving few or none of the program goals.

Figure 55. Top reason for discharge from EASA in 2022 is completing program

Number of youth = 327



Source: EASA Center for Excellence REDCap Database

The top reason for discharge from EASA in 2022 is completing the program (36 percent), with 24 percent achieving all or most goals, 11 percent achieving some goals, and 1 percent achieving few or none of the goals. Other reasons for discharge include the youth disengaged or contact was lost (20 percent), other services were determined more appropriate (10 percent), data is missing (9 percent), and youth moved (9 percent).

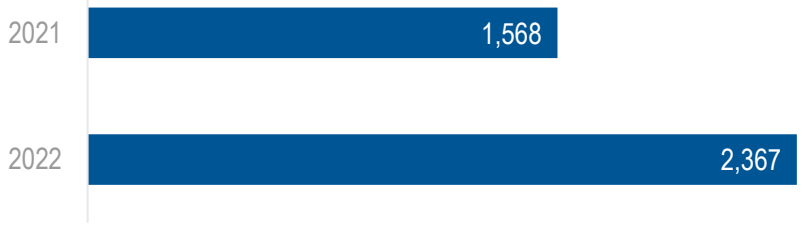
Fidelity Wraparound

Fidelity Wraparound is a voluntary and intensive care coordination model. It offers a unique set of community services and supports individualized for a youth and family to achieve positive outcomes. Fidelity Wraparound is available in every county in Oregon.

Wraparound is for children and youth ages 0-18 who experience complex mental health issues and are involved in mental health and one other system (e.g., foster care, special education, juvenile justice, intellectual/developmental disability programs), and are currently receiving Oregon Health Plan.

OHA collects data from the fidelity measurement tool called the Wraparound Fidelity Index (WFI-EZ). These data show the extent to which each program adheres to the fidelity model. At the end of 2020, data was transferred from the prior system, WrapTrack, into the current system, WrapStat. Wraparound programs began using WrapStat in 2021. For the first 6 to 9 months that WrapStat was being used, programs were focusing on data cleanup, thus the data is skewed somewhat for that year, showing longer lengths of time in Wraparound and higher discharge rates. Use of the data system is inconsistent across programs, with some being diligent in their data collection, and others not using the system at all.

Figure 56. Number of Youth in Wraparound in 2022



Source: WrapStat database, University of Washington

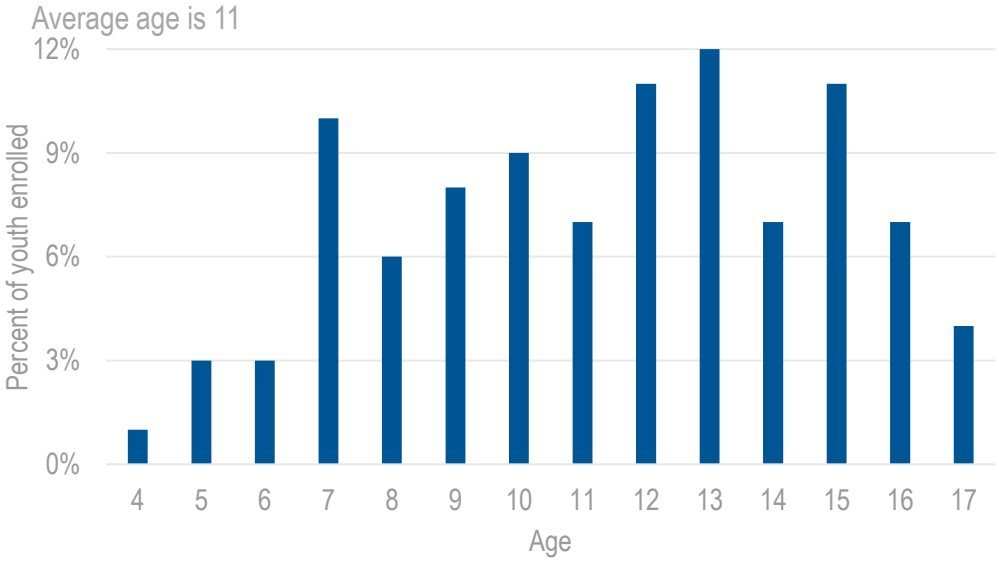
The number of youth in Wraparound was 1,568 in 2021 and 2,367 in 2022.

Figure 57. Average length of stay in Wraparound in 2022, in days

Source: WrapStat database, University of Washington

The average length of stay for participants in Wraparound was 484 days in 2021 and 407 days in 2022.

Figure 58. Age at enrollment for youth in Wraparound, Oct-Dec 2022

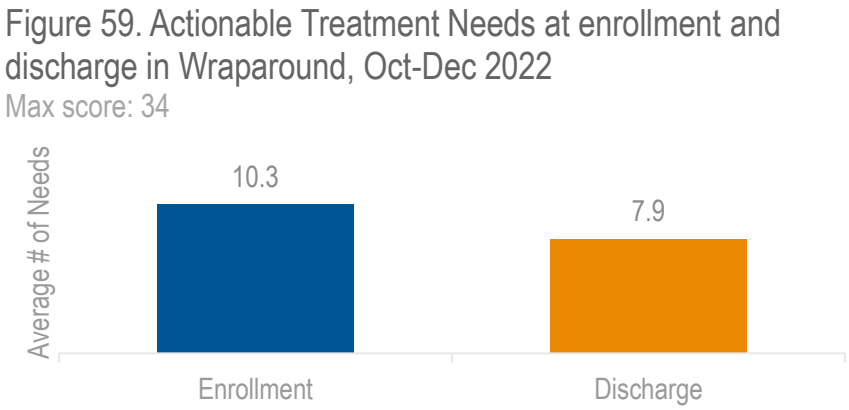


Source: OHSU DAETA REDCap Database

The age of enrollment for youth in Wraparound in 2022 ranged from 4 to 17, with the average age being 11.

As of 2022, OHA collaborated with the Oregon Health & Science University to develop a database for the Child and Adolescent Needs (CANS) tool. The CANS tool is used to identify the strengths and needs of the youth and family as a means of measuring needs and strengths over time and assessing the efficacy of the Wraparound care planning process (Lyons et al., 1999). The CANS Statewide Data Report includes the 206 youth ages 6-20 who have a completed enrollment and discharge Child and Adolescent Needs and Strengths assessment (CANS) in REDCap which equals 206 youth. The report includes all data entered before December 31, 2022.

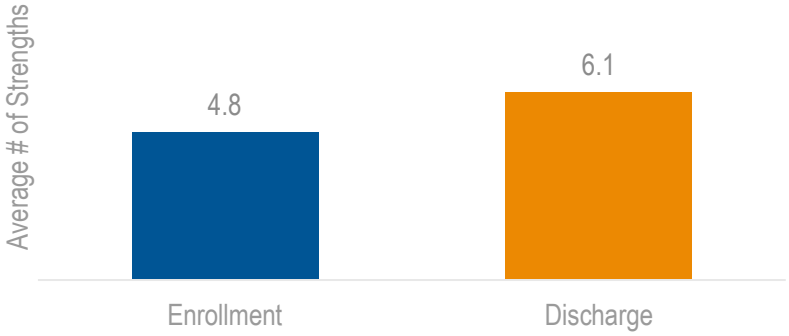
Figure 59. Actionable Treatment Needs at enrollment and discharge in Wraparound, Oct-Dec 2022



Source: OHSU DAETA REDCap Database

The actionable treatment needs for youth in Wraparound in October – December 2022 decreased between enrollment and discharge, from 10.3 to 7.9, out of a total maximum score of 34. A rating of 2 or 3 on CANS needs-based domains (Youth Risk Behaviors, Life Functioning, Behavioral/Emotional Needs) classifies the item as an actionable treatment need. A rating of 0 or 1 indicates that there is no known treatment need. There are 34 total needs-based items. Overall, youth had an average of 2.4 fewer actionable treatment needs at discharge compared to enrollment.

Figure 60. Identified Strengths at enrollment and discharge in Wraparound, Oct-Dec 2022
Max score: 11



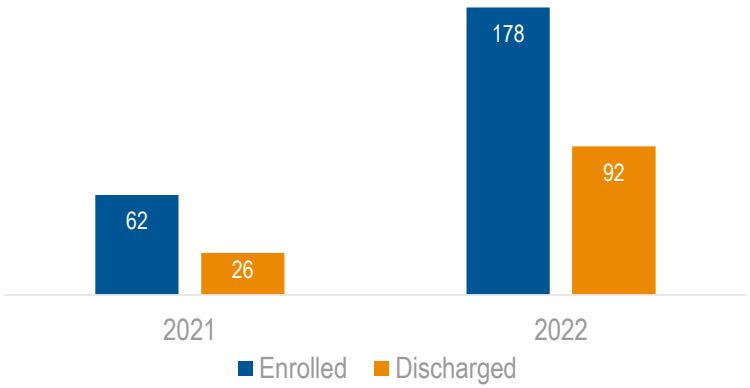
Source: OHSU DAETA REDCap Database

The identified strengths for youth in Wraparound in October – December 2022 increased between enrollment and discharge, from 4.8 to 6.1 out of a total maximum score of 11. For the strengths domain, a rating of 0 or 1 indicates a centerpiece strength. A rating of 2 or 3 suggests that the strength is not currently present and/or needs development. There are 11 total strengths-based items. On average, youth had an increase of 1.3 identified strengths through the course of treatment.

Intensive In-Home Behavioral Health Treatment (IIBHT)

The 2019 Oregon Legislature approved $6.6 million in general funds to expand the existing continuum of care for children. This expansion includes an intensive community-based alternative to residential treatment and inpatient hospitalization called Intensive In-Home Behavioral Health Treatment which is available to children through age 20. Services include psychiatric services, mental health therapy, care coordination, skills training, peer support services, and 24/7 proactive and crisis response to the home. Children can access IIBHT while living in foster care, group homes, shelter care and behavior rehabilitation services while preserving their existing placement in the community. It is also available to children with intellectual and developmental disabilities. Enrollment in IIBHT is not time limited. Instead, enrollment is based on the individual needs of the child and their family. Most youth in IIBHT in 2022 were between the ages of 11 and 15, with an average age of 13.

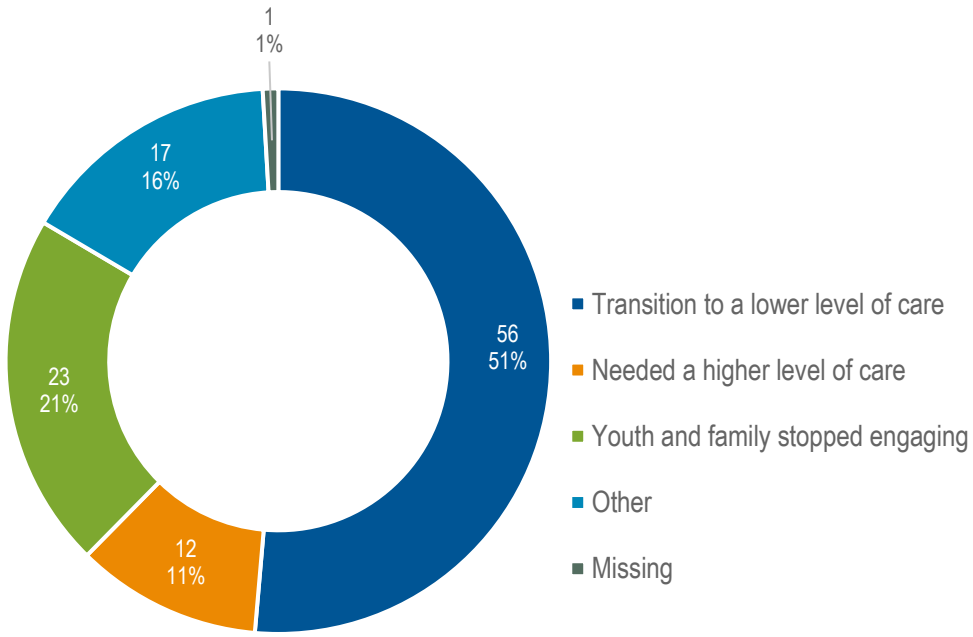
Figure 61. Number of youth enrolled and discharged in IIBHT by year



Source: OHSU DAETA REDCap Database

The number of youth enrolled and discharged in IIBHT in 2021 was 62 and 26, respectively. In 2022, the number of youth enrolled was 178 and the number of youth discharged was 92.

Figure 62. 51% of youth (ages 0-20) in IIBHT in 2022 transitioned to a lower level of care

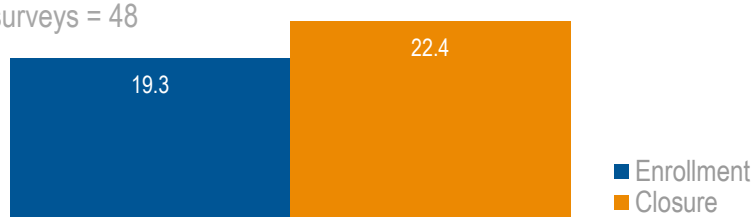


Source: OHSU DAETA REDCap Database

Over half (51 percent) of youth, ages 0-20, in Intensive In-Home Behavioral Health Treatment (IIBHT) in 2022 transitioned to a lower level of care. Eleven percent needed a higher level of care, 21 percent stopped engaging in services, 16 percent are for other reasons, and 1 percent are missing data.

Figure 63. Hope scale pathways and agency scores **increase** from enrollment to closure

Higher scores indicate improvement
Total score range from 6-36
Number of youth surveys = 48



Source: OHSU DAETA REDCap Database

The Hope Scale is used to help measure hope in individuals aged 8 to 16. Research has linked hope with overall physical, social, and psychological wellbeing. Children who can identify a means to carry out goals (pathways) and the ability to initiate action towards goals (agency) are considered more hopeful. The Hope Scale is filled out by youth at enrollment and closure. The measure provides two sub-scores, Pathways and Agency, that range from 3-18 and a Total Hope Score that ranges from 6-36. Pathways represents a youth's perceived ability to make goals and create concrete steps to achieve them. Agency is a youth's confidence, motivation, and belief that they can follow Pathways to achieve their goals. Together, these two sub-scores provide a Total Hope Score, with higher scores indicating more hope (Snyder et al.1997). Both sub-scores and total score increased from enrollment to closure with average 2022 total score at enrollment being 19.3 and 22.4 at closure.

Expedited Assessment Services for Youth (EASY)

Youth at high risk of a need for temporary lodging[2] of potential ER visits, or of losing the availability of home and community care, need access to expedited evaluations for access to appropriate services and supports.

The average wait time for a comprehensive psychological evaluation can be as much as 3 months or longer. The wait time for interdisciplinary evaluations is one year and longer. During these wait times youth become at higher risk for losing their current living arrangement and face likelihood of moving out of their homes, schools and communities.

Locating and accessing psychologists with expertise regarding the screening requirements for Oregon Developmental Disabilities Services (ODDS) can be difficult. The EASY approach includes training to increase the number of psychologists capable of evaluating intellectual and developmental disability eligibility, and in increasing the available knowledge base in the community to recognize when emerging mental health, developmental or the overlay of both concerns are present.

EASY provides access within 7 to 10 days to comprehensive psychological evaluations with psychologists who can collaborate with intellectual and developmental disabilities workers and provide the necessary information for ODDS service eligibility to be determined.

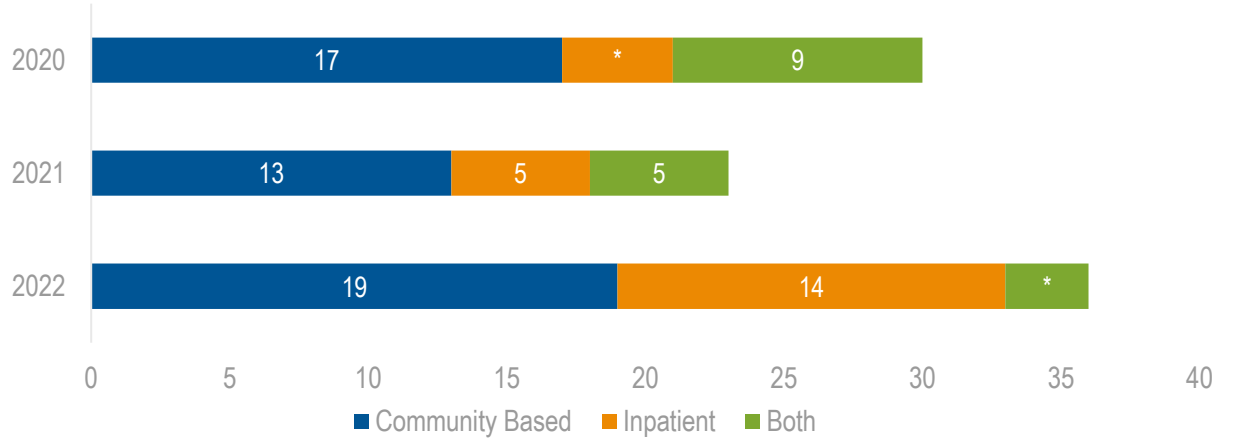
EASY services began in April 2023 and key performance indicators will be reported in future reports.

[2] Temporary lodging = youth in Child Welfare custody who do not have a placement and stay in hotels with Oregon Department of Human Services (ODHS) staff.

Restorative Services

For youth in Oregon's juvenile justice system, the Oregon Health Authority ensures that youth receive appropriate services to restore their mental health and be "fit to proceed" in court proceedings. To be "fit to proceed," a youth must be able to understand the nature of the court proceedings, assist and cooperate with the youth's attorney and participate in his or her own defense. Restorative services are 90-day service episodes provided in the youth's home community on an outpatient basis. Services include case management, skills training, and forensic evaluation every 90 days. Youth must continue restorative services until a judge decides that they are "fit to proceed" or "unlikely to become fit to proceed." Services can continue for up to three years or the maximum amount of time the youth would have been committed to a juvenile facility (whichever is shorter).

Figure 64. Level of care for youth in Restorative Services in 2022

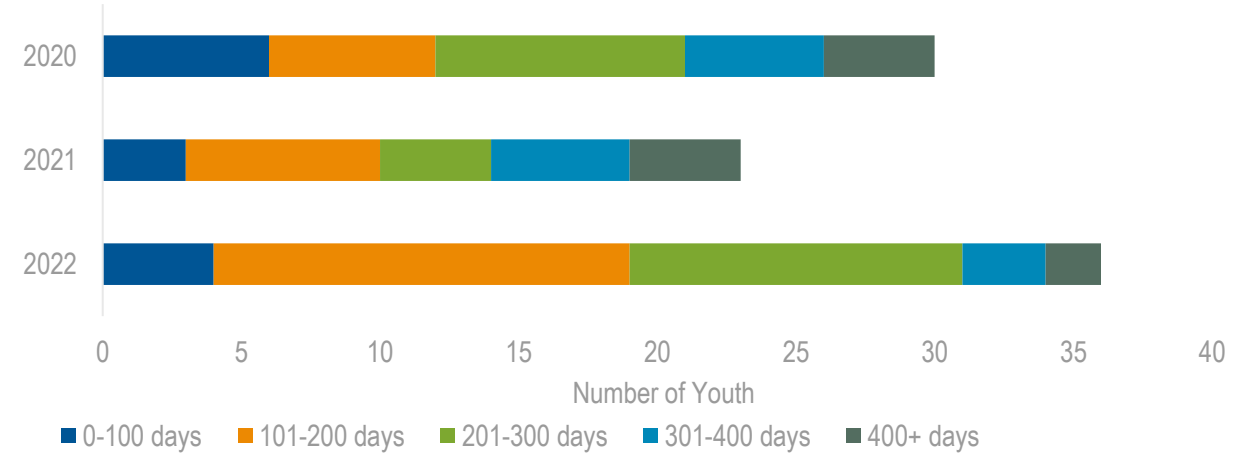


Source: Provider discharge summaries

* data suppressed

The level of care for youth in Restorative Services in 2022 was 19 youth in community-based services, 14 youth in inpatient services, and a small number (data suppressed under 5) in both services.

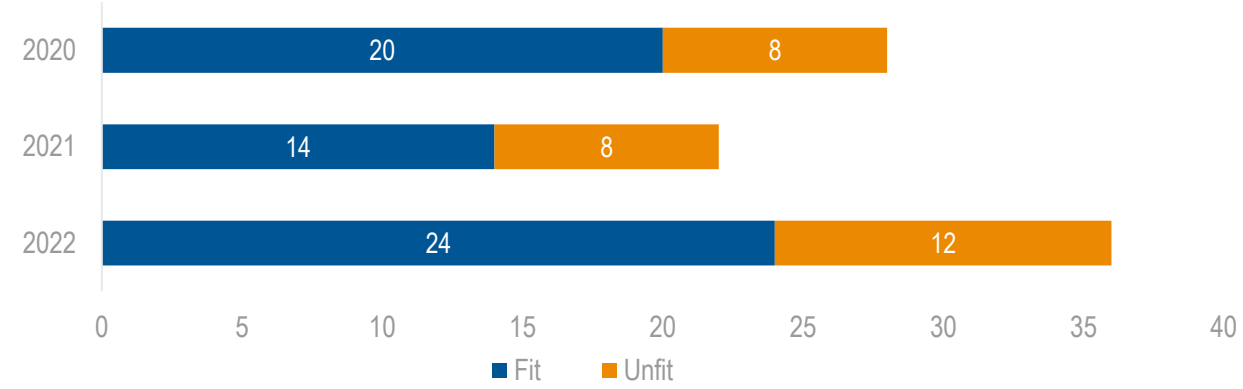
Figure 65. Length of stay for youth in Restorative Services in 2022



Source: Provider discharge summaries

The most common length of stay for youth in Restorative Services in 2022 was 101-200 days, followed by 201-300 days, 0-100 days, 301-400 days, and 400+ days.

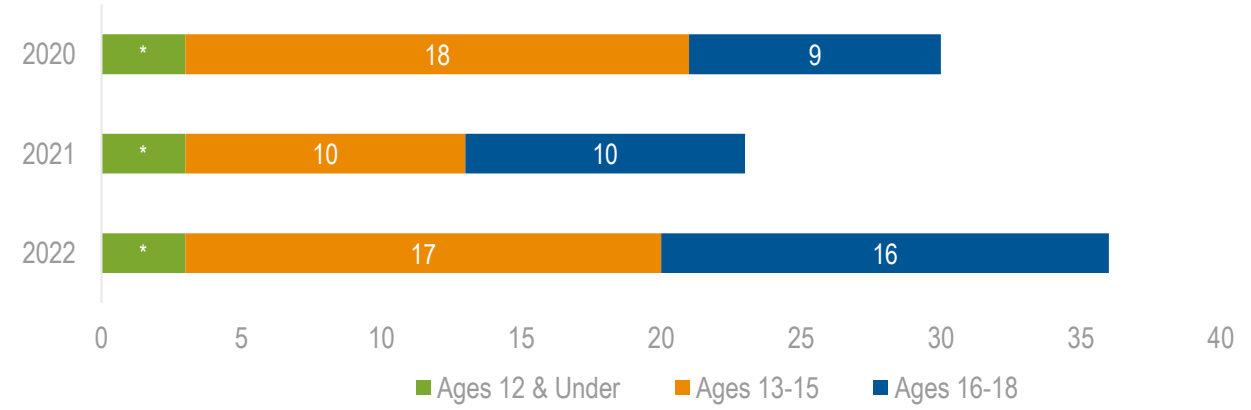
Figure 66. Outcome for youth in Restorative Services in 2022



Source: Provider discharge summaries

In 2022, 24 youth were found to be fit after Restorative Services, and 12 were identified to be unlikely to be found fit to proceed.

Figure 67. Ages of youth in Restorative Services in 2022



Source: Provider discharge summaries

* data suppressed

In 2022, there were 17 youth, ages 13-15, and 16 youth, ages 16-18, in Restorative Services.

Mobile Response and Stabilization Services (MRSS)

Mobile Response and Stabilization Services (MRSS) are developmentally appropriate crisis response services for children, youth, and young adults (through age 20) and the families or caregivers of children, youth and young adults. When someone calls 988 or their Community Mental Health Program (CMHP) local crisis line, a crisis counselor will link them to MRSS if they need it. MRSS is available in each Oregon county. These services:

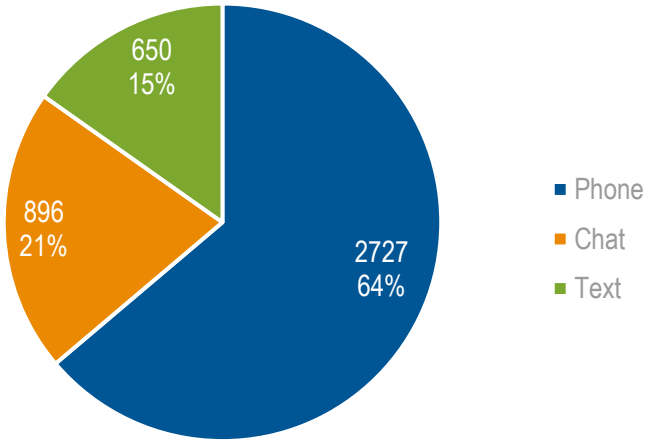
- Provide an in-person, face-to-face crisis response to the youth or family.
- Connect youth and their families to rapid behavioral health supports at home and in their communities.
- Help de-escalate situations.
- Prevent unnecessary trips to emergency departments and interactions with law enforcement.

MRSS began in January 2023 and key performance indicators will be included in future reports.

988 Call Centers

The 988 Suicide and Crisis Lifeline is available 24/7. The Lifeline is for people in any type of behavioral health crisis, such as mental health-related distress, thoughts of suicide or self-harm, or substance use crisis. People can get help by calling 988, texting 988 or chatting online at 988lifeline.org. The Lifeline answers calls in English or Spanish, with interpretation services for more than 250 languages. Text and online chat are in English only. The Lifeline can also help people who worry that their loved may be in crisis. The 988 Suicide & Crisis Lifeline connects people to trained crisis counselors who offer compassion, care, and support. They also connect people with the right kind of help, from the right type of helper, including Mobile Response and Stabilization Services (MRSS) for ages 0-20. The 988 Suicide and Crisis Lifeline transitioned from the National Suicide Prevention Lifeline in Summer 2022. Calls to the Oregon's 988 Suicide and Crisis Lifeline increased by about 30 percent from July – December 2022.

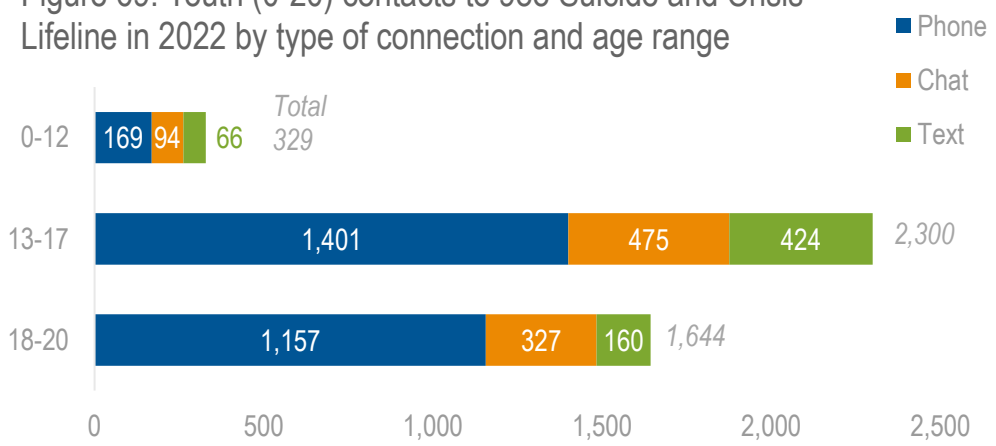
Figure 68. Youth (0-20) contacts to 988 Suicide and Crisis Lifeline in 2022 by type of connection



Source: Oregon 988 Call Centers – Lines for Life and Northwest Human Services

In 2022, youth, ages 0-20, made contacts to 988 that were 64 percent by phone, 21 percent by chat and 15 percent by text.

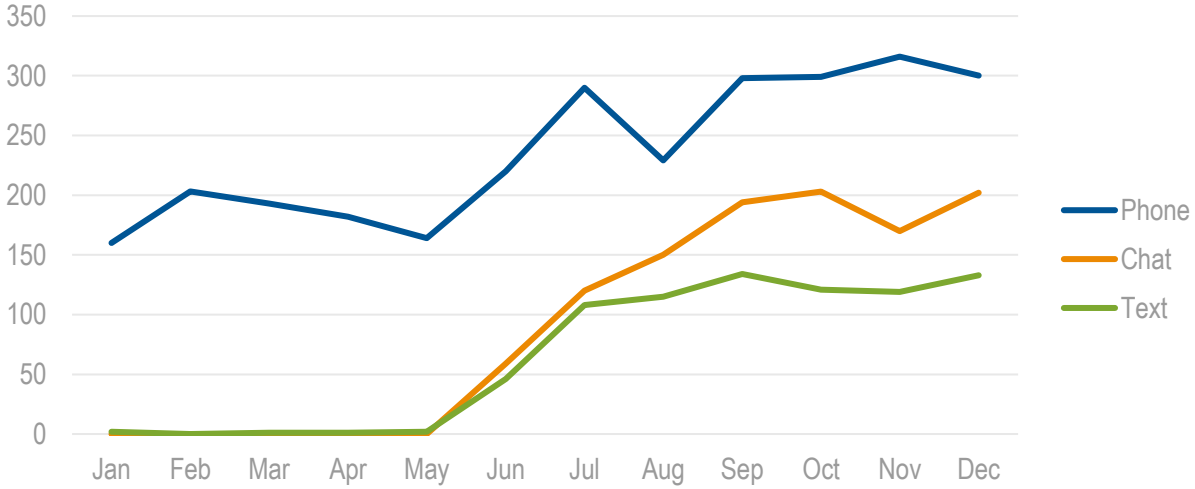
Figure 69. Youth (0-20) contacts to 988 Suicide and Crisis Lifeline in 2022 by type of connection and age range



Source: Oregon 988 Call Centers – Lines for Life and Northwest Human Services

In 2022, contacts to 988 totaled 329 for children, ages 0-12, 2,300 for youth, ages 13-17, and 1,644 for young adults, ages 18-20.

Figure 70. Youth (0-20) contacts to 988 Suicide and Crisis Lifeline in 2022 by type



Source: Oregon 988 Call Centers – Lines for Life and Northwest Human Services

In 2022, youth, ages 0-20, contacted 988 the most by phone. Chat and text increased dramatically in July with the launch of 988. Chat was unavailable before July 2022.

Figure 71. Type of response for 988 Suicide and Crisis Lifeline contacts in 2022

Type of response	Chat	Phone	Text	Total	Percent of contacts
No in-person response	856	2,618	631	4,105	96.07%
Emergency Medical Services	40	97	19	156	3.65%
Mobile Crisis Team		12		12	0.28%
Total	896	2,727	650	4,273	100%

Source: Oregon 988 Call Centers – Lines for Life and Northwest Human Services

Among 988 contacts regarding youth, ages 0-20, in 2022, 96.07 percent had no in-person response. Emergency Medical Services were dispatched to 3.65 percent of the contacts and Mobile Crisis Teams to 0.28 percent of the contacts. Of 988 contacts regarding youth, ages 0-20, in 2022, 3.93 percent received an in-person response.

Figure 72. Referral Source for 988 Suicide Prevention Lifeline contacts in 2022

Referral source	Count	Percent of contacts
Mental Health Services	263	6.2%
Peer Support Services	198	4.6%
Benefits, Self-Sufficiency, Insurance, Public Assistance	46	1.1%
Cross System/Multi System Referral-Child Welfare, Juvenile Justice, School	5	0.1%
Psychiatry	5	0.1%
Other	274	6.4%
No resources offered	3,482	81.5%
Total	4,273	100%

Source: Oregon 988 Call Centers – Lines for Life and Northwest Human Services

Among 988 Call Center contacts regarding youth, ages 0-20, in 2022, 6.2 percent were referred to mental health services, 4.6 percent to peer support services, 1.1 percent to benefits, self-sufficiency, insurance or public assistance; 0.1 percent to another system such as child welfare, juvenile justice, or education; 0.1 percent to psychiatry; 6.4 percent to other; and 81.5 percent were not offered a resource.

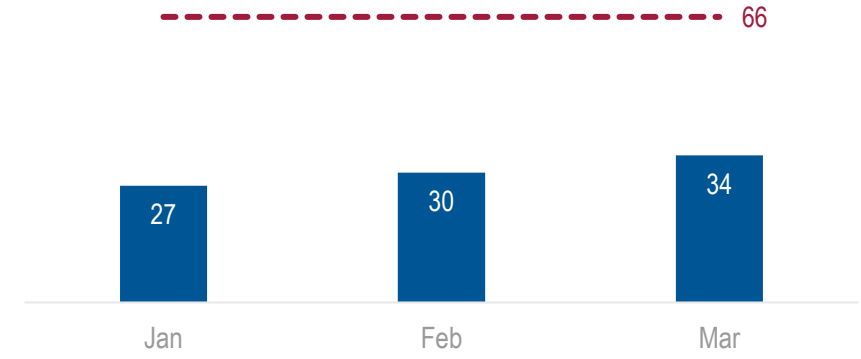
Substance Use Disorder Residential Treatment

Figure 72. Number of youth (ages 0-17 and 18-25) receiving substance use disorder **residential** treatment, by year

Source: Children's System of Care Data Dashboard, 2020-2022, Medicaid Management Information System (MMIS) data source

The number of youth, ages 0-25, who receive substance use disorder residential treatment decreased every year from 2020 to 2022. In every year, more young adults, ages 18-25, receive residential treatment than youth, ages 0-17. Young adults, ages 18-25, make up 83 percent of the youth in residential treatment in 2020, 87 percent in 2021, and 91 percent in 2022.

Figure 73. Substance use disorder residential treatment operational capacity compared to highest possible capacity in 2023



Source: PRTS provider capacity data

The operational capacity of substance use disorder residential treatment facilities for youth at the beginning of 2023 is about half of the highest possible capacity of 66. Data prior to 2023 is missing.

Intensive Psychiatric Residential Treatment Services (PRTS), Subacute Psychiatric Treatment, Secure Child/Adolescent Inpatient Psychiatric Treatment (SCIP/SAIP)

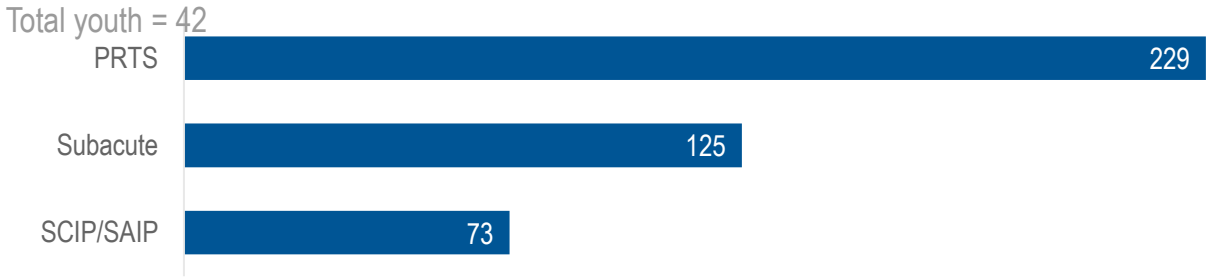
Oregon's children's system includes providers across the state that operate evidence based and trauma informed psychiatric residential treatment programs for children and youth with mental health conditions that cannot be safely treated in their home, school and community-based programs.

In Oregon, non-hospital treatment settings are known as psychiatric residential treatment services. These programs are generally less restrictive than a hospital setting. Intensive Psychiatric Residential Treatment Services (PRTS) treat children and adolescents who have less acute illnesses, but still require a residential environment for assessment and treatment. Youth receive care in 24-hour facilities where they live while receiving treatment. Active psychiatric treatment includes medication management, group therapy, and individual and family therapy.

Similar to residential treatment services, subacute psychiatric treatment is designed to be a short-term psychiatric assessment and stabilization service. It has more frequent access to child psychiatry and nursing.

Secure Child/Adolescent Inpatient Psychiatric Treatment (SCIP/SAIP) offers long-term psychiatric treatment services for children and adolescents. These non-hospital based, secure residential treatment programs are available to all Oregon youth who have not been able to benefit from any of the lower levels of care and need to be treated in a secure setting for an average length of stay of six to nine months.

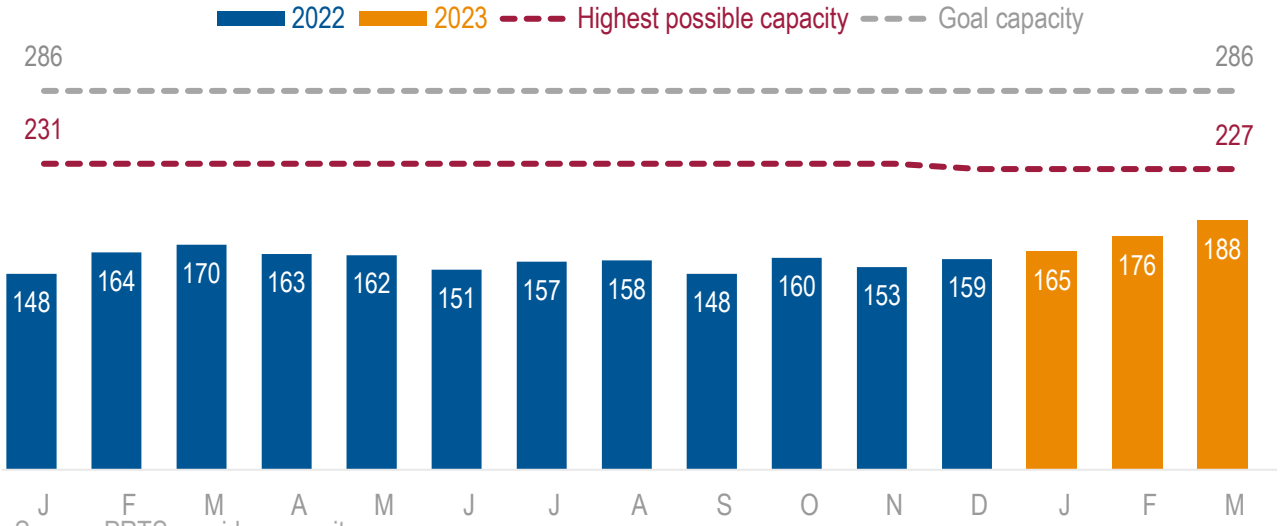
Figure 74. Youth (ages 0-25) receiving mental health in-patient services at Psychiatric Residential Treatment Services (PRTS), Subacute Psychiatric Treatment, and Secure Child/Adolescent Inpatient Psychiatric Treatment (SCIP/SAIP) in 2022



Source: Children's System of Care Data Dashboard, 2020-2022, Medicaid Management Information System (MMIS) data source

The number of youth, ages 0-25, receiving mental health inpatient services in 2022 was 427, with 229 youth in Psychiatric Residential Treatment Services (PRTS), 125 youth in subacute psychiatric treatment, and 73 youth in Secure Child/Adolescent Inpatient Psychiatric Treatment (SCIP/SAIP).

Figure 75. Psychiatric Residential Treatment Services (PRTS) operational capacity compared to highest possible capacity and goal capacity for 2022 and 2023

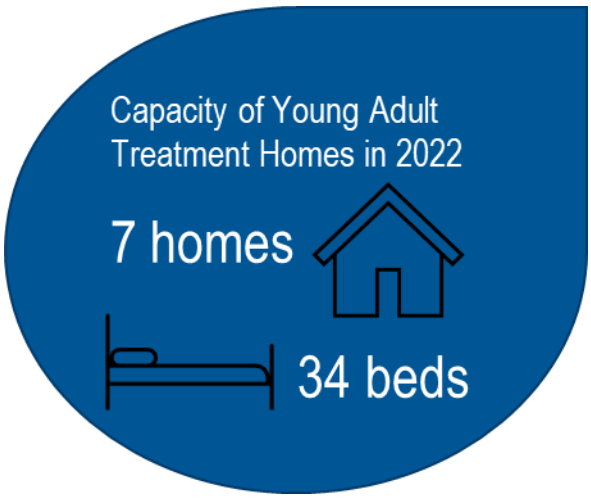


Source: PRTS provider capacity

The operational capacity of Psychiatric Residential Treatment Services (PRTS) facilities is lower than the highest possible capacity in 2021, 2022, and 2023 thus far. In addition, goal capacity is above the highest possible capacity, with not enough services available and youth waiting for treatment. Operational capacity of PRTS has increased for each month of 2023.

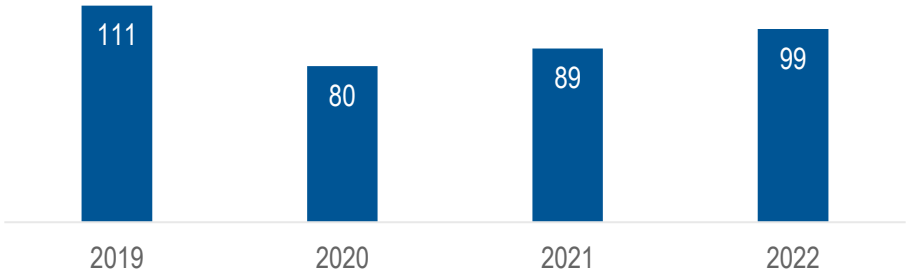
Young Adults in Transition (YAT) Residential Treatment homes (RTH)

Young Adults in Transition (YAT) Residential Treatment Homes (RTH) are for young adults, ages 17.5 to 25, who experience complex behavioral health challenges. YAT RTHs provide 24-hour supervision and support, focusing on helping residents develop the skills needed to manage their mental health symptoms and transition into adulthood. Services and supports include therapy and medication management, case management to connect to additional services as needed, and skill development.



The capacity of Young Adult Treatment homes in 2022 is seven homes, which provide 34 beds.

Figure 76. Number of youth referred to Young Adult Treatment Homes, by year



The number of youth referred to Young Adult Treatment (YAT) homes was 111 in 2019, 80 in 2020, 89 in 2021, and 99 in 2022. As of January 2023, the referral pathway for this program has changed; referrals go directly to YAT homes and not through the Child and Family Behavioral Health unit. This means that from this point the Child and Family Behavioral Health unit will no longer be able to track the number of youth referrals.

Appendix

List of Figures

National Key Performance Indicators

Oregon Key Performance Indicators

Promotion and Prevention

Crisis and Stabilization

Facility Based Treatment

Recovery and Stabilization

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