# DATA REPORT ON THE OREGON SYSTEM OF CARE FOR YOUTH

DAETA
Data, Evaluation & Technical Assistance

OREGON HEALTH & SCIENCE UNIVERSITY

APRIL 22, 2025

Suggested Citation: Ribbers A., Moosavi M., Magers J., Marshall R. Data Report on the Oregon System of Care for Youth. Data, Evaluation & Technical Assistance Team, Oregon Health & Science University. April 22, 2025.

# EXECUTIVE SUMMARY

**System of care** (SOC) is a philosophy of cross-system collaboration that supports youth and families who have complex and significant behavioral and mental health and/or intellectual and developmental disability (I/DD) needs. In practice, an SOC is a coordinated network of services and supports for youth and families. The Oregon System of Care Advisory Council (SOCAC) makes recommendations about the SOC by developing and maintaining a strategic plan for the state SOC.

In 2024, SOCAC contracted with the Data, Evaluation, and Technical Assistance (DAETA) team of Oregon Health & Science University (OHSU) to prepare a data report on the Oregon SOC to guide SOCAC's Strategic Plan for 2026-2029. SOCAC identified the following overarching questions for the report:

- Who is being served within the system of care? Who is not?
- What is working within the system of care? What is not?
- How much money is being invested in the system of care? Where is it being allocated?

These overarching questions were branched into 76 individual queries. The DAETA team collaborated with every agency within the SOC, as well as other agencies and data sources, to answer these overarching and more granular questions. SOCAC participated in the development of the report and approved the final version.

To our knowledge, this report represents the first effort to gather data on the entire SOC in Oregon. Some of the questions asked could be answered, while some could not, for reasons discussed in the *Limitations* section. Overall, this report should be viewed as an *initial* assessment that provides important information, while pointing out additional data needs and data system improvements that will aid future assessments.

Importantly, while the questions asked by SOCAC are clear, relevant to the work of public-serving agencies and aligned with the public interest, answering these questions was not straightforward. Identifying what data existed, where it could be found, who to contact for access, how to obtain access and then obtaining it was complicated and laborious. The primary work of youth-serving agencies must be serving youth and families; however, our state must empower and support agencies to develop better mechanisms to collect, use and present data. **It is through effective and transparent monitoring and evaluation of the SOC that we can identify areas for improvement and implement needed changes**. For more specifics on data barriers that were encountered in this project, please see *Limitations*.

Summarized on the following pages are key points from this report that address SOCAC's overarching questions.

***Who is being served by the SOC? Who is not?***

The agencies included in the SOC include Oregon Health Authority (OHA), Oregon Department of Education (ODE), Office of Developmental Disability Services (ODDS), Child Welfare Division (CWD), Oregon Youth Authority (OYA) and Oregon's regional coordinated care organizations (CCOs).

Over 210,000 youth were served by the SOC between 2020 and 2023, not including ODE, which alone serves over 550,000 youth per year. Of those 210,000 youth, 83% received behavioral health services and supports; 11% received services and supports for I/DD; 12% were involved with child welfare; and 8% were involved with juvenile justice. Youth served by three or more systems accounted for less than 1% of total youth served by the SOC, or approximately 1,500 youth. Of these youth, 60% were served by behavioral health, child welfare and I/DD services, and 31% were served by behavioral health, child welfare and juvenile justice.

Characteristics of youth and families **being served** by the SOC include the following:

- Across all systems, most youth served are White and English speaking.
- Within the Department of Education, race and ethnicity are more similar to Oregon's general population than in any other system, with gender distribution being an almost equal number of males and females, with a small number categorized as "other."
- In the behavioral health system, there are higher proportions of American Indian / Alaska Native, Black / African American and White youth than in Oregon's general population, and fewer Asian and Hispanic/Latino youth.
- The I/DD system serves more older youth (15-24) than other systems, with an elevated proportion of males and higher proportions of American Indian / Alaska Native, Black / African American and White youth than in the general population.
- The child welfare system serves younger youth (under age 9) than other systems. There are disproportionate numbers of Native American / Alaska Native and Black / African American youth throughout the system relative to the general population.
- Within the juvenile justice system, there are higher proportions of males than females and older youth (15-19) being served. Native American / Alaska Native and Black / African American youth are overrepresented.
- Youth served by the SOC have high behavioral health needs. Among high school students, 24-38% report depressive symptoms. In the Oregon Youth Authority, 57% of youth have a mental health diagnosis, 95% have a trauma history and 89% have a substance use history.
- Among youth with Medicaid and the Children's Health Insurance Program (CHIP), there are high rates of poverty, parental incarceration and substance use disorder.
- Youth have complex health needs compared to the U.S., but Oregon medical care reaches the majority: from 2020-2022, an average of 84% of youth and 93% of youth with disabilities with at least two limitations had at least one visit with a PCP.
- Most pregnant mothers receive prenatal and postpartum care.

This report also identifies those **not being served** by the system of care:

- While Oregon high school graduation rates are lower than national average (80% from 2019-2023), rates are even lower for some groups: fewer than 70% of American Indian /

Alaska Native students, students experiencing poverty, students with disabilities, English learners and homeless students graduated. The lowest graduation rates are among foster youth (less than 50%) and currently or formerly incarcerated youth (36%).

- In national rankings based on survey data and surveys of high school students, youth with behavioral health needs have high levels of unmet need. American Indian / Native American students and LGBTQ+ students are the most likely to have unmet need. Youth and family report that youth with complex behavioral health needs often struggle to obtain adequate behavioral health care.
- Youth in rural areas experience more limited access to services than those in urban areas; this includes behavioral health, special education and other services relying on specialized workforces, as well as decreased access to high-speed broadband internet.
- Disproportionately high rates of Native American / Alaska Native and Black / African American youth in the child welfare and juvenile justice systems suggest that upstream prevention and treatment efforts are not adequately serving these youth and families.

***What is working within the SOC? What is not?***

The Oregon SOC's strengths are highlighted throughout this report. Areas where the SOC is **working best** include the following:

*Early childhood and other early intervention programs.* The Oregon Health Authority (OHA) supports a number of early childhood mental health programs and resources, as well as early intervention services. Many of these services and supports are covered by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), which provides comprehensive health care coverage (including medical, vision, dental and behavioral health) for youth with OHP.

*State efforts in youth suicide prevention.* In 2016, OHA began organizing statewide efforts in youth suicide prevention, guided by two consecutive five-year Youth Suicide Intervention and Prevention Plans (YSIPP). These efforts were critical, given increases in Oregon youth suicide rates every year from 2011 to 2018. Since 2018, the total annual number of youth who died by suicide has decreased. Importantly, however, the majority of this decrease has been among White and Hispanic/Latino youth, with either no change or increases among all other racial and ethnic groups; the state recognizes this as a crucial area for improvement. The OHA youth suicide program actively works in schools and communities in prevention and postvention.

*Community-based services for youth with behavioral health crises.* OHA has introduced several statewide programs to address youth behavioral health crises in the community, including Intensive In-Home Behavioral Health Treatment (IIBHT), Mobile Crisis Intervention Services (MCIS) and Mobile Response and Stabilization Services (MRSS). While these programs are still in the early stages of development and have been limited by workforce shortages, they are based on national best practice models and are important additions to the SOC.

*Certified school-based health centers (SBHCs).* There are 87 SBHCs around the state, where youth can obtain medical care, behavioral health services and, often, dental services. These centers reduce barriers that keep parents and students from seeking health services.

*Educational and support services for youth and families*. Oregon has many different agencies and organizations that offer formal or informal supports to youth and families. These include programs run by cities, peer-run youth drop-in centers and organizations offering specific education and support for parents or caregivers.

*Innovative pilots addressing specific high-needs populations*. Oregon Department of Human Services has introduced pilots to address high-needs youth and families in the child welfare system: the Response and Support Network (RSN) and Child Specific Caregiver Supports (CSCS). Both have successfully addressed areas of high needs and are being expanded.

There are many areas within the Oregon SOC where **improvements are needed**, including:

*Barriers experienced by youth and families to receiving needed services and supports*. Barriers are reported across the SOC, including barriers to youth receiving special education services in the education system; barriers to receiving behavioral health treatment, especially youth with I/DD; barriers to gaining access into the I/DD system; and barriers obtaining behavioral health services for youth in the child welfare system.

*Overall mental health needs and access for youth*. Oregon has among the nation's highest rates of youth with depression, substance use, suicidal ideation and deaths by suicide. These rates are reflected across all systems in which they are measured. Access to care and quality of care are variable based on diagnosis, region, insurance and other factors.

*The complexity and difficulty of navigating the SOC, with high rates of caregiver burnout*. Families and caregivers report that the SOC is difficult to navigate and appropriate services are difficult to access. Systems operate in silos, without clear pathways between them, and with poor communication and coordination; this results in multiple, repeated barriers to needed services and supports. Parents and caregivers report high degrees of stress and burnout, particularly for youth in the I/DD and behavioral health systems, as well as re-traumatization and diminished trust in the systems.

*High complexity youth in the child welfare system and ongoing experiences of trauma*. Oregon has higher rates of referrals, investigations and founded abuse claims than U.S. rates as a whole; rates for entry into foster care are similar. Youth in foster care in Oregon experience higher rates of maltreatment while in foster care than the national standard, across all racial groups.

*High rates of unsheltered homeless youth*. Oregon has the nation's highest rate of homeless youth who are unsheltered and the nation's highest rate of unsheltered families with children. This population has lower school attendance and graduation rates and is at high risk of victimization.

*High rates of chronic absenteeism, school dropouts and pushouts, and low graduation rates compared to the national average*. Dropout/pushout rates are particularly high among students in foster care, English learners, those with disabilities, and among American Indian / Alaska Natives, Black / African Americans, Native Hawaiian / Pacific Islanders and Hispanics/Latinos.

*Disproportionate Native American / Alaska Native and Black / African American representation in the juvenile justice system, as well as high rates of trauma and substance use*. Native American / Alaska Native and Black / African American youth are overrepresented throughout the system and at higher risk of placement in OYA facilities. High rates of trauma and substance use among youth

in the system suggest many missed opportunities for early intervention, treatment and prevention.

*Workforce shortages impact performance across all systems.* Oregon continues to face a statewide behavioral health provider shortage, particularly in Eastern Oregon and coastal areas. Non-licensed providers report high rates of burnout, low wages, administrative burden, lack of mentorship and support and absence of career growth opportunities.

### *How much money is being invested in the SOC? Where is it being allocated?*

Oregon has invested almost 25 billion dollars in the youth system of care for the 2023-2025 biennium. Data on these expenditures is detailed in the *System Funding* chapter of this report and summarized below. It should be noted that funding mechanisms in the SOC are complex, and a more in-depth audit is required to fully characterize and understand the flow of funding in the SOC, including CCO funding. The following is a preliminary overview:

Of the child-serving systems, ODE receives the most funding ($16.10 billion in 2023-2025), followed by OHA child-serving programs ($5.8 billion), ODDS ($5 billion), CWD ($1.59 billion) and OYA ($0.47 billion).

In addition to these investments, the state has recently partnered with CCOs to invest $25 million into expanding residential youth psychiatric treatment beds.

### *Using This Report*

This report was intended to be a useful reference tool to understand what is occurring across the Oregon SOC. It begins with a chapter on methods, which describes the process for developing the report as well as the report's limitations. The next section describes the population characteristics of the SOC, followed by a chapter about neighborhoods and communities. Subsequent chapters focus on the different systems in the SOC (education, physical health care, behavioral health care, developmental disability services, child welfare and juvenile justice). The final four chapters address topics overarching all systems: workforce, finance, family and youth experience and system readiness to change. The conclusion summarizes key points from the report and provides recommendations for future reports. Appendix A provides a county crosstab to enable comparison across different regional groupings in the state.

Throughout the document, questions are listed in blue boxes and answers to questions are presented below each set of questions. Appendix B outlines all the research questions and comments on any missing information. Finally, the Annotated Bibliography lists all sources and includes a brief description about each source.

This report is meant to aid in understanding and improving Oregon's SOC. While SOCAC commissioned the project, it is hoped that the report will also be a valuable resource for partners within and across the system of care, other government agencies, Oregon's legislature and members of the public.

# ACKNOWLEDGMENTS


## Oregon Health & Science University
## Data, Evaluation, and Technical Assistance Team

Director
Rebecca Marshall, M.D., M.P.H.

Research Project Manager
Amanda Ribbers, M.S.

Research Project Coordinator
Masooma Moosavi, M.P.H.

Family Engagement & Support Specialist
Julie Magers, B.A.

Contributors

Ilana Freeman, M.S.
Sophia Nguyen, M.S.

Lydia Maitland, B.S.
Matthew Weber, B.A.

Philip Nguyen, M.S.

## Oregon Health Authority
## System of Care Advisory Council

Executive Director
Anna Williams, M.S.W.

SOC Transformation Manager
Christy Hudson, M.S.W.

Research Analyst
Cody Welty, Ph.D.

Family & Youth Engagement Strategist
Joyleen Carter, M.P.H.

Operations Coordinator
Corinna Hazard

Contributing Subcommittees

Data Committee
Chair: Andrew Grover, M.P.H.

Youth Council
Chair: Jesus Nunez-Pineda

DEI Committee
Chair: Annette Majekodunmi, B.S.

We also would like to acknowledge the many individuals who contributed to the information presented in this report, including youth and families, agency leadership, SOCAC committee members and researchers. In addition to the individuals referenced above, we would like to specifically thank the following for their time and contributions:

Dawn Andersson
Shivani Arawal
Jill Baker, LSC
Tamara Bakewell, M.A.
Kamryn Berk, M.P.H.
Stephen Berry, M.S.
Alison Bort, J.D., Ph.D.
Alysia Cox, M.P.H.
Drew Docter, M.P.H.
Ryan Foley, M.S.
Sara Fox, B.A.
Brian Glass, Ph.D.
Mark Greenwald, M.A.
Hilary Harrison, B.A.
Jamie Huiett
Jessica Ickes, M.P.A.
Isabella Jacoby, M.S.
Ajit Jetmalani, M.D.
Monica Moran, M.S.
Abigail Ofstedahl, M.A.
Alisha Overstreet, M.S.
John Parsons
Jacque Serrano, LCSW
Lily Sintim, M.P.H.
Jason Slappe, B.A.
Paige Snow, M.P.H.
Jessica Stout, M.S., LPC
Dan Thoma, M.A.
Jason Wallin, M.S.

# Table of Contents

# INTRODUCTION

The Oregon System of Care Advisory Council (SOCAC) was established in 2019 as a central, impartial forum for statewide policy development, funding strategy recommendations and planning. The council's goal is to improve the effectiveness and efficacy of child-serving state agencies and the continuum of care that provides services to youth (ages 0-25).

SOCAC has partnered with Oregon Health & Science University's Data, Evaluation, and Technical Assistance (OHSU DAETA) team to research, summarize and evaluate data on the SOC. This is the first comprehensive assessment of its kind and will inform the development of the Council's 2026-2029 strategic plan. Past strategic plans have relied on limited data from disparate sources; SOCAC and OHSU hope that this report will provide a more complete picture of the functional strengths and weaknesses of the system of care. Three overarching questions guided the assessment:

Who is being served by the system of care?

Who is not?

What is working within the system of care?

What is not?

How much money is being invested in the system of care?

Where is it being allocated?

SOCAC conceptualized the aims and research questions for this project and contracted with the OHSU DAETA team to complete the assessment and author the enclosed report. SOCAC collaborated in interpreting data for the conclusions drawn in the report and both agencies approved the final version. OHSU is grateful for SOCAC's leadership.

# OVERVIEW OF THE SYSTEM OF CARE

A system of care (SOC) is defined as a coordinated network of services and supports for youth, characterized by individualized care; an array of services provided within the least restrictive environment possible; collaboration among system partners; full participation and partnerships with families and youth; coordination among agencies and programs; and cultural and linguistic responsiveness.[1] SOCAC defines youth served by the SOC as an individual 25 years of age or younger who has, or is at increased risk of developing, chronic behavioral, emotional, physical or developmental conditions and is under the supervision of or engaged with two or more systems within the SOC.

Oregon's SOC is based on a national best practices model. This model was developed for youth with complex physical health, behavioral health, educational, social and developmental needs. It aims to organize and connect agencies serving these youth and their families and to integrate care management across agencies and at multiple levels of care.

### *System of Care Agencies*

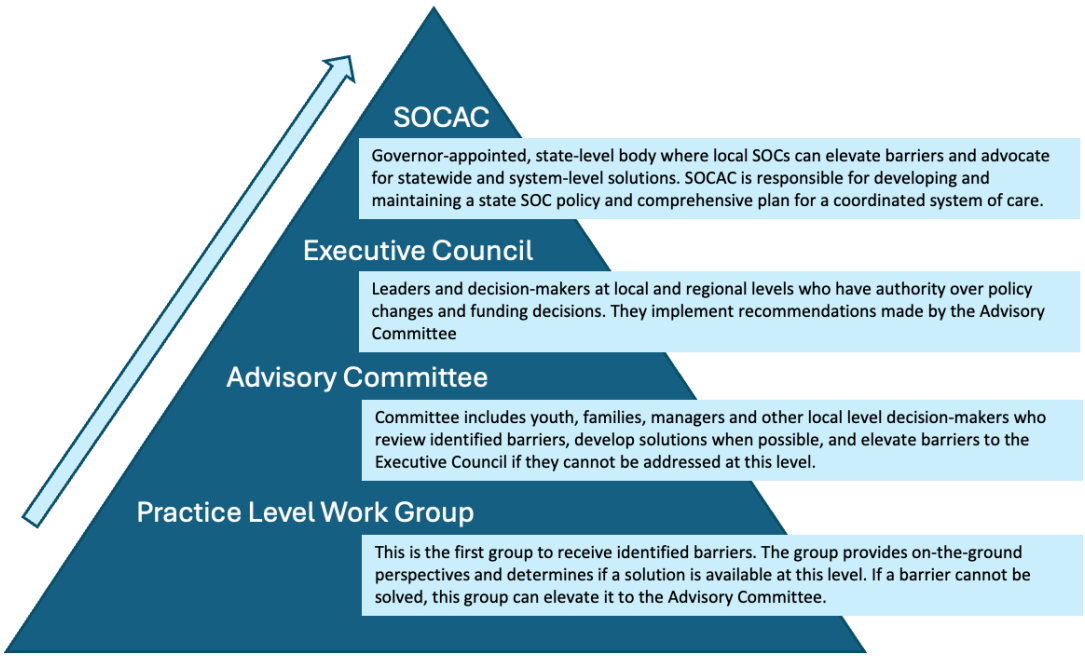
Senate Bill 1 (2019) and Senate Bill 4 (2021) require specific agencies to ensure that services and supports for youth and families are accessible, trauma-informed, coordinated and culturally responsive.[2,3] Agencies include Oregon Health Authority (OHA), Oregon Department of Education (ODE), Office of Developmental Disability Services (ODDS), Child Welfare Division (CWD), Oregon Youth Authority (OYA) and Oregon's regional coordinated care organizations (CCOs). ODDS and CWD are divisions within the Oregon Department of Human Services.

### *System of Care Governance*

In Oregon, the SOC is organized as 15 local system of care regions and one statewide group, called the System of Care Advisory Council (SOCAC) (Figure 1.1). Regional systems of care are required, via OHA's contracts with CCOs, to identify and resolve system barriers brought forth by youth, family members and providers. Barriers are any systemic challenge in accessing desired or needed services.

Each of the 15 SOCs has a Practice Level Work Group, Advisory Committee and Executive Council. Identified barriers advance along the reporting chain to the level most able to resolve them; barriers unable to be addressed at a local SOC are raised to SOCAC to address at the state level. The process to address SOC barriers is presented in Figure 1.1.

*Figure 1.1. Oregon System of Care governance structure*[4]




## METHODS

In early 2024, OHSU and SOCAC outlined the research questions that guide this assessment. This process began with collecting ideas from the SOCAC Data Committee, SOCAC Youth Council and system partner leadership. Individuals shared a number of metrics and indicators that would be helpful in evaluating the system of care. OHSU and SOCAC used these ideas to develop 76 measurable research questions, which were approved by the SOCAC Data Committee (Appendix B). The questions were grouped into 12 interrelated chapters that organize this report:

| | |
|---|---|
| Population Description | Child Welfare System |
| Neighborhood & Community | Juvenile Justice System |
| Education System | System Workforce |
| Physical Health Care System | System Funding |
| Behavioral Health Care System | Youth and Family Experience of the System |
| Intellectual and Developmental Disability Services System | System Readiness for Change |

OHSU gathered existing quantitative and qualitative data from a variety of sources (Table 1.1). Data was collected through extensive literature reviews, data requests and partnerships with SOC agencies. A full list of data sources can be found in the Annotated Bibliography. Data from these efforts is woven throughout the report to present a comprehensive picture of the SOC.

***Quantitative data*** is numerical information that is measurable using things like counts, averages and ratings. This type of data can be analyzed using statistical methods and is a structured and objective way of communicating information.

***Qualitative data*** is information that is more difficult to express with numbers and typically uses words and narratives. This type of data usually comes from open-ended surveys or interviews and can be more subjective than quantitative data. Qualitative data is helpful for contextualizing the "why."

While many of the research questions are answered, some questions were unable to be answered due to a lack of existing or accessible data, inability to connect data across different systems or constraints of the project timeline; these barriers are further discussed in the Limitations section of this report and listed in detail by question in Appendix B.

*Table 1.1. Types of information used in the assessment*

| Type of Data | Example Sources | Strengths and Limitations |
|---|---|---|
| Quantitative aggregate data *(not publicly available)* | Deidentified reports prepared by agencies and shared with the DAETA team | Provides a level of insight and detail that isn't shared with the public; easier to obtain than individual-level data |
| Quantitative aggregate data *(publicly available)* | Online data reports and dashboards | Accessible to the public; data may be difficult to use and may not answer our specific questions |
| Qualitative data | Focus group and feedback data | Helps contextualize the quantitative data and provide in-depth information about peoples' experiences; difficult to analyze and show statistical significance |
| Published literature *(publicly available)* | Academic studies, news articles, legislative reports, etc. | Findings and conclusions offer comparison and context using generalizable results from other regions |

### *Parent & Caregiver Survey*

In addition to relying on the data sources outlined above, OHSU surveyed parents and caregivers of youth for lived-experience perspectives on the SOC. OHSU, SOCAC members, youth and parents/caregivers with lived experience developed the survey. The survey was available in English, Spanish, Vietnamese and Chinese. Recruiting occurred via snowball sampling, with SOCAC leadership identifying initial respondents and additional participants being identified via word of mouth. A $20 incentive was offered to all respondents. Participants were also invited to provide more detailed information about their experiences through an informal interview with

OHSU or SOCAC staff for additional compensation. The results presented in the report represent 108 completed survey responses and 25 follow-up interviews.[5] Representation for individuals served by all systems in the SOC except juvenile justice was achieved (Table 1.2).

Qualitative data was analyzed using sentiment and thematic analysis in NVivo; quantitative frequency data was prepared in SPSS. Descriptive results of quantitative data, themes from qualitative data and direct quotes are shared throughout the report.

*Table 1.2 System represented in the parent/caregiver survey conducted by OHSU[5]*

| System | # of Responses |
|---|---|
| Behavioral health system | 54 |
| Child welfare system | 25 |
| Education system | 97 |
| Intellectual/developmental disabilities system | 59 |
| Juvenile justice system | <= 5 |
| Physical health system | 73 |

***Limitations***

While important questions were answered in this report, a number were either not answered or not answered fully, due to time constraints, access barriers or other data limitations. Unanswered questions and the reasons they were not answered are listed in Appendix B. Important data that was not included in this report, or not consistently included across systems, includes the following:

- Physical and behavioral health data for youth with private insurance, military insurance or no insurance
- Detailed CCO expenditures and outcomes, including itemized and overall expenditures, service availability, services delivered and rates of denials
- Behavioral health services provided in the primary care home
- Consistent cross-system data about demographic characteristics, behavioral health needs and services and medical complexity data
- Consistent age categories across systems. While SOCAC defines youth as under 26 years, other systems collect based on other age parameters, such as under 21 or under 18. In addition, national and state data outside of Oregon may use other age ranges (often 0-17 years) for youth, which makes it difficult to make cross-state comparisons.

Many of the limitations the DAETA team encountered in seeking SOC data were noted by agency staff to be chronic barriers. Inefficient data sharing processes, siloing of data, lack of centralized coordination and redundancy of different data systems and agencies all contributed to the limitations listed above. The section below details the problems and barriers that the OHSU team encountered.

Data sharing processes

This assessment process highlighted multiple problematic aspects of obtaining and using data across the children's SOC. These included:

- Unclear processes to obtain data, including lack of knowledge within agencies about what data they have and how to access it
- Insufficient administrative and analytic support staff to fulfill data requests
- Significant delays in response to data requests
- Data sharing requirements/processes that made requests unfeasible within the timeline for this assessment
- Limited pathways and mechanisms among parts of the SOC to enable tracking individual-level data across systems

Data silos

Each agency within the SOC in Oregon manages its own data, with different data collection, storage and evaluation processes. Counties also have individualized data management systems and processes. Across the state, dozens of different electronic medical records and data systems are used. As a result, there is no streamlined way to connect data across systems and answer questions about youth with cross-system involvement. Both OHA and SOCAC have developed data dashboards to monitor select data for individual systems; however, these dashboards offer static, selective summaries of data. They do not allow for flexible queries and analysis across systems and they are unable to track individuals across systems.

Lack of centralized decision-making and coordination

With a few exceptions, agencies independently determine data points and manage data processes and analyses. There is no centralized body tasked with developing a strategic vision for data collection, management and sharing across agencies. This results in many of the problems encountered in developing this report (i.e., key data points in one system may not be collected in other systems or may be collected using different age ranges or time frames) and impairs the state's ability to effectively track key metrics across systems. It also leads to redundant data efforts, with agency staff being required to enter the same data points into multiple data systems due to lack of coordination within and between agencies. This inefficiency impacts clinical, educational, case management and other important areas of work and contributes to staff burnout.

Redundancy of statewide data projects

Multiple groups have been tasked with data collection and evaluation for the children's SOC, within OHA and SOCAC as well as at educational institutions such as OHSU and Portland State University. Numerous consulting groups have assessed and reported on different parts of the SOC. These efforts are largely uncoordinated, limiting the potential impact of their findings.

Of note, the redundancy of numerous data groups and projects mirrors the SOC itself. There are over 80 different committees and councils related to the SOC. The establishment of SOCAC is an important step in allowing for increased efficiency and effectiveness of these different groups.

Please see the Conclusions chapter of this report for recommendations on future reports, as well as improving data processes within the SOC.

## ACRONYM LIST

| | |
|---|---|
| **ACES** | Adverse Childhood Experiences |
| **ACGME** | Accreditation Council for Graduate Medical Education |
| **APA** | American Psychological Association |
| **BCBA** | Board-certified Behavior Analysts |
| **BH** | Behavioral Health |
| **BIPOC** | Black, Indigenous, and People of Color |
| **BRS** | Behavior Residential Services |
| **B.S.N** | Bachelor of Science in Nursing |
| **BSN** | Behavior Support Need Score |
| **CADC** | Certified Alcohol and Drug Councilor |
| **CAHPS** | Consumer Assessment of Healthcare Providers and Systems |
| **CANS** | The Child and Adolescent Needs and Strengths Tool |
| **CCBCHs** | Certified Community Behavioral Health Clinics |
| **CCO** | Coordinated Care Organization |
| **CDC** | Centers for Disease Control and Prevention |
| **CDDPs** | Community Developmental Disabilities Programs |
| **CEN** | Children's Extraordinary Needs programs |
| **CHIP** | Children's Health Insurance Program |
| **CHSE** | Center for Health Systems Effectiveness |
| **CHW** | Community Health Workers |
| **CIIS** | Children's Intensive In-Home Services |
| **CIRT** | Critical Incident Review Team |
| **CLSS** | Culturally and Linguistically Specific Services |
| **CMHPs** | Community Mental Health Programs |
| **COA** | Certificate of Approval |
| **COD** | Co-occurring Disorders |
| **CPP** | Child-Parent Psychotherapy |
| **CPS** | Child Protective Services |
| **CPS** | Collaborative Problem Solving |
| **CSAC** | Children's System Advisory Council |
| **CSASL** | Culturally Specific After School Learning Program |
| **CSCS** | Child Specific Caregiver Supports |
| **CSHCN** | Children with Special Health Care Needs |
| **CTE** | Career and Technical Education |
| **CW/ CWD** | Child Welfare Division |
| **DOJ** | Department of Justice |
| **DSPs** | Direct Support Professionals |
| **EASA** | Early Assessment and Support Alliance |
| **EDs** | Emergency Departments |
| **EI/ECSE** | Early Intervention/Early Childhood Special Education Services |
| **EPSDT** | Early and Periodic Screening, Diagnostic, and Treatment |
| **ERDC** | Employment Related Day Care |
| **ESD** | Education Service Districts |
| **FAPE** | Free and Appropriate Public Education |
| **FCC** | Federal Communications Commission |
| **FQHC** | Federally Qualified Health Centers |
| **FRPL** | Free and Reduced-price Lunch Program |
| **GOBHI** | Greater Oregon Behavioral Health Inc. |
| **GSN** | General Support Need Score |
| **HPSA** | Health Professional Shortage Areas |
| **HUD** | U.S. Department of Housing and Urban Development |
| **I/DD** | Intellectual and Developmental Disabilities |
| **ICD** | Integrated Co-Occurring Disorder |
| **ICD-10** | International Classification of Diseases, Tenth Revision |
| **ICF-IDD** | Intermediate Care Facility for Individuals with Intellectual Disabilities |
| **ICWA** | Indian Child Welfare Act |

| | |
|---|---|
| **IDEA** | The Individuals with Disabilities Education Act |
| **IEPs** | Individualized Education Plans |
| **IIBHT** | Intensive In-Home Behavioral Health Treatment |
| **IOS** | Intensive Outpatient Services |
| **IOSS** | Intensive Outpatient Services and Supports |
| **ISP** | Individual Support Plan |
| **ISRS** | In-Home Safety and Reunification Services |
| **JJ** | Juvenile Justice |
| **JJIS** | Juvenile Justice Information System |
| **LAB** | Legislative Adopted Budget |
| **LCSW** | Licensed Clinical Social Worker |
| **LMFT** | Licensed Professional Marriage & Family Therapists |
| **LPC** | Licensed Professional Counselor |
| **MBPS** | Megabits per Second |
| **MCHB** | Maternal Child Health Bureau |
| **MCIT/ MCIS** | Mobile Crisis Intervention Team/Services |
| **MHA** | Mental Health America |
| **MHSIP** | Mental Health Statistics Improvement Program Survey |
| **MME** | Multilingual and Migrant Education |
| **MMIS** | Medicaid Management Information System |
| **MOTS** | Measures and Outcomes Tracking System |
| **MRSS** | Mobile Response and Stabilization Services |
| **MSN** | Medical Support Need Score |
| **NAMI** | National Alliance on Mental Illness |
| **NAV** | Personal Health Navigators |
| **NCES** | National Center for Education Statistics |
| **NCI** | National Core Indicators |
| **NHSC** | National Health Service Corps |
| **NEMT** | Nonemergent Medical Transport |
| **NIEER** | National Institute for Early Education Research |
| **NP** | Nurse Practitioner |
| **NSCH** | National Survey of Children's Health |
| **OBCC** | Oregon Behavioral Health Coordination Center |
| **OBHLRP** | Oregon Behavioral Health Loan Repayment Program |
| **OCCAP** | Oregon Council Child and Adolescent Psychiatry |
| **OCID** | The Oregon Child Integrated Dataset |
| **ODDS** | Oregon Department of Developmental Disabilities |
| **ODE** | Oregon Department of Education |
| **ODELC** | Oregon Department of Early Learning and Care |
| **ODHS** | Oregon Department of Human Services |
| **ODOT** | Oregon Department of Transportation |
| **OFSN** | Oregon Family Support Network |
| **OHA** | Oregon Health Authority |
| **OHP** | Oregon Health Plan |
| **OHSU** | Oregon Health & Science University |
| **OJJDP** | The Office of Juvenile Justice and Delinquency Prevention |
| **ONA** | Oregon Needs Assessment |
| **OPAL** | Oregon Psychiatric Access Line |
| **OPEC** | Oregon Parenting Education Collaborative |
| **OPIP** | The Oregon Pediatric Improvement Partnership |
| **OPK** | Oregon Pre-Kindergarten |
| **ORCAH** | Oregon Child Abuse Hotline |
| **OREGON ASK** | Oregon Afterschool and Summer for Kids Network |
| **ORRAI** | Office of Reporting, Research and Analytics |

| | |
|---|---|
| **OSBHA** | Oregon School-Based Health Alliance |
| **OYA** | Oregon Youth Authority |
| **PBs** | Performance-based Standards |
| **PBSP** | Positive Behavior Support Plan |
| **PCIT** | Parent-Child Interaction Therapy |
| **PCPCH** | Patient-Centered Primary Care Homes |
| **PCPs** | Primary Care Physicians |
| **PFA** | Preschool for All |
| **PHD** | Positive Human Development |
| **PMAD** | Perinatal Mood and Anxiety Disorders |
| **PMTO** | Parent Management Training, Oregon Model |
| **PNP** | Psychiatric Nurse Practitioner |
| **POINT** | Public Oregon Intercity Network |
| **PPD** | Postpartum Depression |
| **PRAMS** | Oregon Pregnancy Risk Assessment Monitoring System |
| **PRTF** | Psychiatric Residential Treatment Facility |
| **PSLF** | Public Service Loan Forgiveness |
| **PSRB** | Psychiatric Security Review Board |
| **PSS** | Peer Support Specialists |
| **PSWs** | Peer Support Workers |
| **PWS** | Peer Wellness Specialists |
| **QMHA** | Qualified Mental Health Associate |
| **QMHP** | Qualified Mental Health Professional |
| **QRTPs** | Qualified Residential Treatment Programs |
| **RCM** | Referral and Capacity Management |
| **REI** | Responsible Except for Insanity |
| **RSN** | Response and Support Network |
| **SAMHSA** | Substance Abuse and Mental Health Services Administration |
| **SRSI** | System Reform Support Instrument |
| **SSAGs** | Student Success Advisory Groups |
| **SSI** | Supplemental Security Income |
| **SAVE** | Suicide Assessment in Various Environments |
| **SBHCs** | School-based Health Centers |
| **SBIRT** | Screening Brief Intervention and Referral to Treatment |
| **SBMH** | School-Based Mental Health |
| **SCORP** | Statewide Recreation Outdoor Recreation Plan |
| **SDOH** | **Social Determinants of Health** |
| **SEED** | Student Educational Equity Development Survey |
| **SHS** | Student Health Survey |
| **SNAP** | Supplemental Nutrition Assistance Program |
| **SOC** | System of Care |
| **SOCAC** | System of Care Advisory Council |
| **SPRF** | Strengthening, Preserving and Reunifying Families |
| **STAR** | Substance Use Disorder Treatment and Recovery Loan Repayment Program |
| **STEM** | Science, Technology, Engineering, and Mathematics |
| **SUD** | Substance Use Disorder |
| **TANF** | Temporary Assistance for Needy Families |
| **THWs** | Traditional Health Workers |
| **VA** | Veteran's Affairs |
| **YSIPP** | Youth Suicide Intervention and Prevention Plans |
| **YSS** | Youth Services Survey |
| **YSSF** | Youth Services Survey for Families |

POPULATION DESCRIPTION

## CHAPTER INTRODUCTION

This chapter provides an overview of the population served by Oregon's youth-serving systems, including the education, behavioral health, intellectual and developmental disabilities (I/DD), child welfare and juvenile justice systems. Oregon and national population data are also included for comparison.

Data from a variety of sources was used to estimate population characteristics. There is not a standard way in which youth-serving agencies report population data, which leads to inexact comparisons across systems. The methods for data collection and aggregation differs across sources and generalizability to the entire population served is varied; see the Annotated Bibliography for a description of the time frames and populations analyzed by each source. **Broad estimates of population characteristics are presented here**; more detailed information can be found in the respective system chapters.

## KEY TAKEAWAYS

The education system serves the highest volume of youth among the youth-serving systems, followed by the behavioral health, I/DD, child welfare and juvenile justice systems. For youth accessing care through at least three systems (excluding education), the most common combination was behavioral health, I/DD and child welfare.

The SOC serves a wide range of youth ages, genders, races and ethnicities. One major disparity is the overrepresentation of Native American / Native Alaskan youth and Black / African American youth in the child welfare and juvenile justice systems. This observation in Oregon is consistent with national trends.

Oregon youth have higher prevalence rates of substance use disorders than the national average. Youth under the jurisdiction of the Oregon Youth Authority have markedly higher rates than the other systems and the general population.

Oregon has higher rates of trauma among youth than the national average. Youth in the child welfare system, under the jurisdiction of the Oregon Youth Authority, and in some behavioral health programs have much higher rates than the state average.

Oregon youth suicide death rates are consistently higher than the national average.

Youth in the juvenile justice system and under the authority of the Oregon Youth Authority experience high rates of poverty, housing instability and food insecurity.

**How many youth are being served by each system? How many youth are being served by more than one system?**

For the purposes of this report, system of care (SOC) involvement is defined as accessing services or supports through one or more of the following systems:

- **Education System:** Youth enrolled in K-12 education through the Oregon Department of Education (ODE).
- **Behavioral Health System:** Youth receiving mental health and/or substance use services through Medicaid.
- **Intellectual and Developmental Disabilities (I/DD) System:** Youth receiving services provided by the Oregon Department of Disability Services (ODDS).
- **Child Welfare System:** Youth in foster care and/or receiving in-home services through Child Welfare.
- **Juvenile Justice System:** Youth who have contact with the county juvenile justice system (both formal and informal dispositions) or the Oregon Youth Authority (OYA), except youth who have cases reviewed and closed without further action.

The SOC Data Dashboard provides a dynamic overview of the youth served by each of these systems, with the exception of ODE; this data is not included in the dashboard (data from ODE Student Enrollment Reports, which include data on all youth enrolled in public K-12 schools, is used instead).

From January 2020 to December 2023, the dashboard indicates that there were 210,138 unique individuals served; most of those were served by the behavioral health system, followed by the child welfare system, I/DD system and juvenile justice system (Figure 2.1).[6]

*Figure 2.1. Youth ages 0 to 25 served by the system of care, 2020-2023, from the System of Care Data Dashboard*[6]


Annual data from 2020 to 2023 shows an increase in the number of youth served by the behavioral health and I/DD systems and a decrease in the education and child welfare systems during that time; the juvenile justice system has experienced fluctuation in numbers of youth involved over time (Table 2.1). ODE has observed continuous declines in enrollment since the COVID-19 pandemic, which they partially attribute to an increase in homeschooling.[7]

Many youth are served by more than one system (Table 2.2). Youth in the I/DD system, child welfare system and juvenile justice system are more likely to also be receiving services from the behavioral health system than from any other systems. Some youth are served by three or more

agencies. From 2020-2023, there were 1,578 unique individuals served by three or more agencies; the annual totals are presented in Figure 2.2. For these youth, the most common cross-system involvement was among the behavioral health, child welfare and I/DD systems.[6]

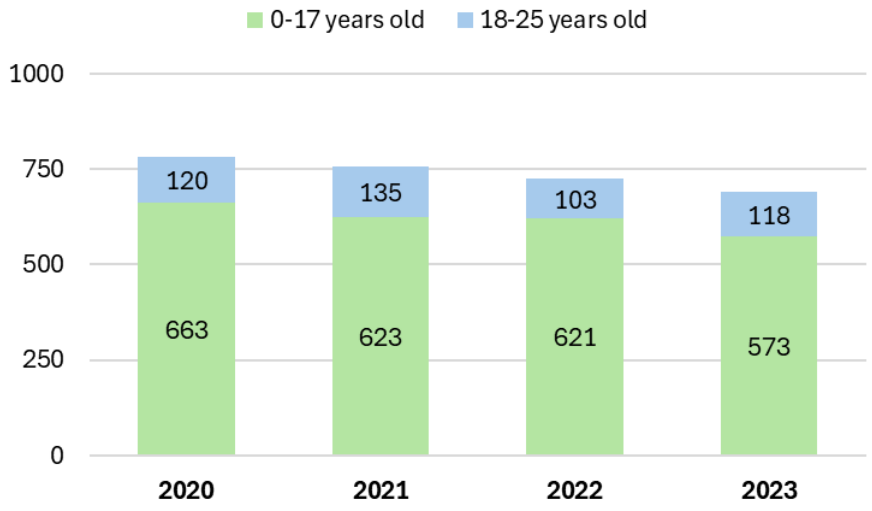
*Table 2.1. Number of youth served by the system of care, 2020*[6, 8-12]

| | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| System | n | n | n | n |
| Education system | 582,661 | 560,917 | 553,012 | 552,380 |
| Behavioral health system | 73,633 | 78,326 | 82,352 | 86,103 |
| Intellectual/developmental disabilities system | 16,215 | 17,089 | 17,709 | 19,014 |
| Child welfare system | 13,689 | 12,178 | 10,800 | 10,262 |
| Juvenile justice system | 7,784 | 5,964 | 6,437 | 7,045 |

*Table 2.2. Percentage of youth with cross-system involvement, 2020-2023*[6]

| | % with Cross-System Involvement | | | |
|---|---|---|---|---|
| System | BH | DD | CW | JJ |
| Behavioral health system (n = 174,421) | -- | 5.2% | 5.7% | 2.7% |
| Intellectual and developmental disabilities system (n = 23,467) | 38.6% | -- | 6.7% | 1.4% |
| Child welfare system (n = 25,798) | 38.5% | 6.1% | -- | 3.1% |
| Juvenile justice system (n = 16,682) | 28.7% | 2.0% | 4.7% | -- |

*Figure 2.2. Number of youth served by three or more agencies, 2020-2023*[6]



**What are the demographics of the youth being served by each system? Are there groups that are disproportionately represented in any system?**

National/Oregon comparison: Oregon's age and gender makeup of the youth population are similar to what's observed nationally. Oregon has more White youth and fewer Asian, Black / African American and Hispanic/Latino youth than the national census.

System comparison

| | |
|---|---|
| **Education System** | Serves a wide range of ages across K-12 grades (exact age data is not published by ODE); almost equal split between males and females; race and ethnicity are the most consistent with Oregon's general population of youth than any other system[8-12] |
| **Behavioral Health System** | Serves a wide range of ages; slightly more females served than males; higher proportions of American Indian / Alaska Native, Black / African American and White youth than the state population; lower proportion of Asian and Hispanic/Latino youth[6] |
| **I/DD System** | Serves more older youth (15-24); elevated proportion of males; elevated proportion of American Indian / Alaska Native, Black / African American and White youth; lower proportion of Hispanic/Latino youth[6] |
| **Child Welfare System** | Serves more younger youth than other systems; disproportionate representation of Native American / Alaska Native and Black / African American youth at every decision point in the system, which is consistent with national data[6,13] |
| **Juvenile Justice System** | Primarily serves youth ages 15-19; elevated proportion of males; Native American / Alaska Native and Black / African American are overrepresented at almost every decision point in the JJ system, including at referral into the system, diversion, pretrial detention and placement in secure confinement at OYA facilities, which is consistent with national data[6, 14] |

***Location/Region***

When looking at the number of individuals served in each county per 100,000 population (except for ODE), the following trends emerge (Figure 2.3):

- Jefferson County serves the highest proportion of youth per capita in the behavioral health and I/DD systems.
- Wheeler County serves very few youth across all systems.
- Southeastern Oregon serves the highest proportion of youth in the child welfare and juvenile justice systems.

*Table 2.3. Demographic estimates for the United States, Oregon and the system of care* [6, 8-12, 15-16]

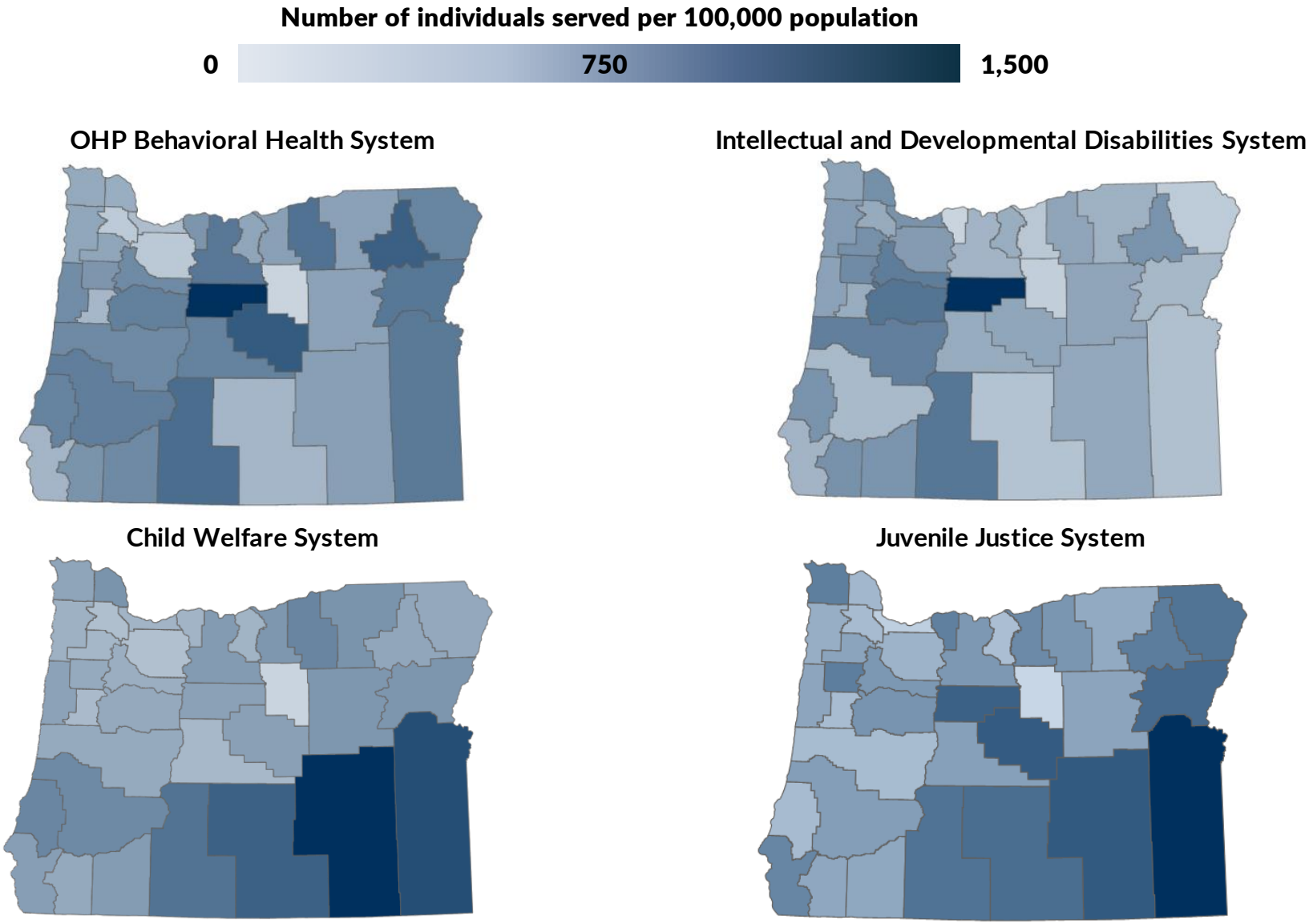
| Demographic | U.S. Population | Oregon Population | Oregon System of Care* | | | | |
|---|---|---|---|---|---|---|---|
| | | | ODE | BH (OHP) | I/DD | CW | JJ |
| **Total N** (column denominator) | 103,123,779 | 1,182,683 | 562,242* | 174,421 | 23,467 | 25,798 | 16,682 |
| Demographic Group | % of U.S. population under 25 years old | % of Oregon population under 25 years old | % of ODE | % of BH | % of I/DD | % of CW | % of JJ |
| Age | | | | | | | |
| 0 to 4 | 17.8% | 16.8% | N/A | 3.2% | 6.8% | 34.3% | N/A |
| 5 to 9 | 19.2% | 18.8% | N/A | 17.3% | 19.2% | 26.0% | <1% |
| 10 to 14 | 20.6% | 21.4% | N/A | 26.0% | 21.7% | 20.9% | 22.0% |
| 15 to 19 | 21.5% | 21.6% | N/A | 26.8% | 24.0% | 16.8% | 74.7% |
| 20 to 24 | 21.0% | 21.4% | N/A | 26.6% | 28.3% | 1.9% | 3.3% |
| Sex | | | | | | | |
| Female | 48.8% | 49.1% | 48.3% | 56.5% | 32.4% | 49.2% | 30.5% |
| Male | 51.2% | 50.9% | 51.5% | 43.5% | 67.6% | 50.6% | 69.2% |
| Other | N/A | N/A | 0.3% | N/A | N/A | N/A | 0.1% |
| Unknown | N/A | N/A | N/A | N/A | N/A | 0.2% | 0.2% |
| Race & Ethnicity | | | | | | | |
| American Indian or Alaska Native | 1.2% | 1.2% | 1.2% | 4.2% | 3.1% | 3.3% | 3.0% |
| Asian | 5.3% | 4.0% | 4.0% | 1.7% | 4.2% | 0.6% | 1.7% |
| Black or African American | 13.2% | 2.6% | 2.3% | 4.4% | 5.5% | 4.7% | 6.1% |
| Hispanic or Latino/a | 25.7% | 23.8% | 24.6% | 17.5% | 11.9% | 17.7% | 21.5% |
| Middle Eastern or North African | N/A | N/A | N/A | 0.3% | 0.3% | N/A | N/A |
| Multiple racial or ethnic identities | 17.8% | 20.1% | 6.9% | 2.3% | 1.7% | N/A | N/A |
| Native Hawaiian or Pacific Islander | 0.2% | 0.5% | 0.8% | 0.7% | 0.9% | 0.6% | N/A |
| Other | 9.2% | 7.5% | N/A | 0.7% | 0.5% | N/A | 9.5% |
| White | 53.0% | 64.0% | 60.2% | 68.3% | 71.9% | 66.1% | 58.2% |
| Unknown | N/A | N/A | N/A | N/A | N/A | 7.0% | N/A |

**System Abbreviations: Oregon Department of Education (ODE), behavioral health (BH) Oregon Health Plan (OHP), intellectual and developmental disabilities system (I/DD), child welfare (CW), juvenile justice (JJ)*

***ODE total n is the average number of youth enrolled from 2019-2023.*

*Sources: 2020 United States Census Bureau[15,16], ODE enrollment reports[8-12], System of Care Data Dashboard[6].*

*Figure 2.3. Youth served by the OHP behavioral health system (except for Oregon Department of Education) and county per 100,000 population*[6]



**What are the clinical characteristics of the youth being served by each system? How does this compare to the national population? Are there groups that are disproportionately represented in any system?**

### *Clinical Diagnoses*

National/Oregon comparison

The Data Resource Center on Child and Adolescent Health provides estimates of the overarching prevalence of *mental, emotional, developmental and behavioral problems* in Oregon versus nationwide (Table 2.4).[18] Their defining criteria for this include anxiety problems, depression, behavioral and conduct problems, developmental delay, intellectual disability, speech or other language disorder, learning disability, autism or autism spectrum disorder, attention deficit disorder or attention-deficit/hyperactivity disorder and Tourette syndrome.

*Table 2.4. Percentage of OHP youth with mental, emotional, developmental or behavioral health symptoms, ages 3 to 17 in Oregon versus the United States, 2022-2023*[18]

| | Oregon | United States |
|---|---|---|
| National Survey of Children's Health Indicator | % of youth | % of youth |
| One or more reported mental, emotional, developmental or behavioral problems* and/or qualifies on Child with Special Health Care Needs (C-SHCN) Screener | 28.6% | 25.8% |

** NSCH defines this as: anxiety problems, depression, behavioral and conduct problems, developmental delay, intellectual disability, speech or other language disorder, learning disability, autism or autism spectrum disorder, attention deficit disorder or attention-deficit/hyperactivity disorder, Tourette syndrome.*

Note: This data only includes youth with Oregon Health Plan (OHP) and does not represent youth with private or no insurance.

According to 2021-2022 national data from the Center for Disease Control (CDC), 10% of children in the U.S. ages 3-17 had anxiety, 7% had behavior disorders and 4% had depression.[19] Another source reported that in 2020, almost 12% of youth ages 3 to 17 nationwide had anxiety or depression, versus 16% in Oregon; this is the fourth-highest rate compared to other states.[20] Mental Health America (MHA) reports that Oregon has the highest rate of youth who have experienced a depressive episode in the past year (25%) in the nation.[21] Additionally, MHA ranks Oregon as second-to-last on their *Youth Flourishing* measure, which is an overall indicator of mental health and well-being.[21]

Oregon system comparison

| | |
|---|---|
| **Education System** | 21-35% of students (6th, 8th & 11th graders) report anxiety symptoms and 24-38% report depressive symptoms[22]; from 2019-2024, approximately 14% of students were enrolled in special education services[23-27] |
| **Behavioral Health System** | 95% of youth served by the OHP behavioral health system have a mental health diagnosis, 1% have an I/DD diagnosis[28-29]<br>Note: The Oregon Child Integrated Dataset (OCID) team is preparing a report on the prevalence of different behavioral health diagnoses (and relation to cross-system involvement) among children with CHIP and Medicaid, with an anticipated release date in spring 2025 |
| **I/DD System** | 46% have autism spectrum disorder, 43% have an intellectual disability, 7% have a global developmental delay, 5% have fetal alcohol syndrome and 6% have Down syndrome[28,30]; ODDS does not collect data on co-occurring mental health diagnoses |
| **Child Welfare System** | 25% have an adjustment disorder, 15% speech/communication disorder, 14% anxiety disorder, 14% mood/depressive disorder and 16% have a developmental disorder, learning disorder and/or other developmental delay[31] |
| **Juvenile Justice System** | 57% of youth in OYA have a mental health diagnosis and 50% have a special education history[32]; clinical data for youth in the juvenile justice system as a whole is unavailable |

***Substance Use***

National/Oregon comparison

The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that Oregon's youth substance use disorder (SUD) rates are higher than the national average (Table 2.5).[33] Oregon ranks 48th out of 51 in prevalence of SUD, which means that Oregon has one of the highest rates of youth SUD in the country.[21]

*Table 2.5. Substance use disorder prevalence in Oregon and the United States, 2021-2022[33]*

| | **Oregon** | **United States** |
|---|---|---|
| Substance Use Disorder Prevalence | % of youth | % of youth |
| Ages 12 to 17 | 12.5% | 9.0% |
| Ages 18 to 25 | 35.7% | 27.0% |

Oregon system comparison

| | |
|---|---|
| **Education System** | 3-17% of students (6th, 8th & 11th graders) report that they use alcohol, 1-12% marijuana, 1% prescription drugs and 1% illicit drugs[22] |
| **Behavioral Health System** | 7-9% have a substance use disorder[28-29] |
| **I/DD System** | ODDS does not collect this information |
| **Child Welfare System** | The DAETA team was unable to locate data on youth substance use in the child welfare system |
| **Juvenile Justice System** | 89% of OYA youth have a substance use history[32]; while clinical data for youth in the juvenile justice system as a whole is unavailable, JJIS reports that in 2023, 0.6% of youth were referred for substance-related felony offenses (0.5% controlled substance/alcohol, 0.1% marijuana), 1.7% for misdemeanors (0.2% controlled substance/alcohol, 1.5% marijuana) and 11.4% for non-criminal violations/infractions (4.7% for alcohol/minor in possession, 0.1% for controlled substance/alcohol, 6.6% marijuana)[34] |

***Trauma***

National/Oregon comparison

The Data Resource Center on Child and Adolescent Health uses the National Survey of Children's Health (NSCH) to estimate the number of adverse childhood experiences (ACEs) children have experienced.[18] The NSCH adds questions related to discrimination and neighborhood violence to the standard categories identified in the ACE study.[35] Overall, Oregon has higher rates of trauma among youth than the United States as a whole.

*Table 2.6. Percentage of youth ages 0 to 17 with adverse childhood experiences in Oregon versus the United States, 2022-2023[35]*

| | **Oregon** | **United States** |
|---|---|---|
| Number of Adverse Childhood Experiences (ACEs) | % of youth | % of youth |
| No ACEs | 57.8% | 61.0% |
| One ACE | 21.6% | 21.5% |
| Two or more ACEs | 20.6% | 17.5% |

Oregon system comparison

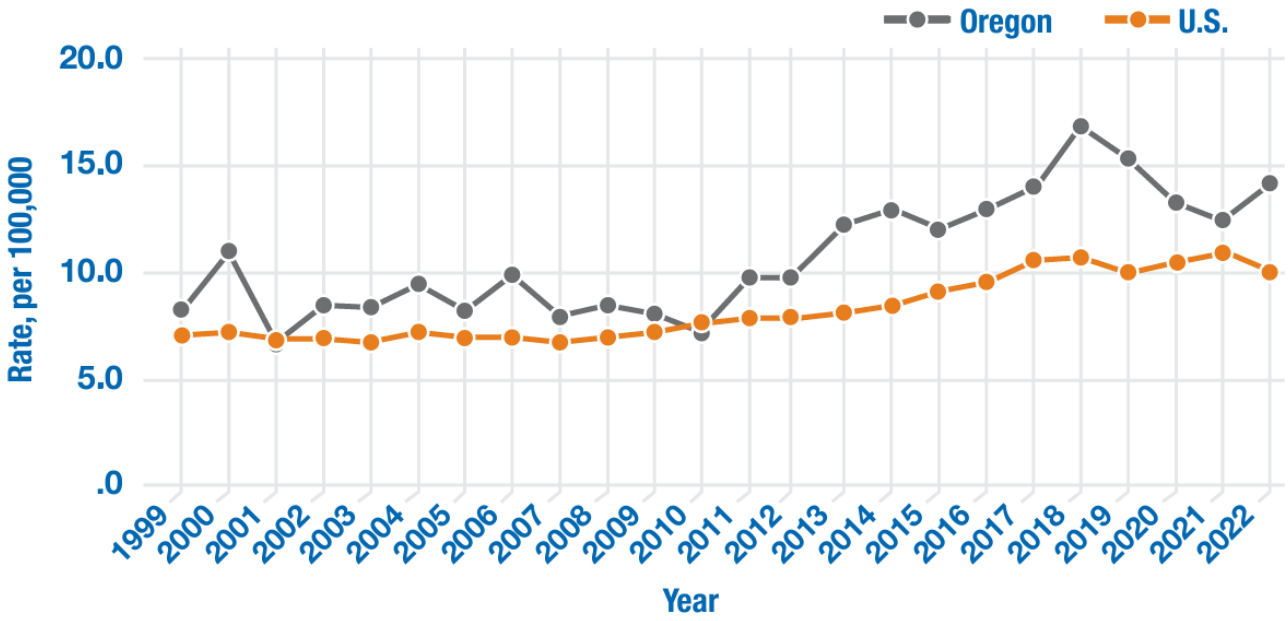
| | |
|---|---|
| **Education System** | 11-19% of students (6th, 8th & 11th graders) report that someone has physically hurt them, 18-21% (6th, 8th & 11th graders) have witnessed physical, emotional or sexual harm at school, and 19% of 11th graders report that a partner has tried to control, manipulate or emotionally hurt them[22] |
| **Behavioral Health System** | While OHA does not collect systemwide trauma data, select program-level estimates suggest high rates of trauma among this population: 87% of youth in Intensive In-Home Behavioral Health Treatment (IIBHT)[36] and 62% of youth in Mobile Response and Stabilization Services (MRSS) have a trauma history[37] |
| **I/DD System** | ODDS does not collect this information. |
| **Child Welfare System** | By nature of their involvement with the child welfare system, it can be assumed that almost all youth have experienced some sort of traumatic event[38]; an estimated 14% of youth have a post-traumatic stress disorder (PTSD) diagnosis and 2% have other trauma/stressor-related disorders[31] |
| **Juvenile Justice System** | 95% of youth in OYA have a trauma history; 40% report 5 to 8 adverse childhood events (ACEs) and 26% report 9+ events (the most common ACEs include losing a biological parent (80%), witnessing violence (78%) and parental substance abuse history (65%)[32]; clinical data for youth in the juvenile justice system as a whole is unavailable |

***Suicidality***

National/Oregon comparison

In 2024, Oregon had the highest rate of youth who report having serious thoughts of suicide in the nation[21]. Additionally, Oregon youth suicide death rates are consistently higher than the national average (Figure 2.4)[39]. Since 2018, the total annual number of youth who die by suicide in Oregon has decreased. The majority of this decrease has been among White youth, with either no change or increases among all other racial and ethnic groups.[39]

*Figure 2.4. Suicide death rates among youth 10 to 24 years old in Oregon and the United States, from the 2023 Youth Suicide Intervention and Prevention Plan Annual Report*[39]




Oregon system comparison

| | |
|---|---|
| **Education System** | 7-15% of students (6th, 8th & 11th graders) report that they have seriously considered suicide and 3-5% report that they have attempted suicide[22] |
| **Behavioral Health System** | While OHA does not collect systemwide suicidality data, select program-level estimates suggest high rates of suicidality among this population: 76% of youth in IIBHT have a history of suicidality[36], 21% of youth in Wraparound present with suicide risk at enrollment[40] and 35% of youth in MRSS have attempted suicide at some point prior to enrollment[37] |
| **I/DD System** | ODDS does not collect this information |
| **Child Welfare System** | While exact rates could not be obtained, the Critical Incident Review Team (CIRT) and the Youth Suicide Intervention Prevention Plan (YSIPP) identify high rates of suicide among youth in child welfare as a priority issue [41-42] |
| **Juvenile Justice System** | 11% of OYA youth have self-harm history and 11% have a history of suicidality (thoughts, plans or attempts in the past 90 days)[32]; suicidality data for youth in the juvenile justice system as a whole is unavailable |

### *Pediatric Chronic Conditions and Health Complexity*

National/Oregon comparison

The Data Resource Center on Child and Adolescent Health provides estimates of the prevalence of Children with Special Health Care Needs (CSHCN), which includes chronic conditions and other special needs (Table 2.7)[18]. *Less complex needs* include youth who experience "chronic conditions that are managed primarily through prescription medication" while *more complex needs* include youth with "elevated need or use of specialized services, therapies, or functional limitations."[18] Overall, Oregon has higher rates of youth with *more complex needs* and lower rates of youth with *less complex needs*. System-specific health complexity data was not able to be obtained as this is not tracked consistently across systems.

*Table 2.7. Degree of health complexity among children with special health care needs (CSHCN) in Oregon versus the United States, 2022-2023*[18]

| | **Oregon** | **United States** |
|---|---|---|
| National Survey of Children's Health Indicator | % of youth | % of youth |
| CSHCN with more complex health needs | 17.9% | 15.8% |
| CSHCN with less complex health needs | 3.6% | 5.0% |
| Non-CSHCN | 78.5% | 79.2% |

OHA defines health complexity as the interaction of medical and social factors in a person's overall health.[43] In Oregon, medical complexity is determined using diagnoses, service utilization and number of bodily systems impacted; Table 2.8 presents the number of Oregon youth who fall in each of these categories. Social complexity is determined using a set of individual, familial and community characteristics, as outlined in Table 2.9. Together, these factors determine a youth's overall health complexity (Figure 2.5).

*Table 2.8. Medical complexity among Oregon youth ages 0-20 with Medicaid and the Children's Health Insurance Program (CHIP), 2020-2023*[43]

| | **2020** N = 497,738 | | **2021** N = 518,076 | | **2022** N = 502,475 | |
|---|---|---|---|---|---|---|
| Medical complexity | n | *%* | n | *%* | n | *%* |
| Complex chronic | 50,473 | *10.1%* | 50,511 | *9.7%* | 48,670 | *9.7%* |
| Non-complex chronic | 102,506 | *20.6%* | 94,751 | *18.3%* | 90,337 | *18.0%* |
| Healthy/Non-chronic | 344,759 | *69.3%* | 372,814 | *72.0%* | 363,468 | *72.3%* |

*Table 2.9. Social complexity among Oregon youth ages 0-20 with Medicaid and the Children's Health Insurance Program (CHIP), 2020-2023*[43]

| | **2020** N = 497,738 | | **2021** N = 518,076 | | **2022** N = 502,475 | |
|---|---|---|---|---|---|---|
| Social Complexity Indicator | n | % | n | % | n | % |
| Poverty (child) | 193,226 | 38.8% | 195,456 | *37.7%* | 185,784 | *37.0%* |
| Poverty (parent) | 164,771 | 33.1% | 169,307 | *32.7%* | 162,233 | *32.3%* |
| Foster care | 60,534 | 12.2% | 62,227 | *12.0%* | 57,161 | *11.4%* |
| Parental death | 6,903 | 1.4% | 9,832 | *1.9%* | 9,746 | *1.9%* |
| Parental incarceration | 96,146 | 19.3% | 108,879 | *21.0%* | 104,127 | *20.7%* |
| Mental health (child) | 170,272 | 34.2% | 184,766 | *35.7%* | 191,982 | *38.2%* |
| Mental health (parent) | 190,431 | 38.3% | 205,970 | *39.8%* | 206,125 | *41.0%* |
| Substance use disorder (child) | 16,966 | 3.4% | 17,399 | *3.4%* | 14,376 | *2.9%* |
| Substance use disorder (parent) | 115,210 | 23.1% | 132,117 | *25.5%* | 125,804 | *25.0%* |
| Child abuse and neglect | 40,420 | 8.1% | 46,119 | *8.9%* | 38,303 | *7.6%* |
| Potential language barrier | 81,593 | 16.4% | 78,681 | *15.2%* | 77,973 | *15.5%* |
| Parental disability | 19,214 | 3.9% | 23,189 | *4.5%* | 23,221 | *4.6%* |

*Figure 2.5. Health complexity among Oregon youth ages 0-20 with Medicaid and CHIP, 2020-2023, adapted from the 2020-2023 Oregon Health Authority Children's Health Complexity Reports*[43]

| **Health Complexity** N = 1,518,289 | | **Social Complexity** (12 indicators maximum) | | |
|---|---|---|---|---|
| | | 3+ Indicators | 1-2 Indicators | None |
| **Medical Complexity** (3 categories) | Complex chronic | **5.2%** (78,383) | **3.8%** (57,252) | **0.9%** (14,019) |
| | Non-complex chronic | **9.3%** (141,455) | **7.4%** (112,517) | **2.2%** (33,622) |
| | Healthy/ Non-chronic | **23.4%** (354,869) | **28.2%** (428,476) | **19.6%** (297,696) |

Decreasing medical complexity >>

Decreasing social complexity >>

**Where do youth in each system live and who do they live with? How do living arrangements vary across different demographic groups?**

National/Oregon comparison

The CDC reports that nationally in 2023, 71% of youth lived with two parents, 21% with their mother only, 4% with their father only and 4% with no parent.[44]

Oregon system comparison

| | |
|---|---|
| **Education System** | 84.2-94.4% of students live in their parent or guardian's home, 1.0-1.4% live in a friend or family member's home and <1% live in each of the following settings: foster home, shelter/emergency setting, hotel/motel, public place, other[22] |
| **Behavioral Health System** | Due to the unreliable nature of living arrangement information in the MMIS and MOTS systems, Oregon Health Authority did not provide this data. However, data from two individuals programs show that 32% of youth in IIBHT live in a private residence and 9% live in a ODHS setting, though 59% of data is missing[36]; in MRSS, 96% of youth live in a private residence[37] |
| **I/DD System** | While ODDS does not collect this information, the SOC Data Dashboard estimates that 94.8% of youth served by IDD received services at home, 8.7% were served in non-relative foster care and 5.2% were served in a group home[6] |
| **Child Welfare System** | 67-68% of youth in child welfare are living with a foster placement; other common placements include trial reunification (11%), pre-adoptive homes (6-9%), residential treatment homes/facilities (4-6%) and independent living (2-3%)[45] |
| **Juvenile Justice System** | 18% of youth who are committed to OYA custody are living at home, 74% are at an OYA facility, 2% are in detention, 3% have a runaway status and 3% are in an unlisted living situation[32]; data for youth in the juvenile justice system as a whole is unavailable |

**How many families experience housing instability or homelessness in each system? How does this compare to Oregon/nationally? Are there groups that are disproportionately affected?**

The McKinney-Vento Homeless Assistance Act, which is a federal law that guarantees free public education to youth experiencing housing instability, defines housing instability as[46]:

- Residing in a shelter
- Staying in a motel or campground because of the lack of alternative, adequate housing
- Living in a car, park, abandoned building, bus or train station
- Sharing housing with others due to the loss of housing or financial hardship
- Lacking a stable, regular and adequate nighttime residence

The U.S. Department of Housing and Urban Development (HUD) further categorizes homelessness as sheltered versus unsheltered. Sheltered homelessness refers to individuals who are staying in shelters, transitional housing or safe havens. Unsheltered homelessness is when individuals spend the night in non-designated sleeping accommodations, like parks or vehicles.

National/Oregon comparison

A national point-in-time analysis in 2023 found that there are 34,703 unaccompanied youth under the age of 25 experiencing homelessness nationally (9.3% are under 18 years old and 90.7 % are 18 to 24 years old).[47] In Oregon, it is estimated that there are 1,424 unaccompanied youth experiencing homelessness.[47] Oregon has the highest rate of *unsheltered* homeless youth in the nation, with 69.9% of homeless unaccompanied youth being unsheltered.[47] Oregon also has the highest rate of *unsheltered* families with children, with 58.7% of homeless individuals in families with children being unsheltered.[47]

Oregon system comparison

| | |
|---|---|
| **Education System** | Around 3% of students are identified as having housing instability annually; however, over 10% of students experience some sort of housing instability at some point during their K-12 education[46]; Native Hawaiian / Pacific Islander and Black / African American students are twice as likely to experience housing instability (Note: ODE reports that the pandemic and shift to virtual learning has significantly impacted its ability to identify youth experiencing housing instability) |
| **Behavioral Health System** | Due to the unreliable nature of living arrangement information in the MMIS and MOTS systems, OHA did not provide this data; however, OHA is preparing a report on youth homelessness set to be released in Q1 2025 |
| **I/DD System** | ODDS does not collect this information |

| | |
|---|---|
| **Child Welfare System** | Inadequate housing is present in 6.0-6.8%% of founded abuse cases[48] |
| **Juvenile Justice System** | 14% of all OYA youth experienced housing instability within the three years prior to commitment[49]; data for youth in the juvenile justice system as a whole is unavailable |

**How many families meet the federal poverty level in each system? How many families experience food and/or financial insecurity in each system? How does this compare to the Oregon/national population?**

***Poverty***

National/Oregon comparison

The *poverty rate* is defined as the percentage of the population whose income falls below the poverty line. The poverty line in 2023 was $30,900 for a family of four.[50] The 2023 national poverty rate was 12.5% and 12.2% in Oregon.[51]

Oregon system comparison

| | |
|---|---|
| **Education System** | 33% of Oregon students experience poverty[12] |
| **Behavioral Health System** | Due to the unreliable nature of financial information in the MMIS and MOTS systems, Oregon Health Authority did not provide this data. |
| **I/DD System** | ODDS does not collect this information |
| **Child Welfare System** | Family financial distress is present in 8.2-10.4% of founded abuse cases; the head of household being unemployed is present in 4.5-5.7% of cases[48]; youth under the age of 5 who have experienced maltreatment have higher rates (49.2%) of family enrollment in the Temporary Assistance for Needy Families (TANF) program than youth who have not experienced maltreatment (7.1%)[52]<br>(Note: While lower socioeconomic status is associated with higher likelihood of Child Welfare involvement, "poverty is often mistaken for neglect, resulting in increased rates of child abuse reports and unnecessary foster care, group and institutional placement" [53-55] |

| | |
|---|---|
| **Juvenile Justice System** | 62.7% of youth with JJ involvement had prior contacts with Oregon's Self-Sufficiency programs, which includes Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) and support for youth experiencing homelessness [56-57]; an analysis of Oregon student data found that youth whose "education records indicated economic disadvantage had about double the odds of county probation and about 1.5 times the odds of OYA commitment compared to students without this indicator" [58] |

***Food Insecurity***

National/Oregon comparison

Approximately 13.5% of U.S. households were food insecure at some point during 2023; Oregon's rates are similar to the national average.[59]

Oregon system comparison

| | |
|---|---|
| **Education System** | 46-55% of students were eligible for the free and reduced-price lunch program (FRPL) from 2019-2023[60] |
| **Behavioral Health System** | Due to the unreliable nature of financial information in the MMIS and MOTS systems, Oregon Health Authority did not provide this data |
| **I/DD System** | ODDS does not collect this information |
| **Child Welfare System** | Systemwide data is not available, but data for youth under the age of 5 who have experienced substantiated maltreatment have higher rates (82.6%) of family enrollment in the Supplemental Nutrition Assistance Program (SNAP) than youth who have not experienced maltreatment (29.5%)[52] |
| **Juvenile Justice System** | 62.7% of youth with JJ involvement had prior contacts with Oregon's Self-Sufficiency programs, which includes Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) and support for youth experiencing homelessness[56-57] |

# NEIGHBORHOOD & COMMUNITY

## CHAPTER INTRODUCTION

The neighborhood and community in which youth and families live have a substantial impact on their health and wellbeing. The 2024 Mental Health America report underscores the importance of living in a supportive neighborhood, defined as "one in which people in the neighborhood helped each other…watched out for each other's children, and people knew where to go for help in their community when they encountered difficulties".[21] Research suggests that *not* living in a supportive neighborhood is a risk factor for poor mental health outcomes.[61-62] In Oregon, 52.6% of families feel like they live in a supportive neighborhood, compared to 56% nationally.[21] The National Survey of Children's Health provides a similar estimate, with 51.9% of children living in a supportive neighborhood compared to 56.1% nationally.[18] This chapter explores ways that Oregon is supporting the neighborhoods and communities where people live and opportunities for further growth.

## KEY TAKEAWAYS

Oregon families participate in outdoor recreational activities at a higher rate than any other demographic group surveyed by the Oregon Parks and Recreation Department. Rural Oregonians, low-income families, people with disabilities and ethnic minorities have less access to these activities.

Oregon's more remote counties (most notably Gilliam County and Lake County) have less access to high-speed internet than urban areas, like the Portland Metro Area. Lower-income households, Native American / Alaska Native individuals and Hispanic/Latino individuals are disproportionately affected.

A higher percentage of Oregonians live in a childcare desert than the national average. Income level of the neighborhood, race and ethnicity, rurality and age of the child all impact the likelihood of living in a childcare desert.

Parents of youth involved with the system of care experience high rates of burnout and stress. Parents of youth involved with the intellectual/developmental disabilities and behavioral health systems are particularly affected.

There are many resources for parents and youth throughout the state. Drop-in centers for youth have regional availability while resources for parents are distributed across the state or available in a more accessible platform, like online or via phone.

**What access to nature, parks and outdoor recreational activities is available in different regions of Oregon? Are there disparities in access?**

Research suggests that time spent outside — like going to parks, community events and trails — has benefits to a youth's mental health.[63-64] Specifically, exposure to nature and outdoor recreation can improve mood, bolster resilience and provide a buffer to stress.[65-67] The National Survey of Children's Health (NSCH) estimates that Oregon youth are more likely to live in a neighborhood with a park or playground (81.3%) than youth nationwide (76.2%).[18]

The 2019-2023 Oregon Statewide Comprehensive Outdoor Recreation Plan (SCORP) describes the positive impacts of exposing youth to outdoor recreation, including physical, emotional and spiritual benefits.[68] However, this report highlights that youth engagement with outdoor recreational activities is decreasing due to several factors, including "urbanization, loss of free time, increased single-parent family households, and greater focus on electronic activities." An annual survey conducted by the department highlighted several important trends:

- Overall, families with children were most likely to visit close-to-home local and municipal parks, with 92% reporting that they had visited in the past year.

- 100% of families with children participated in one or more outdoor activities in the past year, which was higher than any other demographic group of focus (such as different racial demographic groups, income groups, age groups, etc.).
- Families with children participated in a greater array of outdoor activities.
- 17.5% of families with children across the state (41.1% for rural families) reported that they did not have a park or recreation facility within walking distance, compared to 22.9% for the general Oregon population.

Both the 2019-2023 SCORP and the 2025-2029 draft SCORP plans underscore the same imperative: youth and families, particularly those that are low income, racial minorities and/or living in a rural area of the state, need better access to close-to-home outdoor recreation.

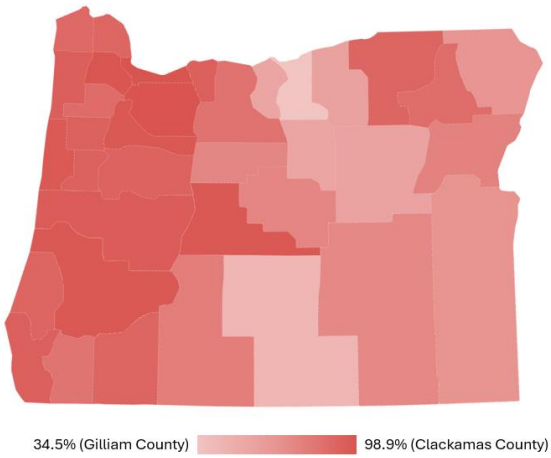
**What type of internet options are available in different regions of Oregon? Are these options reliable, affordable and fast? Are there regional or other disparities in access?**

Oregon, along with the rest of the nation, has been promoting increased use of telehealth-based care to combat inequities, yet some of the most vulnerable populations do not have access to high-speed internet. The Oregon Department of Education has similarly increased remote learning since the COVID-19 pandemic, while also recognizing that the basic need for internet may be impeding efforts.[69]

BroadbandNow utilizes Federal Communications Commission (FCC) data and other publicly available resources to report on internet availability across the nation. Their analyses estimate that around 92% of Oregonians have access to high-speed broadband internet, which ranks 24th in the nation.[70] This is defined as having connectivity at a minimum of 100 MBPS, which is considered sufficient speed for daily tasks such as video calls and streaming.[71] When looking at the data by county, some disparities emerge (Figure 3.1)[70]:

- Gilliam (34.5%) and Lake (42.3%) counties have the lowest rates of access, with less than half of households having sufficient internet speeds.
- The Portland Metro Area, specifically Clackamas (98.9%) and Multnomah (98.7%) counties, and counties along the I-5 corridor have the highest access rates.
- Of individuals without *any* access to internet (broadband, cellular data, satellite or dialup), certain groups are more affected, including lower income households (those making less than $20k per year) and Native American / Alaska Native and Hispanic/Latino households (nuanced data on intersectionality was not able to be obtained).

*Figure 3.1. Percentage of population with access to 100 MBPS broadband internet, from BroadbandNow*[70]



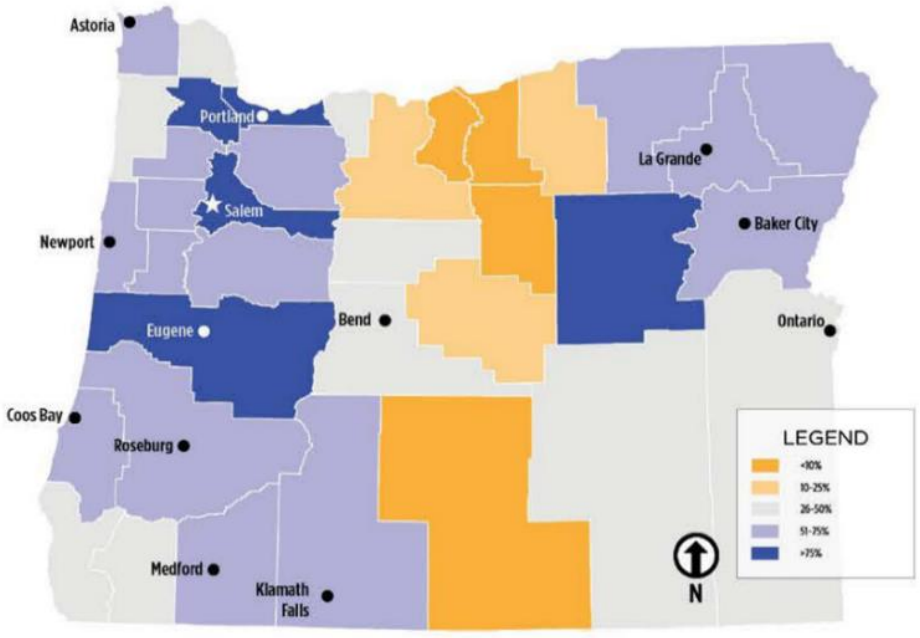
**What public transportation services are available in the different regions in Oregon? Are there regional or other disparities in access?**

Safe, consistent and convenient public transportation is a critical service, and for some, a basic need that enables access to education, health care and employment. While many families use personal vehicles to access essential services, the Oregon Department of Transportation (ODOT) estimates that 9% of Oregon's eligible population does not have a driver's license and 20% of households use public transportation.[72-73]

In Oregon, public transportation ranges from large urban systems to small county or regional providers. There are also intercity systems like Amtrak or the Public Oregon Intercity Network (POINT). Even where public transportation exists, there are disparities in connectivity, accessibility and mobility; vulnerable or disadvantaged populations are most likely to use public transportation, including low-income households, minorities, people with disabilities or those that have limited English proficiency.[73]

Central Oregon has the lowest rates of the population (<10%) having close access to public transportation, with Lake, Sherman, Gilliam and Wheeler counties being the most affected (Figure 3.2).[73]

*Figure 3.2. Percentage of the population served by a transit network within half a mile of their home, from the Oregon Transit Network Report*[73]



**What non-emergent medical transport (NEMT) services are available in different regions of Oregon? Are there some groups that do not have access to NEMT?**

Non-emergent medical transport (NEMT) is an important benefit for individuals with Medicaid who need assistance getting to medical appointments. Individuals with OHP Plus have access to NEMT, which may include a taxi, bus, local ride service or gas/lodging reimbursement when using a personal vehicle. Each county has a designated contractor and process for utilizing OHP NEMT services.[74] CCOs submit quarterly reports to the Oregon Health Authority (OHA) that includes ride information, call center metrics and reimbursement data; this data was requested but unable to be obtained.[75]

The Oregon Department of Veterans Affairs (VA) also offers NEMT services to transport veterans to VA medical facilities for treatment. Additionally, an initiative specifically aimed at supporting veterans living in "highly rural" areas (Baker, Gilliam, Grant, Lake, Harney, Malheur, Morrow, Sherman, Wallowa and Wheeler counties) provides free transportation to all medical appointments, regardless of facility location and affiliation with the VA.[76] From 2014 to 2022, the program provided over 31,932 trips, which greatly improved access to care for these veterans.[77]

Variability across commercial carriers and within their individualized plans limited the team's ability to assess whether NEMT is offered to individuals with private insurance.

**How many families in Oregon have access to childcare and/or early learning programs? How many childcare providers does Oregon have and where are they working? Where are there gaps in the availability of childcare providers serving youth and families?**

High-quality childcare offers many benefits, including supporting children's healthy development and allowing parents to provide for their families. When regions do not have enough affordable and accessible childcare, it negatively impacts children, families and the economy.[78] Childcare deserts are defined as "any census tract with more than 50 children under age 5 that contains either no childcare providers or so few options that there are more than three times as many children as licensed childcare slots".[79] In Oregon, 60% of families live in a childcare desert compared to 51% nationally (Oregon is ranked 41/51 nationally).

The Oregon Department of Early Learning and Care (ODELC) reports that there were 3,816 licensed childcare facilities in Oregon in October 2024 (Figure 3.3).[80] The number of licensed providers and their capacity fluctuates over time. After a notable dip during the COVID-19 pandemic, licensed facilities and capacity have been steadily increasing; as of October 2024, providers had the highest capacity observed in the past five years (Figure 3.4).[80]

*Figure 3.3. Childcare supply in Oregon, from the Center for American Progress*[79]

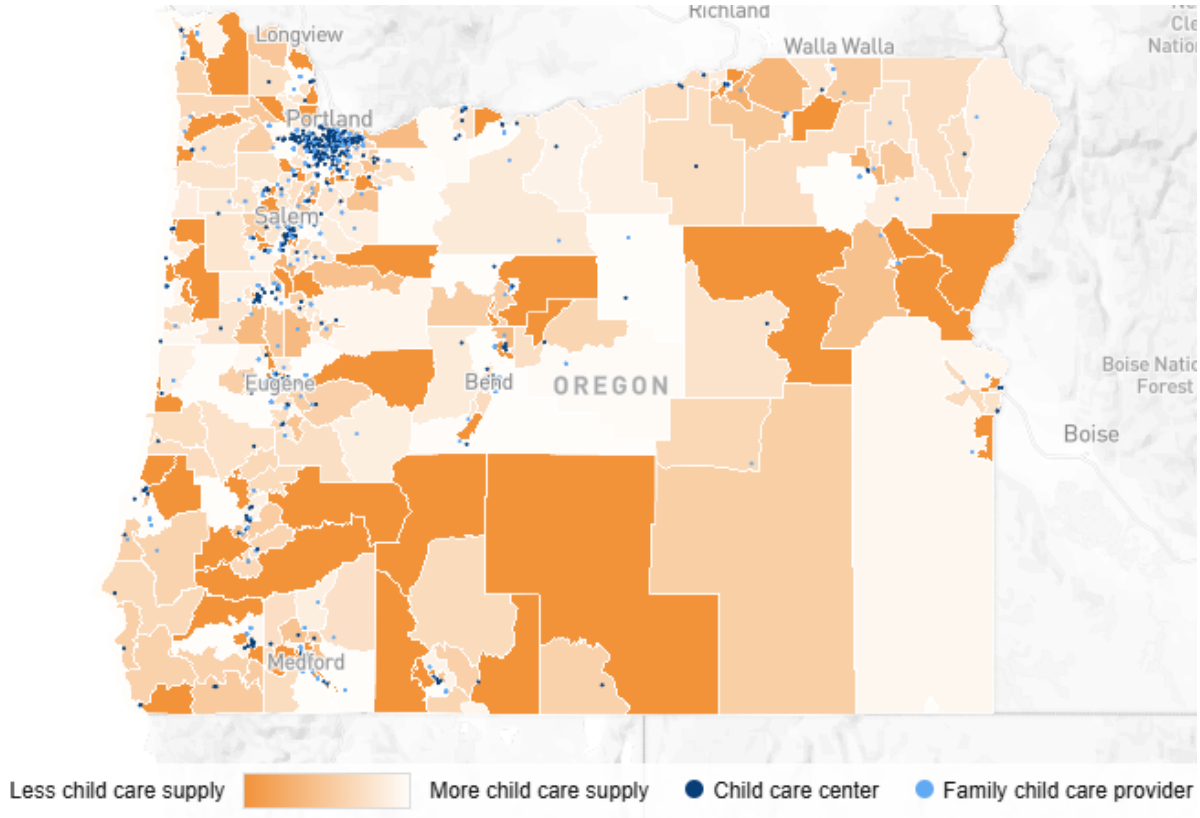
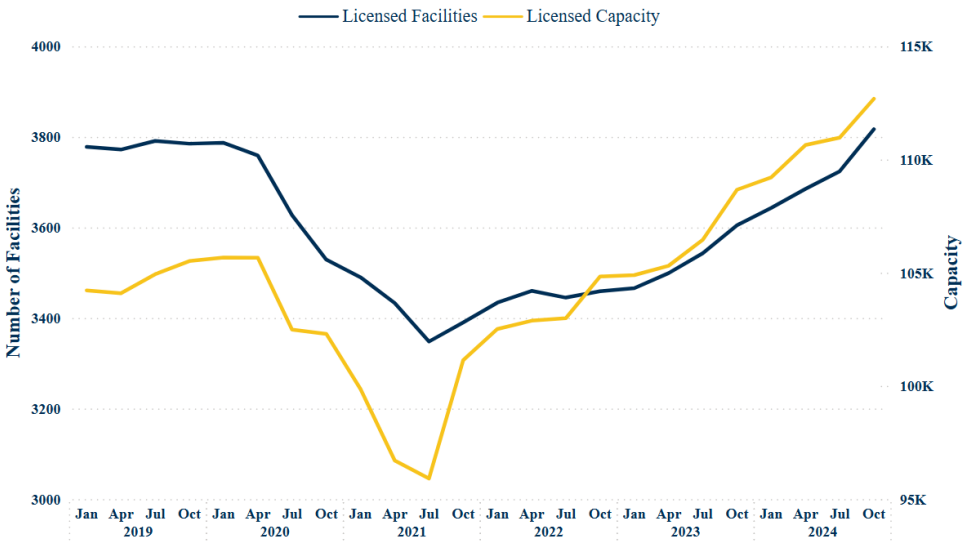



*Figure 3.4. Licensed facilities and licensed capacity in Oregon, from the Oregon Department of Early Learning and Care*[80]



The limited available childcare is often unaffordable, and resources such as Employment Related Day Care (ERDC) and relief nurseries may have lengthy waitlists or other limitations on enrollment. This is especially important given the role that these programs may have in the SOC. ERDC helps pay for childcare expenses for families below specified income levels that are working, in school or receiving Temporary Assistance for Needy Families (TANF) benefits.[81] Relief nurseries provide early intervention and support to families who are experiencing significant stressors that put them at risk of becoming involved with the child welfare and/or juvenile justice systems.[82]

### *Access to Early Learning Programs*

Early learning is key to a child's long-term success. It boosts academic performance, improves health and increases the chances of staying in school, attending college and living a longer, healthier life.[83] The Oregon Department of Early Learning and Care (ODELC) provides early learning programs and services such as Oregon Pre-Kindergarten (OPK) and Preschool Promise, to children from 0-5 years of age.

OPK provides free, high-quality early education and care for infants and children until the age of five for families with low income, families receiving TANF, SNAP, SSI or those that are part of the foster care system.[84-85] In December 2023, 72.4% of pre-K part-day and 84.7% of pre-K extended-day slots were filled.[85] County-specific data can be accessed through the OPK Dashboard.[85]

Preschool Promise serves children from families with incomes up to 200% of the Federal Poverty Level, and operates in varied settings.[86] In 2023, approximately 11,720 children ages 3-4 (16% of 4-year-olds and 12% of 3-year-olds) were enrolled in a public preschool program. [86] According to the ODELC, as of December 2023, 92.4% of preschool slots were filled.[87] In 2024, Preschool Promise had 5,132 seats available at 318 sites and 96% of these slots were filled.[87] County-specific data can be accessed through the Preschool Promise Dashboard.[87]

Oregon school districts also offer public pre-kindergarten programs outside of OPK and Preschool Promise. In 2021, Multnomah County established Preschool For All (PFA) which had 2,200 seats in 2024 at 135 locations in the county.[88] Comprehensive information about county-specific early learning programs can be found at each county's early learning website.

Oregon preschool programs have faced a shortage of qualified teachers. To address this issue, the state will allocate funds from its 2023-25 budgets to raise provider rates by at least 7%, allocating $25.6 million to OPK and $16.7 million to Preschool Promise.[86]

The team was unable to locate demographic information specific to early learning care in Oregon. However, a report by the National Center for Education Statistics (NCES) highlights national disparities in access to early learning, particularly among different racial and socioeconomic groups. In October 2021, enrollment rates in early childhood programs varied by race, with Black and Hispanic youth having lower enrollment rates compared to White youth. Additionally, youth from low-income families were less likely to attend preschool than those from higher-income households.[89]

**Are there supervised and age-appropriate youth drop-in centers available in each community? Who do they serve and what services do they provide? Are there regional or other disparities in access?**

Youth drop-in centers provide a safe space for youth to access basic needs, shelter and services. They may offer showers, clothing, food, connection to case management, behavioral health services, career exploration opportunities, respite and other types of support.

Most regions in Oregon have community centers that offer supervised drop-in space for youth to socialize and spend time in. These are often run by city Parks and Recreation departments or community-based organizations like the Boys and Girls Club or the YMCA. The NSCH reports that 46.2% of Oregon youth live in a neighborhood with a recreation center, community center or Boys and Girls Club, which is slightly less than the national average of 48.3%.[18]

For youth who are involved in the system of care, peer-run drop-in centers provide safe spaces for social connection and systems navigation. Drop-in centers are outlined in Table 3.1; please note that this is not an exhaustive list. With the exception of the Bend/Redmond and Klamath Falls areas, almost all drop-in centers are located in the Portland metro area or along the I-5 corridor.

*Table 3.1. Youth drop-in centers in Oregon*

| Organization | Location(s) | Population Served and Services Provided |
|---|---|---|
| Citizens for Safe Schools[90] | Klamath Falls | Ages 9 to 16, with a focus on youth at risk for delinquency, academic failure or victimization; programming, arts, games, clothing, homework space |
| Connected Lane County[91] | Eugene Springfield | Ages 14 to 24; education support, job seeking support, career mentorship, housing and health care resources, college support, shower and laundry facilities |
| CORE Zephyr House[92] | Eugene | Ages 16 to 24, with a focus on youth experiencing homelessness; life skills support, art, recreation workshops, case management |
| Deschutes County Behavioral Health[93] | Bend Redmond | Ages 14 to 27; peer support, games and puzzles, socialization and discussion, washer and dryer, life skills introduction, hygiene products, computer access |
| Jackson Street Youth Services[94] | Albany Corvallis | Ages 10 to 24, with a focus on youth experiencing homelessness; housing, basic needs, support groups, mental health support, case management, mentoring, positive activities, aftercare |
| Home Plate Youth Services[95] | Beaverton Hillsboro | Ages 12 to 24, with a focus on youth experiencing homelessness; food, laundry, community, clothing, resources |
| Hosea Youth Services[96] | Eugene | Ages 16 to 24, with a focus on youth experiencing homelessness; food, clothing, toiletries, shower and laundry facilities, computer access, a napping room |

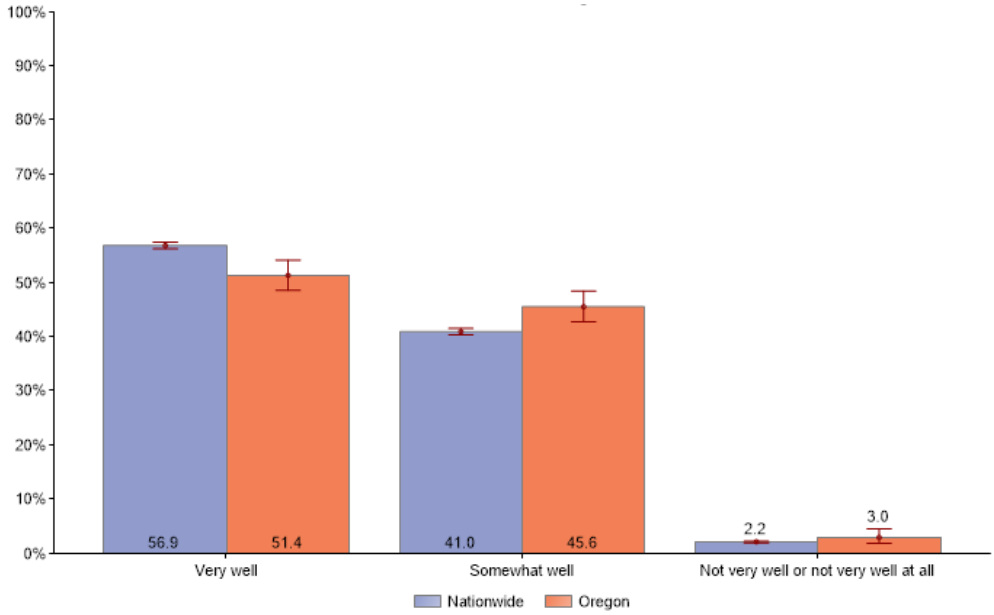
| | | |
|---|---|---|
| Looking Glass New Roads[97] | Eugene | Ages 16 to 24, with a focus on youth experiencing homelessness; food, clothing, showers and other resources |
| New Avenues for Youth[98] | Portland | Ages 13 to 23; meals, safe place to rest, showers, internet |
| Ophelia's Place[99] | Eugene | Ages 10 to 18, female-only space; snacks, games, community, homework assistance |
| Yamhill Community Action Partnership[100] | McMinnville<br>Newberg | Ages 13 to 21; activities, social services, presentation opportunities, community service opportunities, socialization |
| Youth Era[101] | Eugene<br>Medford<br>Milwaukie<br>North Bend<br>Salem | Ages 14 to 21 (some centers up to 25); peer support, leadership skill development, socialization, games, computer access, resume and job interview help, outreach and activism opportunities |
| Youth MOVE Oregon[102] | Eugene<br>Medford<br>Milwaukie<br>North Bend | Ages 14 to 25; peer support, leadership skills development, socialization opportunities, goal-setting support |
| Youth Rising[103] | Klamath Falls | Ages 11 to 21; activities and games, computer access, art and music supplies, socialization, leadership opportunities and career exploration support |

**How many caregivers experience "burnout" and what are some resources available to help? Are there regional or other disparities in access to caregiver resources?**

Caregiver "burnout" is a state of mental, emotional and physical exhaustion that occurs in individuals taking care of someone else, particularly when they encounter barriers to needed supports or services. NSCH reports that Oregon parents feel like they are handling the day-to-day demands of raising children less well than what's observed at the national level (Figure 3.5).[18] Additionally, for parents and caregivers of children with special health care needs (CSHCN) in Oregon:

- 15.4% of CSHCN parents/caregivers have "fair or poor mental health" compared to 10.6% of non-CSHCN parents/caregivers.[18]
- 6.7% of CSHCN parents/caregivers say that they are coping with the daily demands of raising children "not very well or not very well at all," compared to 1.9% for non-CSHCN parents/caregivers.[18]

*Figure 3.5. Degree to which parents feel they are coping with the daily demands of parenthood, from the National Survey of Children's Health*[18]




Parents and caregivers of system-involved youth surveyed by OHSU reported high degrees of stress and burnout, with 66% reporting that they *Always* or *Very Often* experience high rates of burnout. Parents of youth in the I/DD and behavioral health systems were most affected, with 78% and 76% (respectively) reporting that they *Always* or *Very Often* experience high levels of stress or burnout.[18]

A report released by the U.S. Surgeon General highlights several stressors that further exacerbate parent and caregiver burnout[104]:

- Financial strain, economic instability and poverty
- Time demands, like work and time spent on youth care needs
- Children's complex developmental, mental and physical health needs
- Children's safety concerns, particularly at school
- Parental isolation and loneliness
- Increasing use of technology and media among youth
- Societal expectations and pressure

Accessing community and natural support can help mitigate stress and burnout. Parents in Oregon report more emotional support related to parenting and raising children than parents nationwide (79.8% versus 76.8% report having someone they could turn to for emotional support, respectively).[18]

OHSU survey data from parents and caregivers offers a look into families' natural supports.[5] A majority of parents receive support from their family, spouse/partner and friends (Figure 3.6) and report that their identified natural supports are helpful to them, their child or both (Figure 3.7). Additional community resources available in Oregon to assist parents and caregivers experiencing stress or burnout are presented in the next section.

*Figure 3.6. Helpfulness of natural supports from the OHSU Parent/Caregiver Survey[5], n = 107*

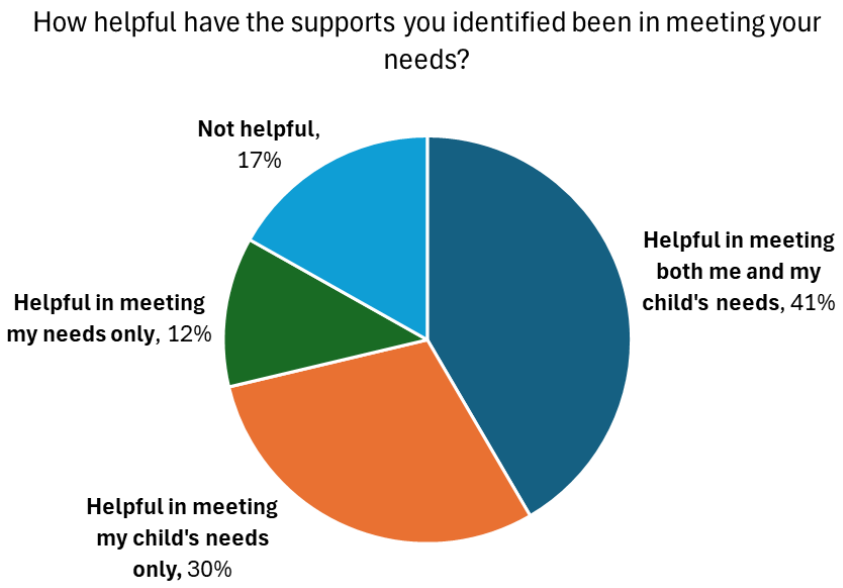
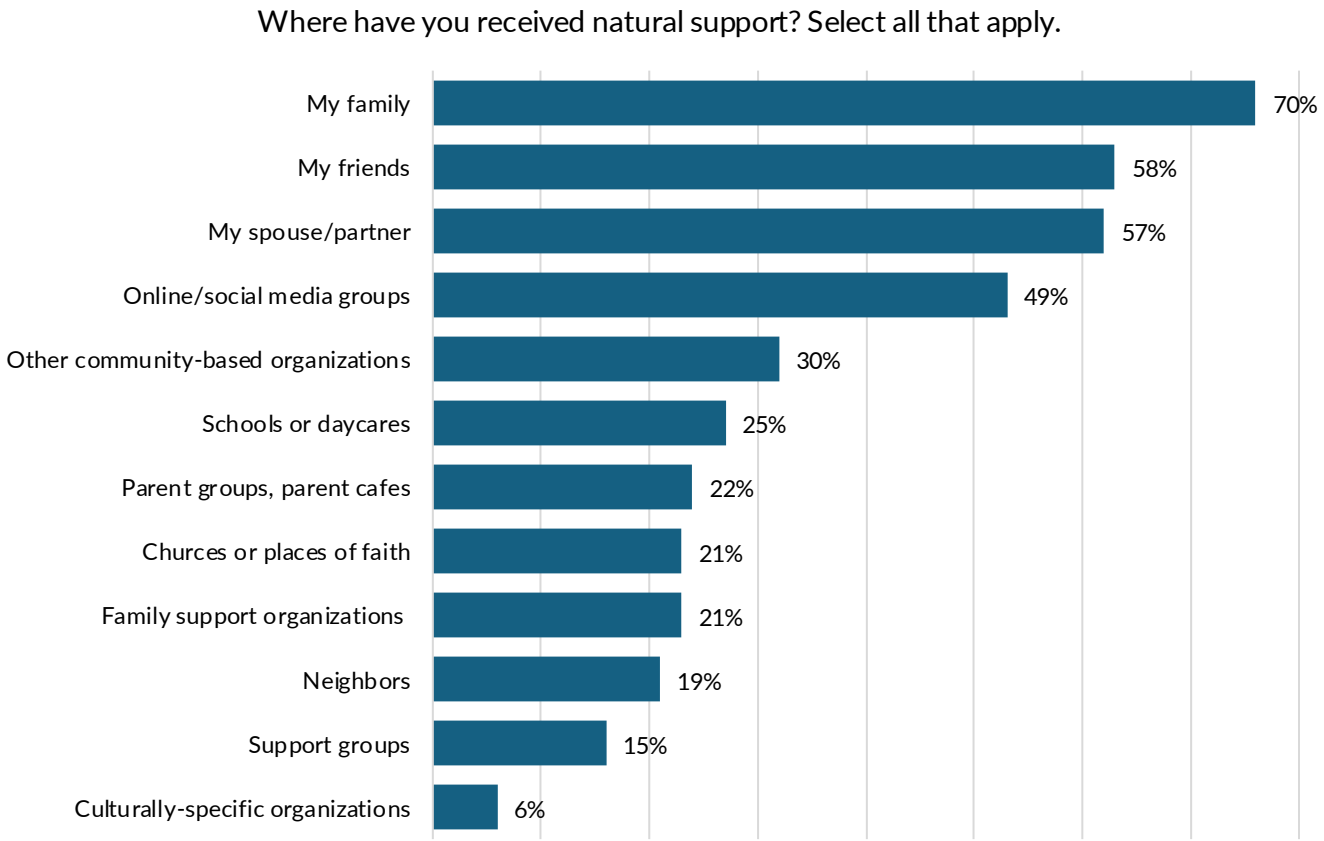



*Figure 3.7. Identified natural supports from the OHSU Parent/Caregiver Survey[5], n = 107*



**What types of educational and support services are available to parents? Are there regional or other disparities in access to educational and support services?**

Helping parents and caregivers access needed education, training and support is an essential aspect of supporting youth who may have different needs within the SOC. A variety of organizations offer resources to help parents/caregivers learn about diagnoses, conditions, behaviors and services that exist to help youth and their families. This is helpful to families, as many are encountering circumstances that are new and feel confusing. Some resources are only available in person (such as classes and home visiting services) and are limited to certain regions. Many other resources are available virtually, which makes them more accessible to families across the state. In addition to the non-exhaustive list below, most organizations that provide treatment services and other family support also offer internal support and education to the families of the enrolled youth. It is unknown how well informed families are about the availability of resources.

- 211 Info: A nonprofit organization in Oregon and Southwest Washington that helps people identify, navigate and connect with the local resources they need.[105]
- CaCoon: A public health home visiting program in 25 counties in Oregon that helps families coordinate care for their youth with special health needs.[106]
- Collaborative Problem Solving: Classes and support groups to assist parents in shifting their mindset about challenging behavior as skills-based needs; provides tools and a process for helping youth develop skills needed to manage stressful or concerning experiences.[107]
- Collaborative & Proactive Solutions: Evidence-based, trauma-informed, neurodiversity-affirming approach for understanding and helping kids with concerning behaviors.[108]
- FACT Oregon: Support line, knowledge library, in-person and virtual classes for families to navigate disability and special education services for their child(ren).[109]
- Family Support and Connections Program: Free program offered by ODHS that connects families with a family advocate. These services are available in every county; families must meet certain eligibility criteria to access.[110]
- National Alliance on Mental Illness (NAMI) Oregon: Offers classes, support groups and other resources to families of youth and adults with mental health needs. Services are free and available online and in person.[111]
- Oregon Consortium of Family Networks: A network of six regional organizations that supports families to become healthier family units, stronger advocates for their children and active in their communities.[112]
- Oregon Family Support Network (OFSN): Family-run statewide organization that provides education, support and advocacy to families, including individual family peer services, classes, support groups and more at low to no cost.[113]
- Oregon Family-to-Family Health Information Center: Supports families/caregivers of youth with special health needs in navigating health care systems. Staffed by parents of youth with complex health conditions; provides free one-to-one support, training and printed materials to families and professionals.[114]

- **Oregon Parenting Education Collaborative (OPEC):** Statewide parenting education network for families, parenting education professionals and partners (Oregon Department of Human Services and Oregon Department of Early Learning and Care. Provides online parenting workshops and classes, links to online resources for parenting tips, learning activities and books.[115]
- **Reach Out Oregon:** A community network for families/caregivers to access community resources and connect with others with similar experiences who are trained to help.[116]
- **Swindells Resource Center:** Centers for parents/caregivers of children with special health, behavioral or developmental needs. Video resources, information and educational workshops are provided throughout Oregon and SW Washington.[117]

**What respite options are available across the state? Who has access to respite?**

Respite is a foundational support in the SOC. Respite services provide a break for primary caregivers of children and youth with complex needs, as well as a break for youth themselves. Effective respite services are culturally and linguistically responsive, developmentally appropriate, flexible and provide a range of options, from drop-in childcare to preplanned or overnight crisis services. According to SOCAC's Youth Respite Report, respite is categorized as formal or informal.[118]

Formal respite is generally defined as services based on specific program eligibility or a diagnosis. Formal respite options in the SOC are outlined in Table 3.2.

Informal respite is more universally offered and offers more flexibility in terms of providers and settings. Informal respite is often accessed via schools, community and faith-based organizations, childcare settings and friends and family. Informal respite is also most desired by youth; youth-initiated respite is provided via peer supports and mentors. See the Neighborhood and Community and Education System chapters for more information on the informal respite settings outlined above.

> **The break it gave me… resulted in me coming back and being a better parent.**
>
> *– Parent describing their experience with respite care*[118]

Youth use respite for a variety of reasons (Figure 3.8).[118] Access to respite is a commonly cited barrier by youth, families and local SOCs.[118] Despite its importance and effectiveness at preventing necessity for more intensive services, very few families have access to respite. Among surveyed youth and families, 45% of families and 54% of youth said they were able to access respite when they needed it. The most common barriers to respite were not having a friend or family member who could care for their child, not knowing respite was an available service and not having an available respite provider in the area (Figure 3.9).[118]

*Figure 3.8. Primary reason youth use respite, from the Youth Respite Policy in Oregon Report*[118]

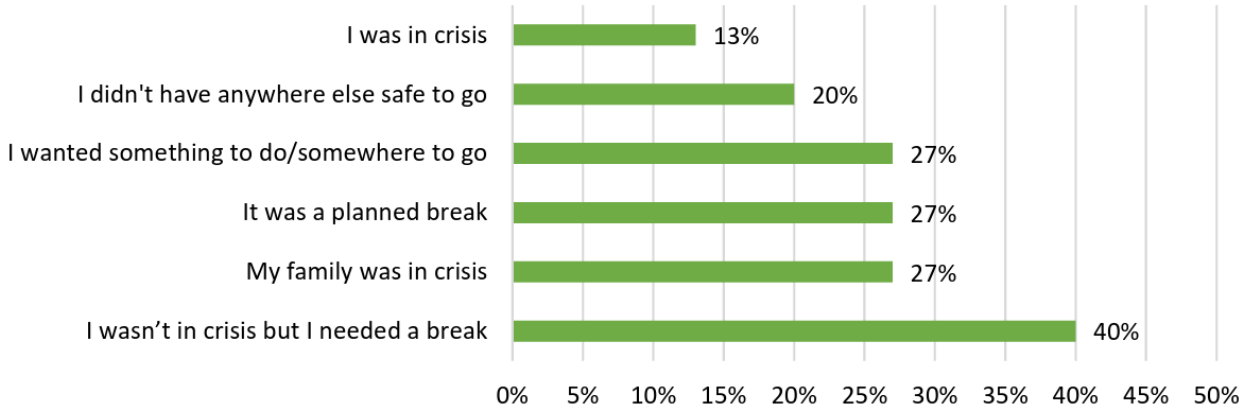



*Figure 3.9. Reasons youth were unable to access respite, from the Youth Respite Policy in Oregon Report*[118]

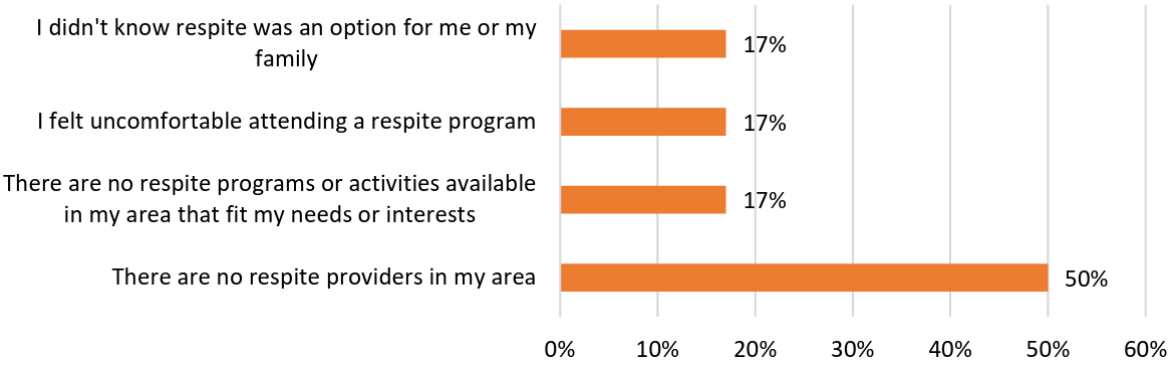


*Table 3.2. Formal respite services in Oregon, adapted from the Youth Respite Policy in Oregon Report*[6,118]

| Type of respite | Where it's provided | Who's providing it | Who is eligible | Funding sources | Number served |
|---|---|---|---|---|---|
| Behavioral health respite | In designated respite facilities and respite lodges | Licensed mental health providers | Youth with a behavioral health diagnosis served by a CCO | CCO global budgets and general funds | 1,134 individuals ages 0 to 25 (2020-2023) |
| Child welfare respite | In certified resource homes and Tribes in Oregon | Certified respite care providers and informal respite providers | Youth 0-18 who are in a resource home and biological families during trial reunification | State general funds | 2,468 youth served (January 2023 – January 2025) |
| I/DD respite | Often in youth's home or through a certified child foster home | Personal support workers, licensed & certified in-home agencies and certified child foster care providers | Any child determined eligible for I/DD services and has a need for the service | 1915(k) Community First Choice State Plan Amendment (K plan – Medicaid) | Average of 2,764 individuals annually (2020-2023) |
| Juvenile justice respite | In respite provider's home | OYA-certified respite providers | Certified OYA foster parents and their youth | General funds and special pay | Unknown |
| Relief nurseries | Designated and certified relief nurseries | Relief nursery staff and community partners | Children 0-5 and families with at least 5 stressors | State general funds, CCO health-related services, foundation or private funding | Unknown |

EDUCATION SYSTEM

## CHAPTER INTRODUCTION

Schools support youth development and well-being through education, prevention and tiered intervention and supports. By fostering safe and supportive environments, connecting students with caring adults and promoting positive peer relationships, schools can reduce the effects of negative experiences, such as bullying and substance use.[119-120] Schools also offer mental health support and link students and families to community resources. Schools that prioritize mental health can improve classroom behavior, student engagement and peer interactions, all of which play a crucial role in academic success.[121] Receiving quality education is crucial for developing the knowledge and skills needed for societal and economic participation. Studies show that educated individuals tend to live longer, participate more in their communities, commit fewer crimes and rely less on social support.[122] Although this report focuses on pre-kindergarten and kindergarten through grade 12 education, further education and vocation programs are also important, especially for transition-aged youth (18 to 26 years of age).

The Oregon Department of Education (ODE) is the largest youth-serving system in the state. Oregon has more than 1,200 public kindergarten to 12th grade schools in 197 school districts.[123] In 2023, Oregon had 726 elementary schools, 198 middle schools, 241 high schools and 107 combined schools.[124] ODE also serves youth aged 3 to 5 though pre-kindergarten programs and early intervention/early childhood special education (EI/ECSE) services. Furthermore, ODE provides special education services to school-aged youth (5-21 years of age).

In addition to public kindergarten through 12th grade schools, ODE provides educational services to youth in juvenile correctional facilities, behavioral health treatment facilities and in hospital settings.[125]

> **"We continue to press forward for our child's rights, advocating not only for his access to special education but also for better resources and support. As a parent, this constant battle to ensure my son receives even basic accommodations has been exhausting."**
>
> *– Parent describing their experience in the education system*[5]

## KEY TAKEAWAYS

The student groups with the highest rates of chronic absenteeism, dropouts and the lowest graduation rates were primarily youth experiencing homelessness, youth in foster care, youth with disabilities, English learners and American Indian / Alaska Native youth.

Many Oregon school districts lack effective substance use prevention programs; a majority of districts do not use evidence-based curricula for substance use education, and some rely on minimal resources like a single textbook chapter.

When asked about safety and inclusion in school, most students reported a relatively high sense of safety and felt a sense of belonging with peers and adults at their school. Many students also said they like going to school, felt welcome at their school and felt that adults at their school care about them.

Schools offer behavioral health services for students in every county in Oregon either through school-based health centers (SBHCs) or directly through Oregon Health Authority. From 2020 to 2023, SBHCs provided behavioral health services to an average of 6,011 youth across all regions in Oregon.

**How many families in Oregon have access to after-school care? How many families are waitlisted for these services? Are there regional or other disparities in access?**

### *Access to Afterschool Care*

As reported by Oregon Afterschool and Summer for Kids Network (OregonASK), after-school programs provide a variety of benefits for youth, including opportunities for social skills development, academic support and exposure to new experiences.[126] After-school programs can also provide respite for youth and families. They offer a structured and safe environment, promote physical activity and help youth spend less time on electronics.[126] These programs also support parents by allowing them to work while ensuring their youth are in a secure setting. Additional benefits include access to food and nutrition and the chance to learn new skills, such as a language.[126] Overall, these programs contribute to youth personal growth and well-being, while also assisting families and communities.

OregonASK reports that 91,595 (16%) of youth in Oregon are enrolled in after-school care. An additional 221,000 (44%) would participate but are limited by cultural, linguistic, financial or other barriers.[126] Of the youth who are *not* in after-school programs, 60% of Black youth and 57% of Hispanic youth reported interest in participating in an after-school program if one were available to them, compared to 35% of White youth. Barriers to accessing after-school programs can include factors like cost, lack of awareness and limited availability, especially in underserved areas.[126] Transportation issues and program capacity, such as full programs or long waiting lists, also prevent families from participating.[126] Cultural or language differences, inflexible hours and the need for accommodations for youth with disabilities can further restrict access.[126] Additionally, some families may face stigma, feeling that these programs are only for youth with specific needs, which could discourage participation.[126]

**How many youth ages 0 to 5 have been referred to, are receiving or were denied Early Intervention/Early Childhood Special Education (EI/ECSE) services? What barriers exist in access and availability across districts? Are there groups that are disproportionately receiving and/or denied access to services?**

The Early Intervention/Early Childhood Special Education (EI/ECSE) System partners with families and caregivers to provide free, equitable, timely and individualized services that enhance learning and development through everyday opportunities for all infants, toddlers and young children with disabilities.[127] Oregon has nine education service districts that offer Early Intervention/Early Childhood Special Education (EI/ECSE) to youth aged 0 to 5.[127] The EI/ESCE programs serve youth with many diagnoses such as intellectual disability, physical disability, communication disorder, traumatic brain injury, autism spectrum disorder and developmental delay.[128-132] The EI/ESCE programs are a partnership between the Oregon Department of Education and nine regional Education Service Districts (ESD). Table 4.1 shows the number of children aged 0-5 receiving EI/ECSE services from 2019 to 2023.[128-132]

*Table 4.1. Number of youth receiving Early Intervention/Early Childhood Special Education by Education Service District from 2019-2024*[128-132]

| | 2019-2020 | 2020-2021 | 2021-2022 | 2022-2023 | 2023-2024 |
|---|---|---|---|---|---|
| Education Service District (ESD) | # of youth | # of youth | # of youth | # of youth | # of youth |
| Clackamas ESD | 1,287 | 1,000 | 1,006 | 1,145 | 1,190 |
| David Douglas ESD | 2,725 | 2,178 | 2,114 | 2,482 | 2,778 |
| Douglas ESD | 1,620 | 1,231 | 1,334 | 1,546 | 1,627 |
| High Desert ESD – Deschutes | 647 | 585 | 582 | 686 | 724 |
| InterMountain ESD – Umatilla | 654 | 588 | 566 | 573 | 670 |
| Lane ESD | 1,583 | 1,206 | 1,263 | 1,440 | 1,520 |
| Linn Benton Lincoln ESD | 859 | 684 | 693 | 784 | 883 |
| NW Regional ESD – Washington | 2,501 | 2,075 | 2,022 | 2,070 | 2,227 |
| Willamette ESD – Marion | 1,471 | 1,019 | 981 | 1,038 | 1,086 |
| **Total** | **13,347** | **10,566** | **10,561** | **11,764** | **12,705** |

Demographic data indicates that youth receiving special education services are about 65% male, 35% female and less than 1% nonbinary.[128-132] This is proportional to the special education population.

In terms of race and ethnicity, most of the youth receiving EI/ESCE services are White students, followed by Hispanic, multiracial, Black / African American and Asian students. American Indian / Alaska Native and Pacific Islander students are the least represented. This is generally proportional to the school-aged youth population in Oregon. However, Asian students were slightly underrepresented, while Black / African American students were slightly overrepresented. Developmental delays and communication disorders are the most represented disabilities of youth in EI/ESCE programs.[128-132]

Youth living in rural areas are accessing EI/ECSE programs at a lower rate than youth living in more populated areas. Early intervention (EI) and early childhood special education (ECSE) contractors depend on community partners, like primary care and childcare providers, to identify and refer youth for evaluations. However, many rural areas lack enough of these providers, resulting in missed opportunities for early evaluations and referrals.[133]

The DAETA team was unable to obtain data on referrals and denials. This data was requested from ODE; however, they were unable to fulfill this request in the timeline of this report.

**How many youth ages 5 to 21 have been referred to, are receiving or were denied special education services? What barriers exist in access and availability across districts? Are there groups that are disproportionately receiving and/or denied access to special education?**

The Individuals with Disabilities Education Act (IDEA) is a U.S. federal law that ensures students with disabilities receive a free and appropriate public education (FAPE) tailored to their individual needs. Other key parts of IDEA include individualized education plans (IEPs), education in the least restrictive environment, active parent involvement and a process to resolve disputes with schools.[134] Special education is crucial as it offers youth with disabilities the additional support necessary to learn alongside their peers. Targeted therapies for speech, motor skills, behavior and social skills help youth catch up on key areas they may be struggling with, enhancing their overall learning experience.[134]

Between 2019 and 2024, approximately 14% of school-aged children in Oregon were enrolled in special education services.[23-27] Table 4.2 provides a breakdown of the number of youth receiving special education services each year. A higher proportion of males received these services compared to females, which aligns with the overall disability rates. Additionally, more White and Hispanic youth were served compared to other racial/ethnic groups, which is proportional to the population of school-aged youth in Oregon. The most common primary disabilities among these students were specific learning disabilities, communication disorders, autism spectrum disorder and other health impairments (Table 4.3).[23-27]

> **My child was accepted for a 504 plan this year. Last year we received help from the McKinney-Vento program coordinator at her school and were able to receive food boxes and access to other resources if needed. The staff have been very helpful.**
>
> *– Parent describing their experience with special education and accommodations*[5]

A reported 0.86% of Oregon students with an IEP are identified as having an emotional disturbance, compared to 0.67% nationally.[21] An emotional disturbance refers to a condition that significantly impacts a child's educational performance, characterized by long-term issues such as difficulty learning, trouble forming relationships, inappropriate behaviors, pervasive sadness or depression, or physical symptoms linked to personal or school problems. It includes schizophrenia but does not apply to youth who are only socially maladjusted, unless they also meet the criteria for emotional disturbance.[21]

> **Failure to ensure IEP requirements are followed due to staffing issues . . . should not impact the status of an evaluation, impede the original process started or delay services and supports provided.**
>
> *– Parent describing their experience with special education and accommodations*[5]

*Table 4.2. Individuals receiving special education, all districts, 2019-2024*[23-27]

| | 2019-2020 | 2020-2021 | 2021-2022 | 2022-2023 | 2023-2024 |
|---|---|---|---|---|---|
| Number of students receiving special education | 81,923 | 79,289 | 78,304 | 79,613 | 81,827 |
| Percentage of total students receiving special education | 14.1% | 14.2% | 14.2% | 14.5% | 15.0% |

*Table 4.3. Demographics of individuals receiving special education, all districts, 2019-2024*[23-27]

| | 2019-2020 | | 2020-2021 | | 2021-2022 | | 2022-2023 | | 2023-2024 | |
|---|---|---|---|---|---|---|---|---|---|---|
| Gender* | N = 71,547 | | N = 63,713 | | N = 68,315 | | N = 66,523 | | N = 71,032 | |
| | n | % | n | % | n | % | n | % | n | % |
| Male | 48,898 | *68.3%* | 44,105 | *69.2%* | 46,877 | *68.6%* | 43,016 | *64.7%* | 47,909 | *67.4%* |
| Female | 22,618 | *31.6%* | 19,558 | *30.7%* | 21,296 | *31.2%* | 23,209 | *34.9%* | 22,778 | *32.1%* |
| Nonbinary | 31 | *<1%* | 50 | *<1%* | 142 | *<1%* | 298 | *<1%* | 345 | *<1%* |
| Race and ethnicity* | N = 80,514 | | N = 77,980 | | N = 76,771 | | N = 73,273 | | N = 80,135 | |
| | n | % | n | % | n | % | n | % | n | % |
| Asian | 1,552 | *1.9%* | 1,510 | *1.9%* | 1,456 | *1.9%* | 1,511 | *2.1%* | 1,596 | *2.0%* |
| Black / African American | 2,223 | *2.8%* | 2,162 | *2.8%* | 2,042 | *2.7%* | 2,072 | *2.8%* | 2,241 | *2.8%* |
| Hispanic/Latino | 20,508 | *25.5%* | 20,310 | *26.0%* | 20,239 | *26.4%* | 20,718 | *28.3%* | 21,397 | *26.7%* |
| American Indian / Alaska Native | 1,130 | *1.4%* | 1,050 | *1.3%* | 1,052 | *1.4%* | 965 | *1.3%* | 1,058 | *1.3%* |
| Native Hawaiian / Pacific Islander | 308 | *<1%* | 322 | *<1%* | 312 | *<1%* | 357 | *<1%* | 365 | *<1%* |
| White | 49,883 | *62.0%* | 47,579 | *61.0%* | 46,494 | *60.6%* | 42,245 | *57.7%* | 47,696 | *59.5%* |
| Multiracial | 4,910 | *6.1%* | 5,047 | *6.5%* | 5,176 | *6.7%* | 5,405 | *7.4%* | 5,782 | *7.2%* |

**Certain data is suppressed on the individual school level due to the ODE confidentiality policy, which leads to different n denominators for the different demographics. The data provided is an estimate of proportions based on non-suppressed data.*

### *Barriers in Access and Availability of Special Education Services*

Workforce capacity may be a barrier to accessing special education services, as nationally, there is difficulty in hiring qualified special education teachers across school districts, especially in rural areas.[21] This is also true of Oregon, as many school districts in the state, especially in rural areas, struggle to meet the needs of students with disabilities, often providing fewer services than required. Rural education service districts must compete with urban areas, which often offer higher salaries,

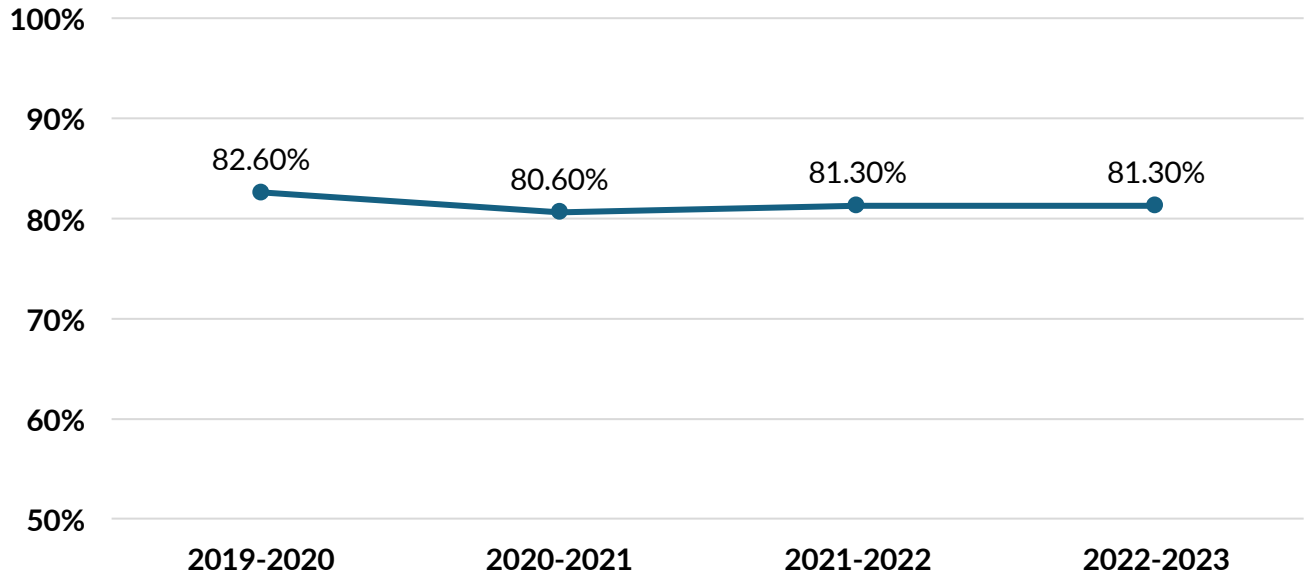
better benefits and lower caseloads, making it harder to attract and retain staff. Additionally, rural districts have difficulty finding professionals who can identify youth in need of services.[133] According to a report by the Oregon Audits Division, failing to address the needs of youth with disabilities leads to poorer outcomes for both the students and schools. Early access to support services is crucial for academic success, graduation and overall well-being. Without these services, students with disabilities cannot fully engage in their education.[133]

The team requested data for referrals and denials of special education services; however, the data request was not able to be fulfilled within the time frame of this report.

**What are Oregon's rates for chronic absence, suspension, expulsion, dropout/pushout and graduation, and how do these rates compare to other states? Are there groups that are disproportionately represented in any of these categories?**

The Oregon Department of Education collects information on student outcomes such as chronic absenteeism, suspensions, expulsions, dropout/pushout rates and graduation rates. Figure 4.1 shows graduation rates, while Table 4.4 outlines data on the other student outcome rates in Oregon from 2019-2024. While some student groups experienced poor outcomes in one or two rates such as students involved in the justice system, students experiencing poverty and Native Hawaiian / Pacific Islander students, certain student groups experienced poorer outcomes across all rates except for disciplinary rates. These were youth experiencing homelessness, youth in foster care, youth with disabilities, English learners and American Indian / Alaska Native youth.[135-139,144-148]

*Figure 4.1. Graduation rates for Oregon public schools, 2019-2024*[156-159]




**The graduation cohort represents students who began high school four years prior to their graduation.*

*Table 4.4. Rates for chronic absence, suspension, expulsion and dropouts/pushouts, all grades, 2019-2024*[135-148]

| | 2019-2020 N = 582,661 | | 2020-2021 N = 560,917 | | 2021-2022 N = 553,012 | | 2022-2023 N = 552,380 | | 2023-2024 N = 547,424 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | n | % |
| Chronically absent* | N/A** | | 150,722 | *28.1%* | 189,064 | *36.1%* | 200,103 | *38.1%* | 179,264 | *34.3%* |
| Out-of-school suspension | 17,677 | *3.0%* | 2,127 | *<1%* | 21,329 | *3.9%* | 24,841 | *4.5%* | N/A | N/A |
| In-school suspension | 9,989 | *1.7%* | 894 | *<1%* | 9,431 | *1.7%* | 11,866 | *2.1%* | N/A | N/A |
| Expulsion | 525 | *<1%* | 35 | *<1%* | 509 | *<1%)* | 537 | *<1%* | N/A | N/A |
| Dropout/pushout | 4,303 | *2.4%* | 3,267 | *1.8%* | 7,407 | *4.1%* | 6,059 | *3.3%* | N/A | N/A |

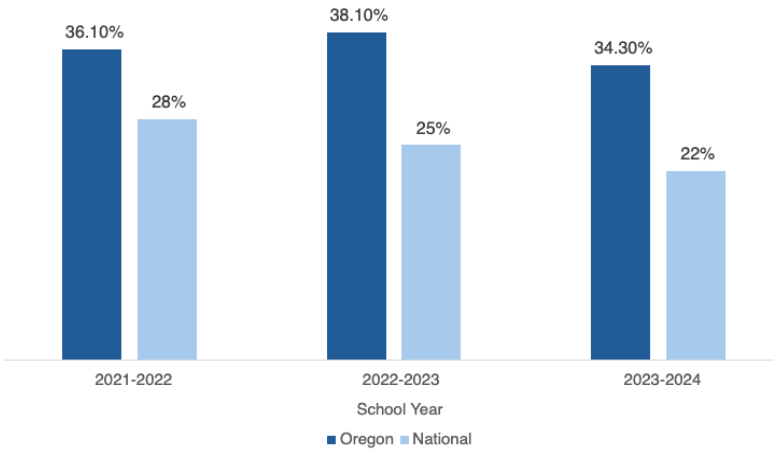
*Note: 2019-2020 and 2020-2021 data was affected by the COVID-19 pandemic and may not be comparable to other years.*
**Students are considered chronically absent if they attended 90% or fewer of their enrolled days between the beginning of the school year and the subsequent month of May.*
***Attendance rates starting in the 2020-2021 school year are not directly comparable to rates published for prior school years.*

### *Chronic Absenteeism*

Students are classified as chronically absent if they attend 90% or fewer of their enrolled school days from the start of the school year through the following May. Between 2021 and 2024, Oregon reported significantly higher rates of chronic absenteeism than the national average, as shown in Figure 4.2.[149]

From 2020 to 2024, homeless students consistently faced high rates of chronic absenteeism, ranging from 56.3% to 60.8%.[136-139] Youth who were currently or formerly incarcerated also had elevated absenteeism rates — 58.7% in 2022-2023 and 64.5% in 2023-2024.[136-139] Students experiencing poverty, those with disabilities, English learners and youth in foster care also had absenteeism rates higher than the annual average for all students in Oregon during the same time period.[136-139]

*Figure 4.2. Comparison of chronic absenteeism rates in Oregon and nationally, from FutureED*[149]



Overall, absenteeism tended to increase with grade level, with 12th grade exhibiting the highest number of absences and grades 1-6 showing the fewest, except for kindergarten.[136-139] Among racial and ethnic groups, Native Hawaiians / Pacific Islander students had the highest absenteeism rates, followed by American Indian/Alaska Native students, Hispanic/Latino students and Black / African American students. In contrast, Asian students and White students had the lowest rates.[136-139]

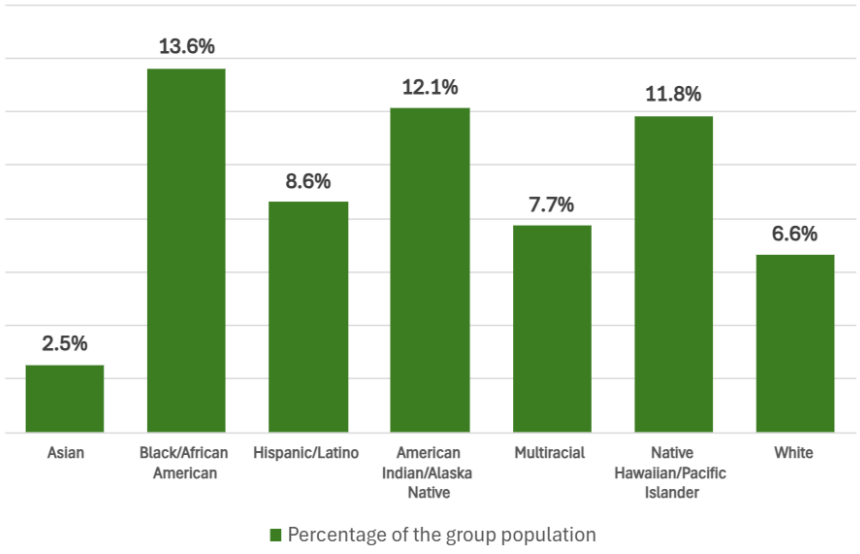
### *Suspensions and Expulsions*

National suspension and expulsion rates are only available for the 2020-2021 school year. During that year, Oregon reported lower percentages of out-of-school suspensions (0.38%), expulsions (0.01%) and dropouts (1.8%) compared to the national averages, which were 1.32%, 0.06% and 5.2%, respectively.[140-143, 144-148, 150-151] However, these numbers were likely impacted by the COVID-19 pandemic and the rise of distance learning, which probably reduced disciplinary actions.

As shown in Figure 4.3, during the 2023-2024 school year, disciplinary actions were most common among Black / African American (13.6%), American Indian / Alaska Native (12.1%), Native Hawaiian / Pacific Islander (11.8%) and Hispanic/Latino (8.6%) students[140-143]. In relation to the overall student population, Black / African American, American Indian / Alaska Native and Native Hawaiian / Pacific Islander students were overrepresented in disciplinary actions. [140-143]

Seventh and eighth graders also had the highest rates of disciplinary actions. Among student groups, those experiencing poverty (10.7%), English learners (8.2%) and students in special education (11.8%) faced the highest percentages of disciplinary incidents, with these rates remaining consistent across school years from 2019 to 2024.[140-143] The most common reasons for disciplinary actions were disruptive behavior, followed by altercations, harassment or intimidation.[152]

*Figure 4.3. Percentage of students who received disciplinary action during the 2023-2024 school year[152]*



### *Dropouts/Pushouts*

Dropout rates represent students who left school in a given school year without having either graduated or transferred to another educational setting. Pushout rates describe students that "may be leaving school (or pushed out of) because the education system is not inclusive or welcoming or meeting their unique needs".[152] While the definitions for dropouts and pushouts are different, ODE does not collect these as separate measurements. This data is combined for any youth that has not graduated or finished their education at another institution in four years from when they entered high school.

As presented in Table 4.5, dropout/pushout rates were highest among homeless students, ranging from 5.0% to 11.9%. Students in foster care, English learners and those with disabilities also had elevated rates. The racial and ethnic groups with the highest dropout rates were American Indian / Alaska Native, Black / African American, Native Hawaiian / Pacific Islander and Hispanic/Latino students.[144-148]

*Table 4.5. Student groups with the highest dropout/pushout rates in Oregon[144-148]*

| | 2019-2020 | 2020-2021 | 2021-2022 | 2022-2023 |
|---|---|---|---|---|
| | % of all students who dropped out/were pushed out | | | |
| All students | 2.4% | 1.8% | 4.1% | 3.3% |
| Demographic group | % of demographic group who dropped out/were pushed out | | | |
| Homeless students | 7.5% | 5.0% | 11.9% | 10.2% |
| Foster care | N/A | N/A | 9.6% | 7.9% |
| American Indian / Alaska Native | 4.7% | 2.9% | 7.8% | 5.2% |
| Black / African American | 4.1% | 3.2% | 5.3% | 5.0% |
| Current English learners | 4.0% | 2.9% | 6.9% | 6.2% |
| Native Hawaiian / Pacific Islander | 3.6% | 2.8% | 6.8% | 5.0% |
| Students with disabilities | 3.2% | 2.2% | 5.5% | 4.7% |
| Underserved races/ethnicities | 3.1% | 2.2% | 5.2% | 4.4% |
| Hispanic/Latino | 2.9% | 2.0% | 5.0% | 4.3% |
| Combined disadvantaged | 2.9% | N/A | N/A | 3.5% |
| Male | 2.7% | 2.1% | 4.6% | 3.7% |
| Economically disadvantaged | 2.6% | 1.6*% | 3.9*% | 3.2*% |
| Multiracial | 2.5% | 1.8*% | 4.5% | 3.4% |
| Currently or formerly incarcerated | N/A | N/A | N/A | 5.2% |

**These rates were equal to or lower than the average (all students) rate for the corresponding school year.*
*Note: This is a non-exhaustive list — more student groups, races, ethnicities and other identities are publicly available through Oregon Department of Education Dropout/Pushout Rates Report.*

### *Graduation Rates*

The average four-year cohort graduation rate in Oregon was 80% or higher across all school years from 2019 to 2023.[135] However, significant disparities in graduation rates were observed among

different student groups, which are shown in Table 4.6. In at least one school year, from 2020 to 2024, fewer than 60% of American Indian / Alaska Native students, students experiencing poverty, students with disabilities, English learners, homeless students and those in foster care or students involved in the justice system graduated. [135] Youth in foster care consistently had the lowest graduation rates, with less than 51% graduating each year from 2019 to 2024.[135] Four-year graduation rate data on currently or formerly incarcerated youth, reported for the first time during the 2022-2023 school year, revealed a graduation rate of just 35.8%.[135] The five-year cohort graduation rate shows an increase for youth involved with the justice system, reaching 54% in 2022-2023.[135-139] However, justice-involved youth still graduated at a much lower rate than youth who were not involved with the justice system. From 2019 to 2024, Oregon's high school graduation rates were lower than the national average for the same years (Table 4.7).[154]

*Table 4.6. Four-year cohort graduation rates among student groups, 2019-2024*[135]*

| Student Group | 2019-2020 | 2020-2021 | 2021-2022 | 2022-2023 | 2023-2024 |
|---|---|---|---|---|---|
| | % graduated | % graduated | % graduated | % graduated | % graduated |
| **All Students** | **82.6%** | **80.6%** | **81.3%** | **81.3%** | **81.8%** |
| **Gender** | | | | | |
| Male | 80.0% | 78.1% | 78.8% | 79.4% | 79.9% |
| Female | 85.5% | 83.5% | 84.2% | 83.6% | 84.0% |
| Nonbinary | NA | NA | NA | 71.8% | 71.2% |
| **Race/Ethnicity** | | | | | |
| American Indian / Alaska Native | 67.2% | 67.0% | 68.9% | 68.2% | 70.1% |
| Asian | 92.2% | 91.9% | 92.1% | 92.1% | 92.0% |
| Native Hawaiian / Pacific Islander | 76.6% | 69.8% | 74.6% | 75.9% | 72.7% |
| Black / African American | 76.3% | 73.5% | 73.7% | 73.1% | 74.8% |
| Hispanic/Latino | 79.5% | 77.0% | 78.7% | 78.6% | 78.8% |
| Multiracial | 81.0% | 79.3% | 79.7% | 79.8% | 80.6% |
| White | 84.0% | 82.1% | 82.5% | 82.6% | 83.1% |
| **Other Student Groups** | | | | | |
| Foster care | 43.9% | 47.8% | 48.4% | 46.9% | 51.0% |
| Students experiencing poverty | NA | 64.7% | 66.6% | 67.2% | 69.2% |
| Students with disabilities | 68.0% | 66.1% | 67.5% | 68.6% | 68.8% |
| English learners | 64.6% | 64.4% | 65.3% | 68.1% | 68.0% |
| Never English learners | 83.1% | 81.1% | 81.7% | 81.5% | 82.2% |
| Talented and gifted | 96.1% | 95.1% | 95.5% | 96.3% | 95.7% |
| Migrant | 79.9% | 78.3% | 81.4% | 81.6% | 82.7% |
| Homeless students | 60.5% | 55.4% | 58.6% | 60.6% | 61.3% |
| Military connected | NA | NA | NA | 86.7% | 85.7% |
| Recent arriver | NA | NA | NA | 63.3% | 66.8% |
| Currently or formerly incarcerated | NA | NA | NA | 35.8% | 39.0% |

*Note: The four-year cohort represents students who began high school four years prior to their graduation year. For example, for the 2022-2023 school year, the four-year cohort represents students who began high school in the 2019-20 school year.*

**Data from the 2019-2020 and 2020-2021 school years may not be comparable to other years due to the impacts of the COVID-19 pandemic.*

*Table 4.7. Oregon's four-year cohort graduation rates by county, 2020-2024*[*154, 156-159]*

| | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 |
|---|---|---|---|---|---|
| | % graduated | % graduated | % graduated | % graduated | % graduated |
| **National** | **89.0%** | **87.2%** | **86.9%** | **86.3%** | **N/A** |
| **Oregon** | **82.6%** | **80.6%** | **81.3%** | **81.3%** | **81.8%** |
| Baker | 83.9% | 78.2% | 81.8% | 80.0% | 79.1% |
| Benton | 87.7% | 86.4% | 83.2% | 85.4% | 84.9% |
| Clackamas | 89.2% | 89.6% | 88.2% | 88.3% | 89.1% |
| Clatsop | 84.9% | 79.2% | 84.2% | 81.2% | 82.7% |
| Columbia | 83.5% | 74.1% | 80.9% | 78.7% | 74.1% |
| Coos | 66.8% | 62.7% | 66.0% | 66.8% | 66.9% |
| Crook | 80.3% | 88.5% | 92.0% | 97.3% | 95.5% |
| Curry | 82.5% | 78.5% | 79.2% | 69.7% | 72.9% |
| Deschutes | 86.8% | 83.8% | 85.1% | 85.1% | 87.2% |
| Douglas | 76.0% | 73.3% | 74.3% | 73.1% | 77.1% |
| Gilliam | 81.0% | 84.0% | 83.3% | 95.0% | 100% |
| Grant | 90.9% | 92.4% | 78.5% | 64.2% | 63.2% |
| Harney | 83.9% | 83.5% | 78.4% | 62.3% | 64.1% |
| Hood River | 92.0% | 90.5% | 89.6% | 89.2% | 90.9% |
| Jackson | 83.4% | 82.2% | 84.5% | 84.1% | 83.6% |
| Jefferson | 86.5% | 85.9% | 89.8% | 88.1% | 91.4% |
| Josephine | 80.5% | 77.2% | 77.7% | 75.1% | 76.3% |
| Klamath | 80.3% | 76.4% | 78.1% | 75.1% | 74.8% |
| Lake | 94.2% | 87.1% | 93.0% | 82.4% | 88.9% |
| Lane | 78.8% | 77.8% | 77.9% | 78.1% | 77.8% |
| Lincoln | 79.9% | 57.8% | 86.3% | 80% | 82.0% |
| Linn | 76.8% | 71.9% | 74.5% | 79.4% | 83.0% |
| Malheur | 88.0% | 88.7% | 88.9% | 85.4% | 86.8% |
| Marion | 80.9% | 80.3% | 79.0% | 79.2% | 79.7% |
| Morrow | 91.9% | 96.6% | 95.1% | 96.4% | 95.6% |
| Multnomah | 80.6% | 77.4% | 79.1% | 78.6% | 77.9% |
| Polk | 85.0% | 83.6% | 79.9% | 75.0% | 82.4% |
| Sherman | 95.7% | 92.3% | 87.5% | 92.3% | 80.0% |
| Tillamook | 87.2% | 82.3% | 81.6% | 85.3% | 83.1% |
| Umatilla | 85.1% | 82.7% | 83.6% | 80.4% | 85.5% |
| Union | 90.0% | 85.4% | 73.6% | 82.9% | 84.4% |
| Wallowa | 86.6% | 92.5% | 88.9% | 91.9% | 80.5% |
| Wasco | 81.9% | 70.8% | 71.0% | 75.5% | 79.5% |
| Washington | 88.4% | 87.0% | 87.7% | 88.5% | 87.9% |
| Wheeler | 33.9% | 40.6% | 49.2% | 54.3% | 61.9% |
| Yamhill | 86.2% | 87.1% | 85.7% | 87.7% | 87.4% |

**Data from the 2019-2020 and 2020-2021 school years may have been affected by the COVID-19 pandemic. This data may not be comparable to other school years.*

**What school-based mental health services are available in each region and what is the utilization rate? Are there regional or other disparities in access?**

School-based mental health services provide mental health care to students within their school environment. This reduces barriers and improves access, aids early identification and treatment of behavioral health needs and may contribute to other positive outcomes like reduced absenteeism.[160] Services can be provided in schools through qualified professionals and through school-based health centers (SBHCs).[161] Some professionals that provide behavioral health services in schools include school counselors, school psychologists, school social workers and other qualified staff that have been trained in behavioral health-related topics.[161]

SBHCs are school-based clinics within schools or on school property that are funded "through public-private partnerships among the Oregon Public Health Division, school districts, local public health authorities, health care providers, parents, students, and community members".[162] As of September 2024, Oregon has 87 certified SBHCs in 28 counties.[163] About 65% of these SBHCs are located in Health Professional Shortage Areas (HPSAs).[164] The eight counties that lack SBHCs are Curry, Gilliam, Harney, Lake, Linn, Malheur, Sherman and Wallowa counties.[163]

Oregon's SBHCs commonly provide health screenings and behavioral health services, including substance use screening and assessment, mental health counseling, prevention and wellness education and health-related classroom presentations as part of their outreach efforts.[164] Behavioral health information collected by SBHCs encompasses mental health, substance use and integrated behavioral health services. Table 4.8 shows the number of school-aged youth and the number of visits to SBHCs for behavioral health.

*Table 4.8. Behavioral health* visits among school-aged youth, 2020-2023*[164]

| | 2019-2020 | 2020-2021 | 2021-2022 | 2022-2023 |
|---|---|---|---|---|
| Number of visits | 44,258 | 32,808 | 42,458 | 47,229 |
| Number of clients | 6,537 | 4,619 | 6,281 | 6,608 |

**Behavioral health includes mental health, substance use and integrated behavioral health.*

School-based health centers collect demographic data on youth receiving behavioral health services, as shown in Table 4.9. Most youth receiving behavioral health services through SBHCs were White, non-Hispanic youth, followed by Hispanic/Latino youth. This is proportional to the general youth population of Oregon.

The counties in Oregon that lack SBHCs (primarily located in rural areas) offer mental health services to schools through direct funding from the Oregon Health Authority (OHA).[165] In these schools, local mental health professionals deliver person-centered, trauma-informed crisis interventions and clinical support to students and their families. They also assist teachers with addressing mental health challenges in the classroom.[165]

*Table 4.9. Demographics of youth receiving behavioral health services through school-based health centers, 2020-2023*[164]

| | 2019-2020 | | 2020-2021 | | 2021-2022 | | 2022-2023 | |
|---|---|---|---|---|---|---|---|---|
| Demographic | n | *% of Clients* | n | *% of Clients* | n | *% of Clients* | n | *% of Clients* |
| Gender | | | | | | | | |
| Female | 3,517 | *61%* | 2,387 | *61%* | 3,492 | *62%* | 3,775 | *62%* |
| Male | 2,258 | *39%* | 1,493 | *38%* | 2,077 | *37%* | 2,278 | *37%* |
| Gender-expansive | N/A | *N/A* | N/A | *N/A* | N/A | *N/A* | 30 | *<1%* |
| Transgender | 26 | *<1%* | 14 | *<1%* | 71 | *1%* | 7 | *<1%* |
| Unknown | 10 | *<1%* | 8 | *<1%* | 12 | *<1%* | 17 | *<1%%* |
| Race/Ethnicity | | | | | | | | |
| Asian | 147 | *3%* | 77 | *2%* | 168 | *3%* | 163 | *3%* |
| American Indian / Alaska Native | 480 | *8%* | 159 | *4%* | 297 | *5%* | 261 | *4%* |
| African American / Black | 233 | *4%* | 148 | *4%* | 296 | *5%* | 311 | *5%* |
| Hispanic or Latino, Latina, Latinx | 1,368 | *24%* | 1,031 | *26%* | 1,444 | *26%* | 1,376 | *23%* |
| Native Hawaiian / Pacific Islander | 56 | *1%* | 31 | *1%* | 57 | *1%* | 69 | *1%* |
| White | 4,382 | *75%* | 3,082 | *79%* | 4,217 | *75%* | 4,572 | *75%* |
| White, non-Hispanic | 3,153 | *54%* | 2,232 | *57%* | 3,034 | *54%* | 3,352 | *55%* |
| Unknown race and ethnicity | 291 | *5%* | 251 | *6%* | 368 | *7%* | 488 | *8%* |

**What substance use education is occurring in schools, at what grade levels, and what are the outcomes? Are there regional or other disparities in access to substance use education in schools?**

Substance use education in schools is an important way to influence youth attitudes and behaviors regarding substance use. There is also evidence that it can help youth develop strategies for high-risk situations and make safer choices.[166] ODE

provides substance use education specific to each grade level from kindergarten to 12th grade. The Oregon Health Standards for substance use education build progressively each year. Early grades focus on understanding substance use and basic decision-making. Middle school students learn about peer pressure, refusal skills and the effects of substances on health. In high school, the focus deepens with topics like addiction, mental health and the social consequences of substance use, emphasizing personal responsibility and understanding the impact on long-term well-being.[167] Additionally, starting in the 2024-2025 school year, all Oregon school districts and public charter schools must implement one of the ODE Synthetic Opioid Prevention Lessons for each grade level (grades 6, 7, 8 and at least once in high school).[168]

***Outcomes of Substance Use Education in Oregon***

A 2024 report from The Lund Report, University of Oregon and Oregon Public Broadcasting reveals that many Oregon school districts lack effective substance use prevention programs.[169-170] Sixty percent of districts, including Portland Public Schools, do not use evidence-based curricula, and 20% rely on minimal resources like a single textbook chapter.[170] Only 44 out of 119 districts use expert-endorsed programs at the elementary level, and only one district includes parents in evidence-based prevention efforts.[170] Additionally, there is limited state support for selecting effective programs, and students report that the substance use education they receive is often repetitive across grade levels.[169] County-level information is available at the Lund Report's Data Portal.[170]

The team was unable to locate specific regional disparities; however, substance use education is required annually in each public K-12 school and public charter school under the jurisdiction of ODE.[171]

**Do students feel safe and included at school? Are certain groups of students more likely to feel unsafe or not included?**

OHA's Public Health Division administers the Oregon Student Health Survey (SHS), which is Oregon's largest youth survey, and provides an overview of students' physical, emotional and social well-being. The 2022 SHS was administered to youth in grades 6, 8 and 11.[22] Over 45,000 students completed the survey, representing 85 districts and 327 schools.[22] State-run schools or schools without an associated school district, such as juvenile justice facilities, treatment centers and boarding schools, were excluded from this survey.

The Student Educational Equity Development (SEED) Survey is an annual questionnaire offered to students in Oregon in grades 3-11, designed to gather data on their school experiences. The SEED survey includes an alternative version (Alt-SEED) for students with alternate academic standards, such as students with disabilities. The survey collects both quantitative and qualitative data to provide a comprehensive view of student performance when combined with other data sources. In the 2023-2024 survey, over 169,000 students participated, alongside 2,500 in the Alt-SEED version.[172]

***Results from the Student Health Survey***

A variety of questions in the SHS assessed youth safety. While feelings of inclusion was not a direct survey question, some survey questions can be used as proxies to understand if youth feel included in school, such as if they have access to spaces in school where they can meet with other students who share similar identities, and if they have been bullied in general or based on their identity. Table 4.10 summarizes student responses. In all grades surveyed, most students felt that they were safe in schools. However, 10.7% of sixth graders, 19.4% of eighth graders and 20.4% of 11th graders said they did not feel safe in school.[22] One-fifth (20.3%) of students in sixth grade said that they did not have a space at school to meet with other youth with whom they identify and 19% said they were bullied in the last 30 days.[22] Bullying was highest in eighth grade, with 25.5% of students reporting that they were bullied. In contrast, bullying was lowest in 11th grade, with 15.6% of students reporting that they were bullied.[22] In both eighth and 11th grades, more students reported that they were bullied for reasons other than identity such as race, gender, disability, etc.[22]

*Table 4.10. School climate and culture results from the 2022 Student Health Survey*[173]

| Student Responses | Grade 6 | Grade 8 | Grade 11 |
|---|---|---|---|
| | % | % | % |
| I feel safe at my school | | | |
| Strongly Agree | 29.5% | 14.9% | 11.5% |
| Agree | 45.1% | 49.6% | 54.1% |
| Disagree | 7.5% | 13.8% | 15.6% |
| Strongly Disagree | 3.2% | 5.6% | 4.8% |
| I am not sure | 9.3% | 11.9% | 10.8% |
| There is a student group or space at school where you can meet with other students whom you identify with or are like you | | | |
| Yes | 27.9% | N/A | N/A |
| No | 20.3% | N/A | N/A |
| I am not sure | 28.5% | N/A | N/A |
| Bullied at school in last 30 days | | | |
| Yes, bullied at school | 19.0% | 25.5% | 15.6% |
| No, not bullied at school | 81.0% | 74.5% | 84.4% |
| Bullied due to race, gender, disability or sexual orientation* | | | |
| Yes, identity-based bullied at school | N/A | 11.6% | 7.1% |
| No, bullied at school, but not identity-based | N/A | 14.0% | 8.5% |
| No, not bullied at school | N/A | 74.5% | 84.4% |

**Denominator is number of bullied students, not total.*

Stratification by demographic groups is available through the SHS crosstabs function. However, this information was not able to be included in this report due to the complexity of this data and

the limited time frame of this report. Responses were not adjusted to be mutually exclusive or to sum to 100%, meaning respondents could be included in multiple categories. This approach allows for more detailed data, making smaller groups more visible rather than combining them into larger categories. To see the percentage for each specific response, each response option must be examined individually.

***Results from the Student Educational Equity Development (SEED) Survey***

The SEED survey measures inclusion and safety in school through a measure called *Sense of Belonging*, which refers to how students feel accepted, respected and cared for in their school environment. The SEED Survey breaks this concept down into two areas: *1) Social Identity*, which focuses on how students' communities are represented in school materials, and *2) Comfortable at School*, which evaluates students' emotional and social connections with their school, including relationships with peers and staff.[172]

The 2023-2024 SEED Survey found that for the *Social Identity* measure, 79% of students reported some level of representation, shown in Figure 4.4. For the *Comfortable at School* measure, 91% of students reported feeling cared for by adults, and 83% reported feeling welcome (Figure 4.5). However, positive perceptions of school climate decline during middle school.[172] In the Alt-SEED survey, which measures *Sense of Belonging* differently, 63% of students reported opportunities to connect with peers and staff outside of class time, as depicted in Figure 4.6.

*Figure 4.4. 2023-2024 SEED Survey Sense of Belonging and Social Identity (Grades 3-11), from the Student Education Equity Development Survey Results*[172]

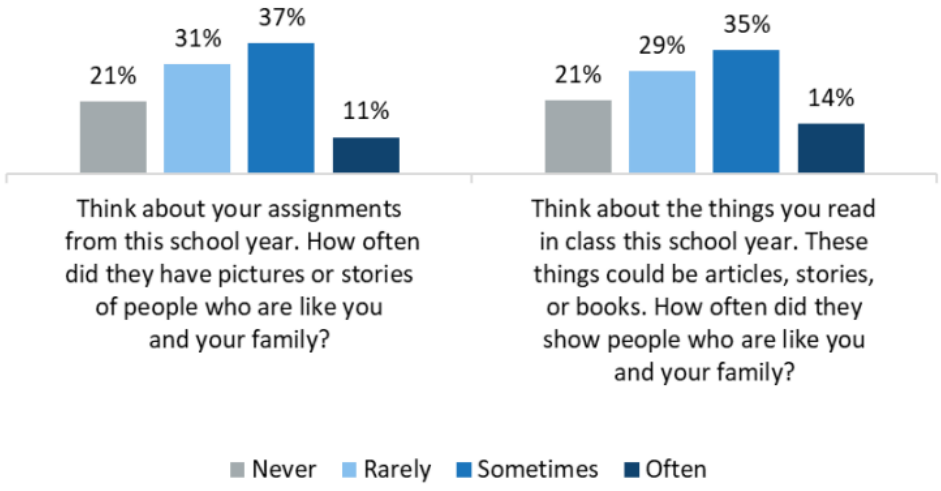
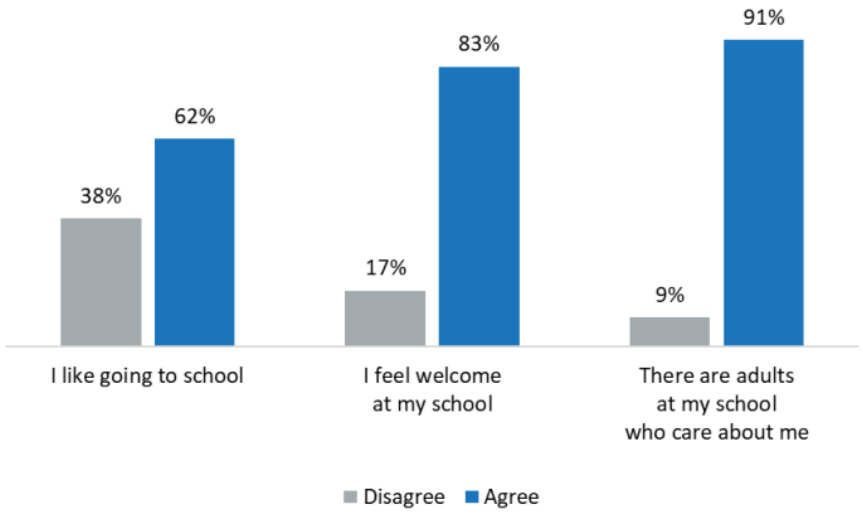
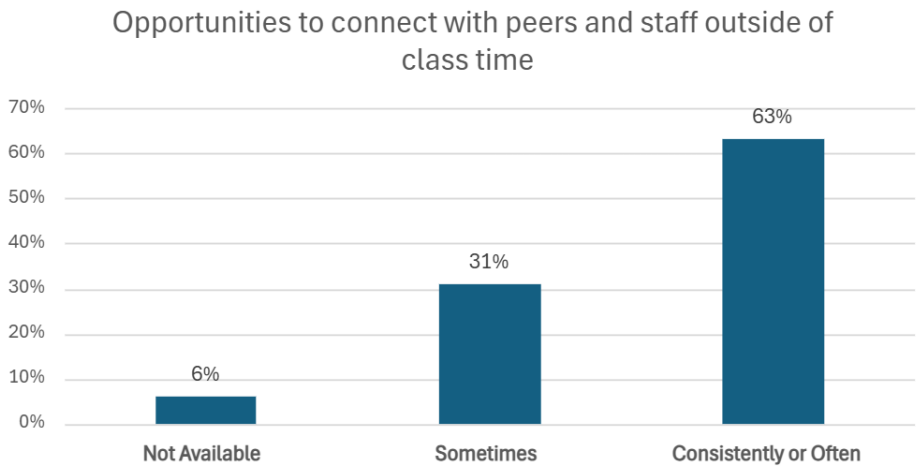


*Figure 4.5. 2023-2024 SEED Comfortable at School (Grades 3-11), from the Student Education Equity Development Survey Results*[172]




* *'Strongly disagree' and 'Disagree' were combined and labeled as 'Disagree; 'Strongly agree' and 'Agree' were combined and labeled as 'Agree.'*

*Figure 4.6. 2023-2024 Alt-SEED Sense of Belonging (Grades 3-8 and 11), adapted from the Student Education Equity Development Survey Results*[172]




Note: This data includes connection between students, peers and staff both virtually and in person.
* 'Consistently' and 'Often' were collapsed together.

While the SEED survey collects information on the demographics of participating youth, the team was unable to locate data specific to the variables associated with the *Sense of Belonging* in the time frame of this report.

**What is the role of education stress and how does it contribute to chronic stress/risk for mental health challenges? Are there groups that are disproportionately at risk of education stress?**

Academic pressure and high expectations can cause significant stress for students, leading to performance anxiety, fear of failure and a constant urge to succeed. This stress can negatively affect self-esteem and contribute to mental health struggles, such as anxiety, depression and self-harm.[174] The American Psychological Association (APA) outlines the different ways stress presents across age groups[174]:

- Pre-K and kindergarten students may experience physical symptoms such as stomach aches or incontinence or start habits like thumb sucking.
- Elementary students may cry frequently, visit the nurse often or display irritability and disruptive behavior.
- Middle school students might feel anxious, worried or isolated, with some showing anger or excessive laughter.
- High school students may withdraw, give up easily or exhibit strong emotional reactions like anger.

The DAETA team was unable to locate data referring to groups in Oregon that experience education stress disproportionately.

# PHYSICAL HEALTH CARE SYSTEM

## CHAPTER INTRODUCTION

This chapter looks at physical health care for youth in the primary care setting, lending insights into the prevalence of health screening, early identification and treatment. It also looks at maternal health care during pregnancy and postpartum as an important indicator of a mother's mental, physical and overall well-being, which all benefit the child.

Integrated health care is a central emphasis in Oregon and is reflected in the coordinated care organization (CCO) model. Oregon's vision for better health, better care and lowered costs for all also gave rise to the Patient-Centered Primary Care Homes (PCPCH) program in 2009, with every CCO being required to include PCPCHs in their care networks. PCPCH standards for care delivery were most recently revised in 2025.[175] There are more than 600 primary care practices recognized by this program in 35 counties across the state, accepting both public and private insurance. 93.8% of CCO members (not delineated by age) received their primary care at a PCPCH clinic in 2023.[175] PCPCH are important because they prioritize high-quality, patient-centered care by building strong relationships with patients and their families. This model improves care, reduces costs and focuses on prevention, early problem detection and managing chronic conditions.[176]

## KEY TAKEAWAYS

In Oregon, most pregnant mothers receive prenatal and postpartum care. However, disparities exist among women who are Native Hawaiian / Pacific Islander, Black / African American, Middle Eastern / North African and some women who have certain disabilities.

While screening and treatment for postpartum depression and anxiety are highly recommended, not all Oregon mothers are being screened or treated. Barriers include insurance gaps and coverage limitations, and providers report staffing or time constraints, language and cultural differences and limited knowledge of or access to referral services.

Youth with two or more disabilities are the most likely to have a primary care physician and attend well-child visits among all youth in Oregon.

Most screening for youth social determinants of health, social-emotional health and risk for suicide happens through the Oregon Student Health Survey administered through public schools.

Most telehealth primary care service data found was for school-based health centers (SBHCs). Primary care telehealth visits at SBHCs were highest at the peak of the COVID-19 pandemic (2020-2021).

**How many mothers are accessing prenatal and postpartum care? Are there groups that are disproportionately not accessing/receiving care?**

***Prenatal Care***

Prenatal care takes place during pregnancy and plays a crucial role in minimizing health risks for the mother and fetus. Monitoring the well-being of both the mother and fetus through physical exams, weight checks, urine and blood tests, and imaging procedures like ultrasounds helps ensure a healthy pregnancy.[177]

Nationally, in 2022, 74.9% of mothers received adequate prenatal care, defined as live births in which the mother received prenatal care beginning in the first four months of pregnancy with the appropriate number of visits for the infant's gestational age. In the same year, Oregon ranked 24th at 77.8%.[178] For members of coordinated care organizations (CCOs), the percentage of women who received timely prenatal care in 2022 was 79.9%, slightly higher than the state average. Table 5.1 shows a breakdown of prenatal care visits by CCO from 2020-2023. In this time period, the CCO statewide average of timely prenatal care remained relatively consistent.[179]

*Table 5.1. Percentage of pregnant women who received a prenatal care visit within the first trimester or within 42 days of enrollment in Medicaid by CCO, 2020-2023*[179]

| | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| Coordinated Care Organization | % | % | % | % |
| Statewide | 80.7% | 80.0% | 79.9% | 80.5% |
| Advanced Health | 80.8% | 82.0% | 88.1% | 87.3% |
| AllCare CCO | 90.7% | 87.3% | 85.2% | 87.3% |
| Cascade Health Alliance | 91.7% | 92.0% | 94.2% | 93.2% |
| Columbia Pacific | 86.8% | 88.0% | 85.9% | 77.1% |
| Eastern Oregon CCO | 89.4% | 86.5% | 86.8% | 75.7% |
| Health Share of Oregon | 85.4% | 79.5% | 83.1% | 84.1% |
| InterCommunity Health Network | 89.3% | 88.8% | 87.3% | 88.7% |
| Jackson Care Connect | 87.7% | 85.5% | 83.9% | 78.8% |
| PacificSource Central | 73.4% | 77.1% | 76.2% | 77.9% |
| PacificSource Gorge | 76.5% | 89.3% | 78.9% | 89.7% |
| PacificSource Lane | 84.2% | 79.3% | 75.1% | 84.8% |
| PacificSource Marion Polk | 68.1% | 67.7% | 67.2% | 77.3% |
| Trillium North | N/A | 69.4% | 70.7% | 62.3% |
| Trillium South | 81.8% | 77.9% | 78.2% | 80.1% |
| Umpqua Health Alliance | 59.1% | 55.1% | 50.3% | 56.4% |
| Yamhill Community Care | 66.1% | 74.0% | 87.2% | 91.0% |

### *Postpartum Care*

The postpartum period lasts six to eight weeks after delivery of an infant. Access to adequate postpartum care is important for a mother's mental, physical and overall well-being and is also beneficial to the infant's well-being and health.[180] Most postpartum physician visits occur about four to six weeks after delivery.

According to Oregon PRAMS, in 2020, 91.9% of mothers reported having a postpartum checkup.[182] This percentage slightly decreased to 90.8% in 2021. Statewide, postpartum care services for members of coordinated care organizations (CCOs) have increased from 40% in 2011 to 83.6% in 2023.[183] In 2022, 12 out of 16 CCOs showed improvement in postpartum care rates. By 2023, 14 CCOs met incentive benchmarks, which are quality measures that CCOs must meet to receive bonus money.[183-184] Table 5.2 illustrates the percentage of women who received postpartum care through a CCO from 2020 to 2023.

*Table 5.2. Percentage of women who received postpartum care by CCO, 2020-2023*[179]

| Coordinated Care Organization | 2020<br>% received care | 2021<br>% received care | 2022<br>% received care | 2023<br>% received care |
|---|---|---|---|---|
| Statewide | 73.7% | 77.8% | 80.8% | 83.6% |
| Advanced Health | 84.2% | 76.1% | 82.3% | 91.4% |
| AllCare CCO | 71.5% | 71.8% | 76.9% | 81.5% |
| Cascade Health Alliance | 91.7% | 87.6% | 84.3% | 86.3% |
| Columbia Pacific | 88.4% | 81.0% | 84.6% | 86.9% |
| Eastern Oregon CCO | 76.4% | 70.4% | 72.4% | 75.7% |
| Health Share of Oregon | 80.4% | 82.2% | 81.6% | 86.2% |
| InterCommunity Health Network | 75.3% | 82.7% | 85.9% | 85.1% |
| Jackson Care Connect | 78.9% | 81.4% | 85.8% | 83.7% |
| PacificSource Central | 74.1% | 85.4% | 86.1% | 85.7% |
| PacificSource Gorge | 71.1% | 91.1% | 84.0% | 87.0% |
| PacificSource Lane | 66.8% | 85.4% | 81.5% | 82.2% |
| PacificSource Marion Polk | 68.1% | 71.1% | 76.0% | 82.6% |
| Trillium North | N/A | 63.9% | 69.3% | 73.5% |
| Trillium South | 76.1% | 73.2% | 79.6% | 82.9% |
| Umpqua Health Alliance | 65.8% | 73.7% | 79.1% | 82.9% |
| Yamhill Community Care | 41.1% | 62.0% | 79.2% | 84.5% |

### *Disparities in Prenatal and Postpartum Care*

The Oregon CCO metrics dashboard and the CCO metrics annual report collect information on race/ethnicity, disability status and language for both prenatal and postpartum care. The report shows that in 2023, there were racial disparities in accessing care (Table 5.3): Native Hawaiian / Pacific Islander women had the lowest prenatal and postpartum care access rates.[179] Black /

African American women also had low rates of timely prenatal care. In comparison, Hispanic/Latino women had some of the highest prenatal and postpartum access rates. American Indian / Alaska Native women had the highest percentage of prenatal care. The prenatal and postpartum rates for White women were 80.6% and 82.7% respectively.[179]

*Table 5.3. CCO prenatal and postpartum care rates by race/ethnicity, 2023*[179]

| | Prenatal Care | Postpartum Care |
|---|---|---|
| Race/Ethnicity | % received care | % received care |
| American Indian / Alaska Native | 82.3% | 83.8% |
| Asian | 79.2% | 83.3% |
| Black / African American | 77.4% | 80.1% |
| Hispanic/Latino | 81.1% | 86.9% |
| Middle Eastern / North African | 72.5% | 85.0% |
| Native Hawaiian / Pacific Islanders | 58.7% | 64.0% |
| White | 80.6% | 82.7% |

Regardless of race/ethnicity, women who had two or more disabilities (82.8%) and women with cognitive / mental health disabilities (82.9%) had the highest rate of timely prenatal care.[179] For non-disabled women, the timely prenatal care rate was 80.6%.[179] Women who had disabilities that impacted their ability to live independently or complete self-care activities had the lowest rate of timely prenatal care (79.4%).[179]

Women with cognitive or mental health disabilities had the highest postpartum care access rate at 84.9%.[179] Women with limitations in independent living or self-care received the least postpartum care, at 80.6%.[179] For women without disabilities, the postpartum care access rate was 84.1%.[179]

**What screening is occurring for and what is the prevalence of postpartum depression and anxiety? Are there groups that are disproportionately not getting screened?**

Perinatal mood and anxiety disorders (PMAD) affect 1 in 7 mothers nationwide, making it the most common complication of pregnancy and childbirth.[185] A reported half of all perinatal women nationally with a diagnosis of depression do not get the treatment they need. Untreated PMADs are not only costly, but also have multigenerational consequences.[186] Treatment and screening for PMADs are crucial for the well-being of mothers and the health and development of their children. Research indicates that children of mothers with depression are at an increased risk of experiencing health problems, as well as having complex developmental, behavioral and cognitive needs — that can persist long into the future.[187]

According to the Oregon Health Authority, "prenatal and postpartum depression screening in Oregon is being carried out in a wide variety of settings, including obstetric and primary care practices, as well as early childhood services, home visiting programs and other settings that serve pregnant women and young families."[188]

An estimated 12.5% of women in Oregon suffered from postpartum depression (PPD) in 2021.[181] A cross-sectional study of health care providers in Oregon revealed that 29% screened for PPD at the infant's well-child visits; 64% screened at least once in the postpartum year; and 31% did not meet any screening guidelines.[189] According to Oregon PRAMS, about 5% of women reported that they had not received any postpartum screening after giving birth.[181]

Providers in Oregon struggle to deliver postpartum screening and treatment of PMAD due to staffing or time constraints, language and cultural differences, and limited knowledge or access to referral services.[189] Training, screening tools and resources are available for Oregon providers, as well as parent education materials; however, there does not seem to be available data to indicate what is occurring in practice.[190]

**How many youth have primary care physicians and are attending well-child visits? Are there groups of youth that do not have a primary care physician?**

Having a primary care physician is important for preventing, detecting and treating medical, developmental and behavioral health problems in youth, as well as for overall well-being of youth and families. The CCO Performance Metric Dashboard keeps a record of the number of youth ages 12 months to 19 years who have had well-child visits with a primary care provider. Table 5.4 depicts this metric from 2020-2022 per coordinated care organization (CCO) and statewide percentage.[179] Overall, most youth are having well-child visits with their PCP. This metric is relatively stable over time. All CCOs have over 80% compliance on this metric except for the Trillium CCOs.

Table 5.5 shows this metric by race/ethnicity.[179] On average, from 2020-2022, Multiracial/Other race or ethnicity had the highest percentage of youth attending well-care visits with a physician (89.23%), followed by Whites (85.23%).[179] Other races and ethnicities had similar percentages for this metric. Table 5.6 shows this metric broken down by disability experience.[179] Youth with two or more disability limitations had the highest percentage of visits with a primary care provider (92.83%).[179] Those who identified as non-disabled had the lowest percentage of visits with a primary care provider (85.53%).[179] As noted earlier, this data does not include non-CCO members.

*Table 5.4. Percentage of youth (ages 12 months to 19 years) who had a visit with a PCP by CCO, 2020-2022*[179]

| | 2020 | 2021 | 2022 |
|---|---|---|---|
| Coordinated Care Organization | % received care | % received care | % received care |
| CCO Statewide | 86.7% | 84.6% | 85.4% |
| Advanced Health | 88.0% | 84.3% | 85.6% |
| AllCare CCO | 84.2% | 80.3% | 81.6% |
| Cascade Health Alliance | 86.4% | 80.7% | 81.0% |
| Columbia Pacific | 85.5% | 81.0% | 83.1% |
| Eastern Oregon CCO | 86.6% | 85.2% | 86.4% |
| Health Share of Oregon | 87.0% | 84.0% | 84.9% |
| InterCommunity Health Network | 85.4% | 83.6% | 85.3% |
| Jackson Care Connect | 87.5% | 86.5% | 87.2% |
| PacificSource Central | 89.4% | 87.7% | 88.3% |
| PacificSource Gorge | 89.6% | 87.3% | 88.2% |
| PacificSource Lane | 85.0% | 86.5% | 87.5% |
| PacificSource Marion Polk | 84.4% | 87.0% | 87.0% |
| Trillium North | N/A | 65.3% | 68.0% |
| Trillium South | 81.4% | 76.9% | 76.8% |
| Umpqua Health Alliance | 88.5% | 85.1% | 86.7% |
| Yamhill Community Care | 87.4% | 82.9% | 84.2% |

*Table 5.5. Percentage of youth (ages 12 months to 19 years) that had a visit with a PCP by race/ethnicity, 2020-2022*[179]

| | 2020 | 2021 | 2022 | Average |
|---|---|---|---|---|
| Race/Ethnicity | % received care | % received care | % received care | % received care |
| Hispanic or Latino | 85.9% | 82.9% | 83.5% | 84.1% |
| American Indian / Alaska Native | 86.6% | 83.1% | 83.1% | 84.3% |
| Asian | 86.5% | 83.3% | 83.6% | 84.4% |
| Black / African American | 86.0% | 82.9% | 83.6% | 84.2% |
| Native Hawaiian / Pacific Islander | 86.0% | 83.0% | 83.5% | 84.2% |
| White | 87.1% | 84.2% | 84.4% | 85.2% |
| Other or multiracial | 90.2% | 88.3% | 89.3% | 89.2% |

*Table 5.6. Percentage of youth (ages 12 months to 19 years) that had a visit with a PCP by disability, 2020-2022*[179]

| | 2020 | 2021 | 2022 | Average |
|---|---|---|---|---|
| Disability | % received care | % received care | % received care | % received care |
| 2+ limitations | 93.1% | 92.6% | 92.8% | 92.8% |
| Blind/low vision | 90.5% | 88.7% | 88.2% | 89.1% |
| Cognitive/mental health | 93.6% | 92.0% | 91.3% | 92.3% |
| Communication | 85.5% | 88.9% | 92.6% | 89.0% |
| Deaf/hard of hearing | 92.4% | 89.4% | 92.5% | 91.4% |
| Mobility/physical | 94.2% | 95.6% | 92.7% | 94.2% |
| Non-disabled | 86.2% | 84.7% | 85.7% | 85.5% |
| Other severe disability | 92.4% | 90.4% | 90.6% | 91.1% |

**What Early and Periodic Screening, Diagnostic, and Treatment services are youth requesting and receiving? How many denials are occurring and for what services and why? How have services requested, received and denied changed over time?**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is comprehensive health care coverage (including medical, vision, dental and behavioral health) for youth with OHP under 21 years of age or up to 26 if they also have special health care needs.[191] Prior to 2023, coverage was limited to placement on the prioritized list of health services. Updated rules effective January 2023 expanded this coverage to include services regardless of placement.[191]

NOTE: Data throughout this report highlights the medical and behavioral health services youth are accessing in Oregon; while data is not specific to EPSDT, many of the services described are part of this program.

OHA reports that the EPSDT program is still in its early development in terms of quality assurance and data monitoring. Authorization and claims data contain errors and need to be interpreted with caution. OHA was only able to provide data on service denials for 2023 (Table 5.7). There were 293,616 total denials that occurred in 2023; it is unknown what the denominator of total requests for service was. As OHA continues to hire and train data analysts and quality assurance staff, the agency states that it plans to develop more robust monitoring and data sharing mechanisms.

*Table 5.7. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) prior authorization and claim denial rates, 2023*[192]

| Denial Reason | % of Total Denials |
|---|---|
| **Total EPSDT Denials** | **293,616** |
| The denial, in whole or in part, of payment for a service | 88.9% |
| The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit | 10.6% |
| The failure of a managed care entity/coordinated care organization to act within the identified time frames regarding the standard resolution of grievances and appeals | < 1% |
| The reduction, suspension or termination of a previously authorized service | < 1% |
| The failure to provide services in a timely manner, as defined by the state | < 1% |
| Denial of a member's request to obtain services outside the managed care entity panel. Use this category when the MCE/CCO is denying a member's request to exercise his or her right to obtain services outside the network. | < 1% |
| Unknown reason | < 1% |

**What type of health screening and treatment is occurring in primary care settings, including screening for social determinants of health, early social-emotional health screening? Are there groups that are disproportionately receiving screening or treatment?**

Screening in primary care settings can enable early identification of behavioral health needs and facilitate supports and services before needs become more severe. This section discusses different types of screening that occur in Oregon. Individual-level data that would identify which groups are receiving treatment was not able to be obtained within this project's time frame.

### *Developmental Screening*

Developmental screenings assess for the child's risk for developing "developmental, behavioral and social delays".[179] These screenings typically occur in the first few years of life. The NSCH reports that Oregon youth ages 9 to 35 months receive a developmental screening more often (49.1%) than youth nationally (33.7%).[18] The CCO Metrics dashboard reports a higher rate (65.9% in 2023) among youth with OHP.[179]

### *Social Determinants of Health (SDOH)*

Primary care providers are encouraged to use a SDOH screening tool to assess their patients' food, transportation and housing needs; OHA publishes a comprehensive list of screening tools that providers can use.[193] SDOH screening is a recently implemented quality incentive metric for

CCOs.[179] In its first year of implementation (2023), all but one CCO (InterCommunity Health Network) met benchmarks in developing processes related to screening, referral and data collection.[183] Specific data about the number of youth receiving SDOH screening is not yet available.

### *Social-Emotional Health Screening*

OHA has also partnered with the Oregon Pediatric Improvement Partnership[195] and the Children's Institute[196] to implement social-emotional health screening for young children ages 0 to 5.[193] This is part of a statewide effort to measure readiness for kindergarten.[197]

CCOs use screening tools and OHA data reports to improve social-emotional health. They submit asset maps detailing local services and track intervention rates, including counseling, therapy, parent education and skills training.[198] While there have been slight but steady increases in the number of young children screened and treated for social-emotional health concerns, overall statewide rates remain low (Table 5.8).[198]

*Table 5.8. Number and percentage of young children aged 1-5 who were screened and/or received issue-focused interventions for social-emotional health*[198]

| | **2020-2021** N = 98,467 | | **2021-2022** N = 101,088 | | **2022-2023** N = 100,894 | |
|---|---|---|---|---|---|---|
| Coordinated Care Organization | % screened | % treated | % screened | % treated | % screened | % treated |
| Statewide | 3.9% | 2.9% | 4.3% | 3.0% | 5.3% | 3.7% |
| Advanced Health | 2.0% | 3.2% | 4.1% | 3.4% | 5.3% | 5.4% |
| AllCare CCO | 3.0% | 2.2% | 3.5% | 2.6% | 3.5% | 2.7% |
| Cascade Health Alliance | 6.6% | 2.6% | 6.0% | 2.4% | 6.1% | 2.5% |
| Columbia Pacific | 3.6% | 2.9% | 3.3% | 2.9% | 6.3% | 2.7% |
| Eastern Oregon CCO | 8.3% | 2.3% | 7.0% | 2.5% | 6.5% | 2.5% |
| Health Share of Oregon | 3.8% | 2.9% | 4.8% | 3.1% | 7.0% | 3.9% |
| InterCommunity Health Network | 2.4% | 2.5% | 2.6% | 2.2% | 3.2% | 3.1% |
| Jackson Care Connect | 3.4% | 3.4% | 3.7% | 2.9% | 6.1% | 4.0% |
| PacificSource Central | 6.5% | 3.3% | 6.4% | 3.6% | 6.4% | 4.8% |
| PacificSource Gorge | 4.1% | 2.8% | 2.9% | 3.2% | 2.2% | 3.2% |
| PacificSource Lane | 3.2% | 3.5% | 3.5% | 4.0% | 4.0% | 5.6% |
| PacificSource Marion Polk | 2.2% | 3.1% | 2.7% | 2.7% | 2.4% | 3.3% |
| Trillium North | 1.7% | 0.6% | 3.4% | 1.0% | 4.0% | 2.4% |
| Trillium South | 1.9% | 2.0% | 2.7% | 2.4% | 2.6% | 2.8% |
| Umpqua Health Alliance | 1.9% | 2.6% | 2.4% | 2.9% | 2.4% | 3.9% |
| Yamhill Community Care | 5.7% | 3.4% | 6.4% | 3.0% | 9.0% | 3.8% |

### *Screening for Depression*

Mental health screenings are essential for youth, as an estimated 50% of mental health conditions develop by age 14, and 75% by age 24.[200] Table 5.9 shows the percentage of OHP members aged 12+ who were reported by CCOs to have been screened for depression from 2020-2022 in Oregon (youth-specific data is unavailable as data is not collected by age). Overall, less than two-thirds of individuals are appropriately screened for depression; rates in two CCOs are below 50% (Cascade Health Alliance and InterCommunity Health Network in 2023).

*Table 5.9. Percentage of patients (ages 12 and older) who had appropriate screening and follow-up planning for depression*[179]

| | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| Coordinated Care Organization | % screened | % screened | % screened | % screened |
| Statewide | 52.0% | 52.0% | 58.3% | 64.9% |
| Advanced Health | 48.9% | 42.8% | 19.8% | 49.0% |
| AllCare CCO | 41.4% | 45.6% | 49.8% | 63.6% |
| Cascade Health Alliance | 47.1% | 32.8% | 35.5% | 37.3% |
| Columbia Pacific | 59.5% | 55.1% | 64.5% | 69.5% |
| Eastern Oregon CCO | 72.9% | 58.1% | 65.8% | 74.6% |
| Health Share of Oregon | 47.1% | 58.0% | 61.9% | 67.6% |
| InterCommunity Health Network | 51.0% | 28.1% | 42.6% | 44.9% |
| Jackson Care Connect | 52.0% | 59.6% | 70.6% | 72.9% |
| PacificSource Central | 74.5% | 78.9% | 78.8% | 75.7% |
| PacificSource Gorge | 35.1% | 42.7% | 56.9% | 67.6% |
| PacificSource Lane | 55.1% | 59.7% | 55.4% | 67.2% |
| PacificSource Marion Polk | 49.8% | 51.7% | 52.2% | 55.4% |
| Trillium North | N/A | 38.5% | 63.4% | 69.9% |
| Trillium South | 49.5% | 42.2% | 60.6% | 68.2% |
| Umpqua Health Alliance | 51.0% | 25.3% | 47.1% | 58.7% |
| Yamhill Community Care | 55.5% | 62.3% | 65.0% | 71.0% |

### *Substance Use Screening and Treatment*

Screening Brief Intervention and Referral to Treatment (SBIRT) rates measure the number of individuals ages 12 and up who receive screening and brief intervention/referral if needed (youth-specific data is not published).[201] In 2023, three CCOs were below the benchmarks for both screening and treatment/referral (Eastern Oregon CCO, Health Share of Oregon and InterCommunity Health Network) (Table 5.10).[179]

*Table 5.10. Screening Brief Intervention and Referral to Treatment (SBIRT) rates*[179]

| | **2020** N = 273,574 | | **2021** N = 305,105 | | **2022** N = 329,006 | | **2023** N = 363,281 | |
|---|---|---|---|---|---|---|---|---|
| Coordinated Care Organization | % screened | % treated | % screened | % treated | % screened | % treated | % screened | % treated |
| Statewide | 50.2% | 29.2% | 55.2% | 28.2% | 53.9% | 37.0% | 60.2% | 38.9% |
| Advanced Health | 50.6% | 2.6% | 43.5% | 3.0% | 57.8% | 22.1% | 73.0% | 13.2% |
| AllCare CCO | 42.0% | 69.9% | 50.3% | 78.9% | 52.4% | 72.0% | 57.6% | 47.5% |
| Cascade Health Alliance | 23.8% | 47.7% | 57.3% | 19.7% | 49.0% | 64.3% | 56.0% | 46.5% |
| Columbia Pacific | 59.2% | 23.2% | 61.3% | 15.4% | 64.8% | 15.4% | 67.5% | 20.0% |
| Eastern Oregon CCO | 68.7% | 70.2% | 58.8% | 27.0% | 51.4% | 28.8% | 55.2% | 26.2% |
| Health Share of Oregon | 41.9% | 18.1% | 49.9% | 17.4% | 54.1% | 23.5% | 59.1% | 24.1% |
| InterCommunity Health Network | 61.7% | 19.6% | 51.6% | 0% | 17.0% | 20.4% | 18.9% | 18.9% |
| Jackson Care Connect | 48.0% | 29.4% | 51.8% | 17.0% | 58.3% | 16.8% | 70.1% | 30.8% |
| PacificSource Central | 68.9% | 21.7% | 78.6% | 33.7% | 80.2% | 55.8% | 81.2% | 53.3% |
| PacificSource Gorge | 39.0% | 10.1% | 43.4% | 25.2% | 52.4% | 17.7% | 60.1% | 34.9% |
| PacificSource Lane | 47.2% | 32.0% | 53.8% | 21.2% | 38.9% | 39.1% | 53.9% | 48.2% |
| PacificSource Marion Polk | 51.4% | 25.6% | 66.2% | 47.7% | 64.1% | 44.0% | 67.2% | 46.4% |
| Trillium North | N/A | N/A | 68.2% | 21.8% | 73.1% | 32.7% | 71.6% | 29.3% |
| Trillium South | 59.9% | 53.9% | 68.2% | 56.0% | 66.1% | 54.6% | 77.7% | 62.4% |
| Umpqua Health Alliance | 60.6% | 82.0% | 36.8% | 22.2% | 47.2% | 41.4% | 58.7% | 61.9% |
| Yamhill Community Care | 57.9% | 13.8% | 74.2% | 10.3% | 69.4% | 36.4% | 77.0% | 30.3% |

## What support do primary care providers have in working with system-involved youth?

A key component to improving care for system-involved youth is coordination between primary care and other youth-serving systems. Historically, it has been a challenge for community mental health programs, intellectual and developmental disability

services, the education system and primary care services to engage with each other. Although specific provider data could not be found to reflect this, it is reflected in surveys from youth and families, mentioned later in this report.

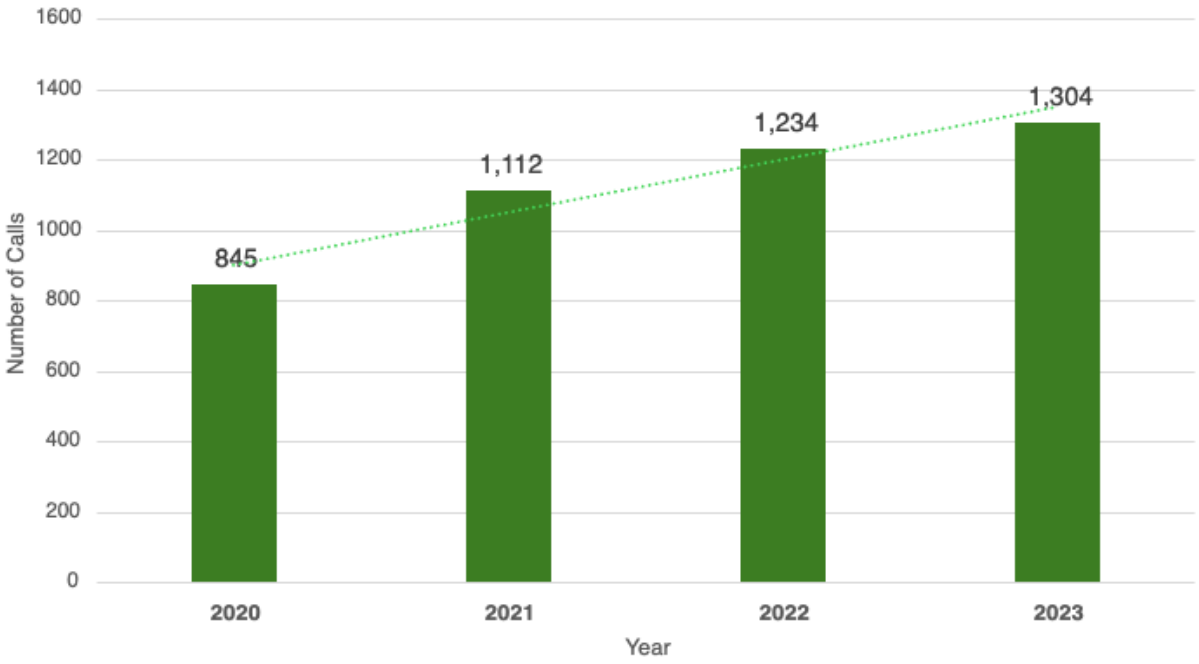
System-involved youth often present with complex medical and social needs. Co-located behavioral health providers in primary care clinics is an expanding practice to address these needs. This practice often focuses on short-term mental health and refers out for longer-term and more complex needs.

Some resources to support primary care providers in coordinating with agencies and other providers or accessing specialized support through consultation with specialists include:

Oregon Psychiatric Access Line (OPAL)[202]

OPAL is a program funded by OHA that provides free psychiatric phone consultations to primary care providers and developmental-behavioral pediatricians (DBP) in Oregon. OPAL also supports primary care providers through medical practitioner education services and by connecting providers with other mental health professionals in Oregon. From 2020-2023, OPAL – about Kids (OPAL-K) received 4,495 consult calls. The volume of calls OPAL-K received has increased per year from 2020 to 2023 (Figure 5.1).[203] In a post-service survey, a large majority of providers who used OPAL-K strongly agreed that the consult was useful and that their patient was able to get mental health assistance more quickly due to this program.[203]

*Figure 5.1. Number of OPAL-K consultations from 2020-2023, from the Oregon Psychiatric Access Line*[203]



Collaborative Problem Solving (CPS)[204]

OHA supports training in the CPS model for providers, equipping them with tools to address challenges and develop necessary skills to support youth with complex needs. The model helps providers guide their patients in becoming more flexible and adaptable.

The Oregon Pediatric Improvement Partnership (OPIP)[195]

OPIP is a four-year cooperative agreement between various organizations, including the Health Resources and Services Administration (HRSA) and the Maternal Child Health Bureau (MCHB). The program hosts learning collaboratives and provides consulting and training for a variety of topics. Focus areas include Children with Special Health Care Needs, Developmental Screening, Engaging Health Complexity and more. From 2020 to 2023, OPIP trained 100 providers in behavioral health-related topics[205]:

- From Screening to Services project: Developmental screening, brief interventions and referral pathways from primary care to behavioral health providers (34 attendees).
- Health Share of Oregon project: Social-emotional development, behavioral health care in primary care settings, interventions and referral to external providers (60 attendees).
- Transforming Pediatrics for Early Childhood project: Social-emotional assessment, strategies for treating young children (six attendees).

**How many primary care visits occur via telehealth? Are there some groups of people who do not have access to primary care visits via telehealth?**

For many youth and families, telehealth may increase access to health care. This is particularly true for families in rural areas, with limited access to transportation, mobility barriers or unmet childcare needs. According to the Center for Connected Health Policy, OHA authorizes coverage for telehealth and telemedicine services, defined as video conferencing, store-and-forward imaging, streaming media including services with information transmitted via landlines, and wireless communications.[206]

Additional research is needed to comprehensively answer how many telehealth visits are occurring in the primary care setting for different groups of youth. While individual-level utilization data couldn't be obtained given the time frame of the report, data on overall use of telehealth by individuals with OHP (for all ages) and use for behavioral health services within primary care (ages 0 to 26) is presented.

A state workforce report found that the overall use of telehealth has increased since the COVID-19 pandemic began in 2020 (Figure 5.2).[207] In fiscal year 2022, "62% of OHP telehealth claims were for behavioral health and 25% for primary care," which reflected national trends. Individuals living in urban areas were most likely to be accessing telehealth (Figure 5.3).[208]

OHA reports that for behavioral health-related visits to primary care (for youth up to age 26), an average of 13.5% of visits occur via telehealth; this has slightly decreased over time (Table 5.11).[28-29]

*Figure 5.2. Percentage of OHP claims that are telehealth over time, from the Oregon's Health Care Workforce Needs Assessment 2023 Report*[207]

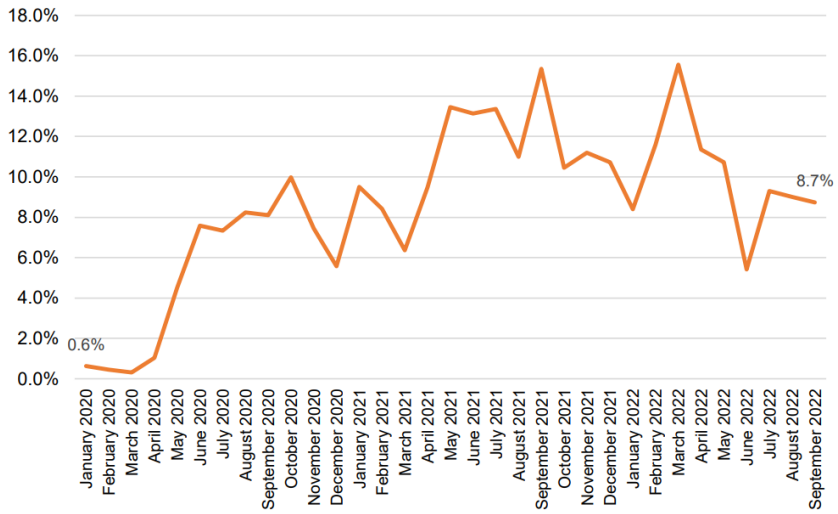



*Figure 5.3. Percentage of OHP ambulatory claims that are telehealth, by rurality of residence, fiscal year 2023, from the Oregon's Health Care Workforce Needs Assessment 2025 Report*[208]

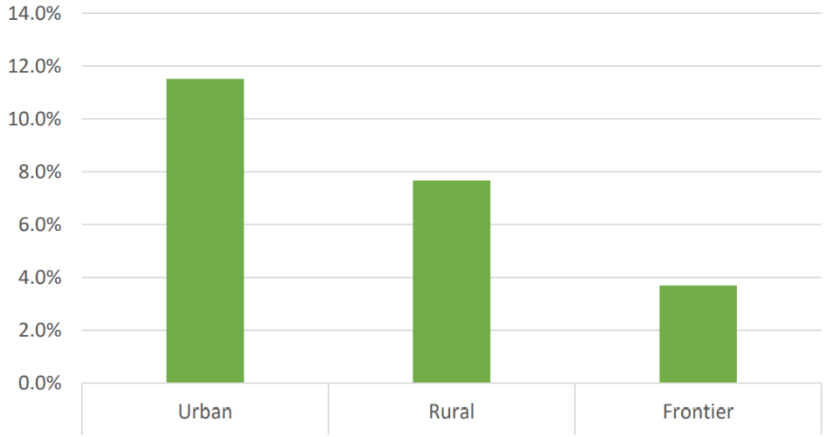



*Table 5.11. Percentage of behavioral health-related primary care visits for youth up to 26 years of age that occurred via telehealth, 2020-2023*[28-29]

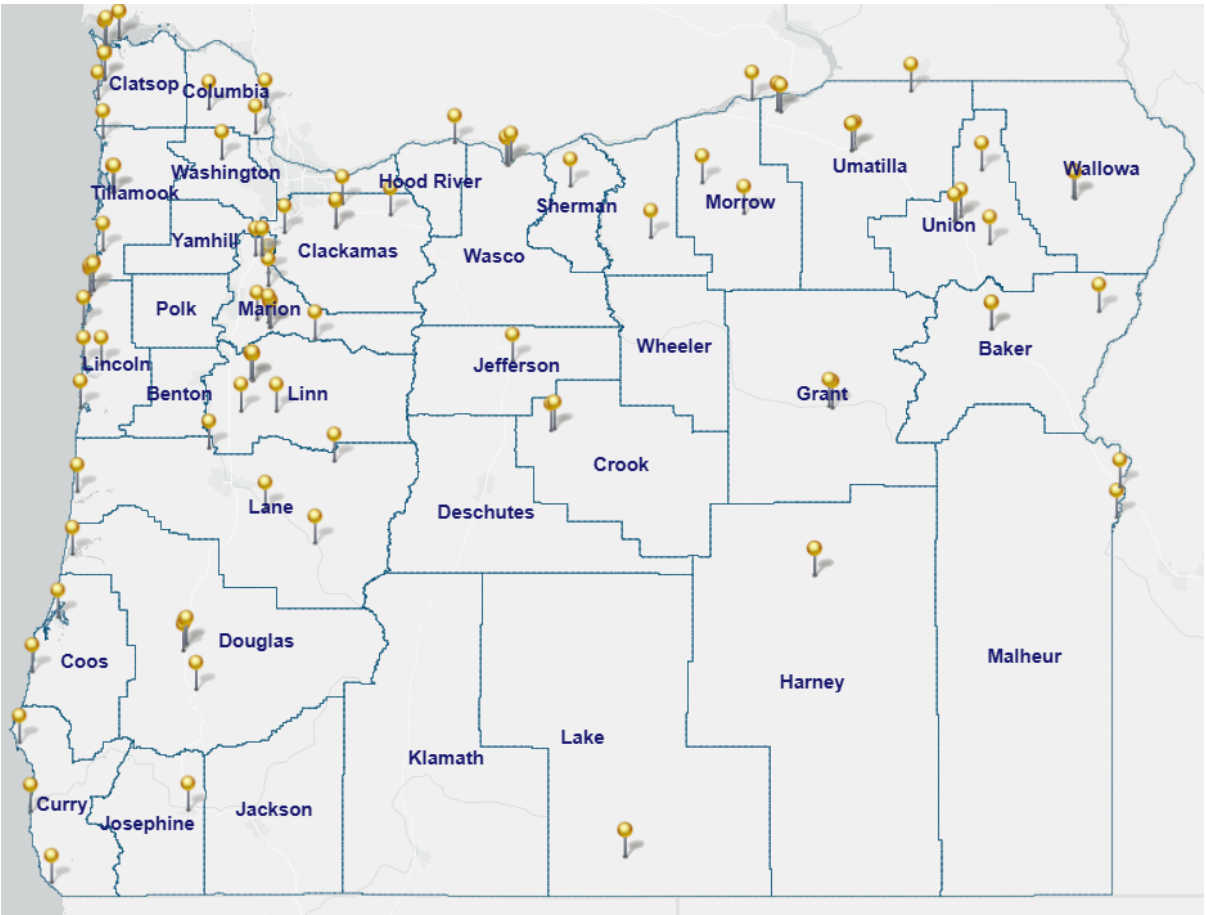
| | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| | % | % | % | % |
| % of behavioral health-related primary care visits that occurred via telehealth | 14.3% | 14.7% | 12.9% | 12.4% |

### *Gaps in Access to Telehealth*

A report by the Pew Charitable Trust indicates that while Americans with lower incomes have made gains in availability and access to modern technology (such as broadband internet and smartphone ownership), this group still experiences significant differences in the way they access and utilize technology compared to individuals with higher income levels. For example, in 2021, those with lower incomes were more likely to own a smartphone compared to previous years and this technology is also often their only available access to internet, which may impact their ability to utilize telehealth software.[209]

OHSU's Oregon Office of Rural Health published an interactive story map of Oregon's federally designated Rural Health Clinics (RHCs) that offer telehealth, including primary care [210], as shown in Figure 5.4. This map indicates counties not offering telehealth services at a RHC at the beginning of 2021: Jackson, Klamath, Deschutes, Wheeler, Polk, Yamhill, Benton and Multnomah. A closer look at this map provides more details on specific RHCs and which telehealth services are provided.

*Figure 5.4. Oregon Rural Health Clinic map of clinics that offer telehealth, 2020, from the Oregon Office of Rural Health*[210]



### *Telehealth in School-Based Health Centers*

School-based health centers (SBHCs) provide their services both in person and virtually during the school year. Table 5.12 shows the percentage of telehealth visits per school year for primary and behavioral health visits provided by an SBHC. At the peak of the COVID-19 pandemic (2020-2021), primary care telehealth visits at SBHCs were highest at 33%.[164]

*Table 5.12. Oregon school-based health centers visits (all ages), FY 2020-2023*[164]

| | 2019-2020 | 2020-2021 | 2021-2022 | 2022-2023 |
|---|---|---|---|---|
| Primary Care and Behavioral Health Visits Combined | | | | |
| Total number of visits* | 121,144 | 91,058 | 126,673 | 129,181 |
| % Provided via telehealth | 7% | 33% | 16% | 9% |
| Primary care visits | | | | |
| Number of visits* | 76,886 | 58,250 | 84,209 | 81,951 |
| % Provided via telehealth | N/A | 33% | 12% | 8% |
| Behavioral health visits | | | | |
| Number of visits | 44,258 | 32,808 | 42,464 | 47,229 |
| % Provided via telehealth | N/A | 54% | 26% | 12% |

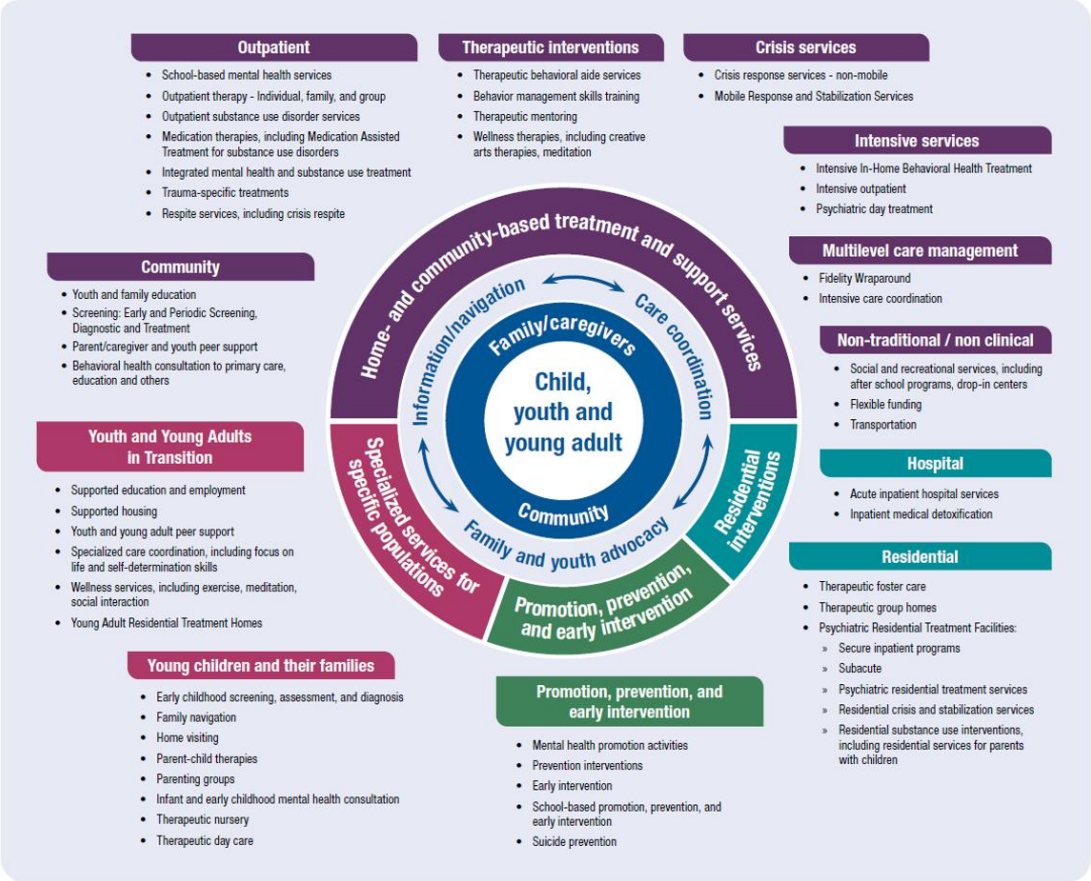
**This includes dental/oral health visits.*

## INTRODUCTION

This chapter provides information on youth served by the behavioral health system. The continuum of behavioral health care in Oregon ranges from promotion, prevention and early treatment to inpatient levels of care (Figure 6.1).[232] Information on the various components of the continuum is presented throughout this chapter.

**Behavioral health** is the term used to refer to mental health and substance use conditions and treatment.[211]

*Figure 6.1. Behavioral health continuum of care in Oregon, from OHA[232]*




Oregon administers Medicaid behavioral health care through Community Mental Health Programs (CMHPs), which are by rule "responsible for the planning and delivery of safety net services for persons with mental or emotional disturbances, drug abuse problems and alcoholism and alcohol abuse in a specific geographic area of the state under a contract with the Division or a local mental health authority."[212] Many of the services provided by CMHPs

are directed to Oregon Health Plan (Medicaid) members, but the CMHPs are also responsible for providing certain services, such as mobile crisis services, to all Oregonians regardless of insurance.

Youth also access services through large health care systems (like OHSU or Providence), Certified Community Behavioral Health Clinics (CCBHCs)[213], private community-based agencies and individuals in private practice who bill a variety of insurance providers, including OHP and private insurance.

## KEY TAKEAWAYS

Oregon youth face more difficulties in obtaining mental health care compared to levels observed at the national level.

OHA has developed several community-based intensive care and crisis care options for youth with public and private insurance, which have potential to reach a large number of youth throughout the state once fully implemented.

There are currently four facilities offering residential treatment for youth with SUD, eight partial hospitalization programs for youth under 18 and eight for transitional age youth, and 10 facilities offering psychiatric inpatient care for youth. Oregon is below its 2019 goal to increase statewide youth psychiatric bed capacity. A state partnership between the Governor and CCOs has pledged an additional $25 million to expand residential beds.

> **Oregon's reputation as the worst in the nation for mental health services for children and teens is not just a statistic — it's a reality that families like ours endure every day. It's time for Oregon's leaders to … take concrete steps toward a mental health care system that genuinely supports and protects the most vulnerable among us. We are exhausted from fighting alone, and we urge those in power to take responsibility and make the changes Oregon's children so desperately need.**
>
> *– Parent describing their experience with the youth behavioral health system*[5]

**How does access to youth behavioral health services in Oregon compare nationally? Are there gaps in access to youth behavioral health services for various groups or regions?**

Ensuring that youth and families can obtain the behavioral health services they need is a critical part of preventing and treating behavioral health needs, as well as maintaining overall well-being. Oregon ranks 49th out of 51 on Mental Health America's 2024 overall state youth ranking, which relies on national survey data to compare state mental health indicators (Figure 6.2). Based on this data, Oregon has reported higher rates of mental illness prevalence and lower rates of access to care than most other states.[21] The 2023 National Survey of Children's Health found that 72.9% of Oregon youth faced difficulties in obtaining mental health care, compared to 56.7% nationally (Figure 6.3).[18] The Substance Abuse and Mental Health Services Administration (SAMHSA) also reports that youth have less access to care in Oregon (73.4%) than the national average (87.5%).[214]

*Figure 6.2. Overall ranking for youth prevalence of mental illness and access to care, from Mental Health America*[21]

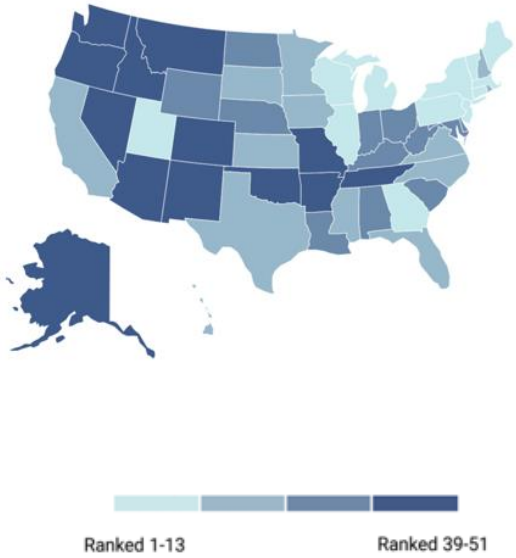
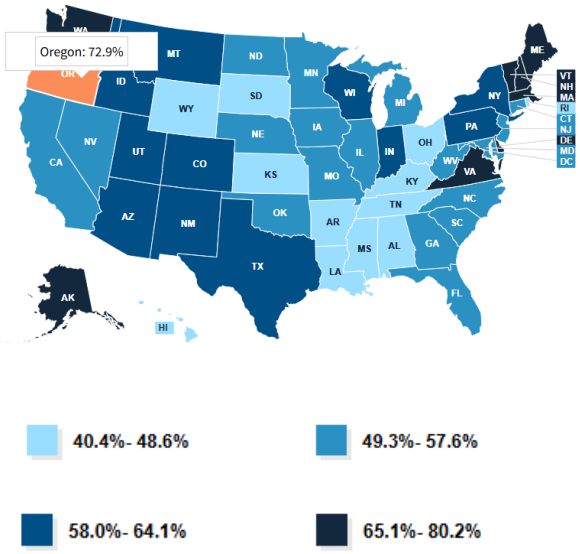



*Figure 6.3. Children who faced difficulty obtaining mental health care, from the Kaiser Family Foundation*[18]




The 2022 Oregon Student Health Survey (SHS) reported that 16% of eighth graders and 23% of 11th graders have unmet emotional or mental health care needs. American Indian/Native American students and students who identify as LGBTQ+ were most likely to have unmet needs.[22]

The Mental Health Statistics Improvement Program (MHSIP) conducts annual surveys that assess youth and family experience of behavioral health services.[215] Among their measures is a series of questions related to access to mental health care, which is defined as being able to obtain services at a time and location convenient to the family. Caregiver reports on this measure indicate that on average, around three-quarters of caregivers are satisfied with their access to care. Jackson Care Connect and Pacific Source Community Solutions: Columbia Gorge Region consistently have high rates of satisfaction among their members; on the other hand, Advanced Health, Trillium and Umpqua Health Alliance have the lowest satisfaction rates in the state (Table 6.1).

*Table 6.1. Percentage of caregivers who were satisfied with their child's access to mental health care on the Youth Services Survey for Families, by coordinated care*[215]

| | 2020 | 2021 | 2022 |
|---|---|---|---|
| Coordinated Care Organization | % satisfied | % satisfied | % satisfied |
| Statewide | 75% | 75% | 72% |
| Advanced Health | 65% | 67% | 70% |
| AllCare | 74% | 71% | 77% |
| Cascade Health Alliance | 66% | 79% | 66% |
| Columbia Pacific CCO | 76% | 66% | 63% |
| Eastern Oregon CCO | 69% | 77% | 66% |
| Health Share | 76% | 75% | 71% |
| InterCommunity Health Network | 78% | 76% | 75% |
| Jackson Care Connect | 83% | 77% | 81% |
| PCS: Central | 78% | 79% | 74% |
| PCS: Gorge | 83% | 85% | 81% |
| PCS: Lane | 82% | 80% | 73% |
| PCS Marion/Polk | 70% | 73% | 68% |
| Trillium | 71% | 65% | 70% |
| Umpqua Health Alliance | 64% | 65% | 65% |
| Yamhill Community Care Organization | 82% | 80% | 73% |

**What early intervention services and supports are available in Oregon? What is the utilization rate for the different services?**

Early intervention services and supports for behavioral health needs may help prevent more serious needs in the future. The CDC outlines several reasons for promoting early intervention, stating that "intervention is likely to be more effective when it is provided earlier in life rather than later." [216] In Oregon, there are a variety of these available to youth.

### *Early Childhood Interventions*

OHA supports a number of early childhood mental health programs and resources. [217] Clinicians can be trained in these interventions; insurance coverage varies by program.

Child-Parent Psychotherapy (CPP)[217]

OHA partners with Greater Oregon Behavioral Health, Inc., to provide CPP training across the state. CPP treatment is for children ages 0 to 5 who have experienced trauma and their parent

or other caregiver. Over more than 10 years, OHA and GOBHI (Greater Oregon Behavioral Health Inc.) have funded CPP training for 31 agencies statewide.

Generation Parent Management Training, Oregon Model (PMTO)[217]

Generation PMTO is an evidence-based program for youth ages 2 to 17 years old. The program promotes positive parenting and helps prevent and treat conduct-related behaviors in youth.

Parent-Child Interaction Therapy (PCIT)[217]

PCIT is an intervention for youth ages 2 to 7. The program helps build parenting skills and improve youth social-emotional and behavior challenges.

Incredible Years[218]

Evidence-based early intervention programs utilized by some primary care clinics and focused on youth ages 0-12 years old. A set of curricula designed for families, educators and children promote social-emotional learning, academic skills and positive behavioral outcomes.

Oregon Parenting Education Collaborative (OPEC) Hubs[219]

Statewide parenting education network that provides infrastructure and community partnerships, promoting and fostering positive and reliable parenting practices.

***Early Intervention***

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)[191]

EPSDT is comprehensive health care coverage (including medical, vision, dental and behavioral health) for youth with OHP under 21 years of age or up to 26 if they also have Youth with Special Health Care Needs benefits. Please see the Physical Health Care System chapter for additional information on this service.

Early Assessment and Support Alliance (EASA)[220]

EASA is a statewide network of programs that provides early intervention for youth and young adults ages 12-27 who are at risk for developing psychosis (often called psychosis risk syndrome) and those experiencing early symptoms of psychosis (often called first episode psychosis).

Program referral rates and the percentage of individuals screened in/out of the program have been consistent from 2020 to 2023 (Table 6.2). If an individual is screened in, that means that they were deemed eligible for the program; if they were screened out, the individual did not have a qualifying diagnosis or alternative services were deemed a better fit.

Wait times for EASA vary across the state. In half of the programs, the median wait time from referral to admission is three weeks or less. For others, the median wait times extend past two months, although it is important to note that this may include reasons such as patient hospitalization or juvenile justice/legal involvement that may delay admission to the program. On average, individuals are enrolled in the program for 5.2-5.9 quarters (estimated 16 months).[221]

*Table 6.2. Total number of referrals and percentage of individuals screened in/out of the Early Assessment and Support Alliance program*[221]

| | **2020** N = 842 | | **2021** N = 894 | | **2022** N = 889 | | **2023** N = 896 | |
|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % |
| Screened into the program | 336 | *40.0%* | 342 | *38.3%* | 340 | *38.2%* | 345 | *38.2%* |
| Screened out of the program | 506 | *60.0%* | 552 | *61.7%* | 549 | *61.8%* | 551 | *61.8%* |

A higher proportion of Black/African American youth are served by EASA compared to state demographics (Table 6.3). A lower proportion of Asian, Hispanic/Latino, and White youth are served.[221]

*Table 6.3. Race and ethnicity of individuals served by the Early Assessment and Support Alliance*[221]

| | **2020** N = 787 | | **2021** N = 793 | | **2022** N = 801 | | **2023** N = 785 | |
|---|---|---|---|---|---|---|---|---|
| Race/Ethnicity | n | % | n | % | n | % | n | % |
| American Indian / Alaska Native | 9 | *1.1%* | 12 | *1.5%* | 9 | *1.1%* | 10 | *1.3%* |
| Asian | 19 | *2.4%* | 18 | *2.3%* | 14 | *1.7%* | 20 | *2.5%* |
| Black / African American | 49 | *6.2%* | 54 | *6.8%* | 49 | *6.1%* | 55 | *7.0%* |
| Hispanic/Latino | 155 | *19.7%* | 150 | *18.9%* | 150 | *18.7%* | 125 | *15.9%* |
| Native Hawaiian / Pacific Islander | 6 | *<1%* | <5 | *<1%* | 6 | *0.7%* | 4 | *0.5%* |
| White | 434 | *55.1%* | 446 | *56.2%* | 483 | *60.3%* | 458 | *58.3%* |
| Multiracial | 53 | *6.7%* | 48 | *6.1%* | 46 | *5.7%* | 52 | *6.6%* |
| Unavailable | 62 | *7.9%* | 62 | *7.8%* | 44 | *5.5%* | 61 | *7.8%* |

## School-Based Mental Health Services[222]

An essential component of Oregon's education system, these services help in areas of trauma, stress and conflict, which can interfere with almost every aspect of a child's learning. Access to these services improves students' physical and psychological safety and reduces negative outcomes, such as chronic absenteeism, disciplinary incidents, dropout, suicidal thoughts and more. For utilization rates, please reference the Education System and Physical Health Care System chapters.

## Suicide Prevention[223]

Throughout the state, there are many resources to support suicide prevention and early intervention for youth. These include programs for schools and a variety of trainings designed for school staff, community-based providers, pediatric health professionals and the general public. Support for OHA's "Big River" suicide prevention and intervention efforts has increased since 2019, which is reflected in the increased number of active trainings in most programs from 2021

through 2024 (Table 6.4).[224] The number of individuals trained in each program has more variation across the same period, although totals show an overall increase (Table 6.5).[224]

*Table 6.4. Number of active trainers statewide in the Big River suicide prevention, intervention and treatment programs*[224]

| | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|
| Program | # of active trainers | | | |
| Sources of Strength: Elementary grades K-6 | 83 | 312 | 269 | 327 |
| Sources of Strength: Middle school, high school and college | 115 | 73 | 114 | 154 |
| MHFA (Mental Health First Aid) | 100 | 106 | 112 | 283 |
| QPR (Question, Persuade, Refer) | 775 | 781 | 891 | 985 |
| ASIST (Applied Suicide Intervention Skills Training) | 109 | 139 | 185 | 108 |
| Youth SAVE (Suicide Assessment in Various Environments) | 38 | 31 | 31 | 34 |
| Oregon CALM (Counseling on Access to Lethal Means) | N/A | 13 | 10 | 27 |
| Total | 1,220 | 1,455 | 1,612 | 1,918 |

*Table 6.5. Statewide number of individuals trained in/ number of schools implementing the Big River suicide prevention, intervention and treatment program*[224]

| | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|
| Program | # of implementing schools | | | |
| Sources of Strength: Elementary grades K-6 | 49 | 185 | 226 | 236 |
| | # of individuals trained | | | |
| Sources of Strength: Middle school, high school and college | N/A | 2,186 | 1,636 | 1,684 |
| MHFA (Mental Health First Aid) | 1,693 | 3,680 | 1,876 | 4,226 |
| QPR (Question, Persuade, Refer) | 1,285 | 600 | 600 | 518 |
| ASIST (Applied Suicide Intervention Skills Training) | N/A | N/A | 2,416 | 2,563 |
| Youth SAVE (Suicide Assessment in Various Environments) | 612 | 362 | N/A | 195 |
| Oregon CALM (Counseling on Access to Lethal Means) | N/A | N/A | 371 | 292 |
| Advanced Skills (includes CAMS, DBT, AMSR, CBT) * | 544 | 379 | 250 | 400 |
| Total | 4,134 | 7,317 | 7,249 | 9,951 |

**CAMS (Collaborative Assessment and Management of Suicidality), DBT (Dialectical Behavioral Therapy), AMSR (Assessment and Management of Suicide Risk), CBT (Cognitive Behavioral Therapy).*

*Note: The cumulative total of students associated with fully implementing the Sources of Strength Elementary programming is 84,924 (as of Dec, 2024).*

**What types of early intervention services and supports are not available in Oregon that youth, families or providers have expressed a need for?**

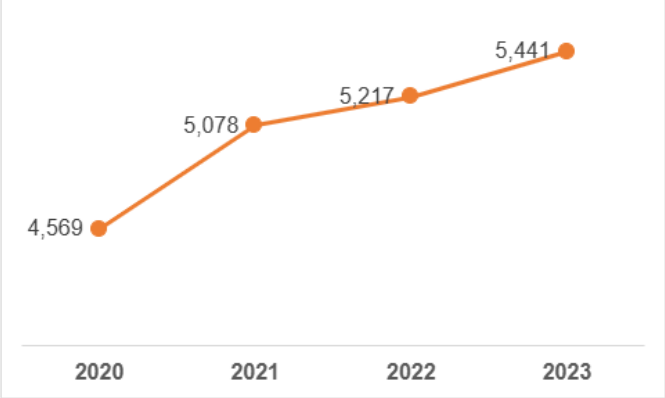
Family representatives of the Oregon Children's System Advisory Council (CSAC) expressed the need for several early intervention and support services that either don't exist, are too difficult

to access or are not widely available. The CSAC Family Representative Recommendations[225] were compiled for use in the implementation of the OHA's Child and Family Behavioral Health Program's Policy Vision[226] and workplan for 2021-2025. The recommendations describe the need for more peer-delivered services, agency-neutral care coordinators, parenting training and information campaigns to help families know what resources exist and how to access them.

**What types of crisis services are available, and for each, what is the eligibility, regional availability, capacity/waitlist, population served, cross-system involvement, services provided, utilization rate and outcomes?**

Nationwide, the number of youth experiencing mental health crises has steadily increased for over a decade. In Oregon, the number of individuals 0 to 26 years old with OHP accessing crisis psychotherapy has steadily increased from 2020 to 2023 (Figure 6.4). Crisis psychotherapy services "help reduce a patient's mental health crisis through an urgent assessment and history of a crisis state, a mental status exam, and a disposition."[227] These Medicaid codes can be used in a facility (hospitals, medical clinic, outpatient mental health clinics, etc.) and non-facility locations (schools, mobile response, homes, etc.).[228]

*Figure 6.4. Number of individuals ages 0-26 with OHP who received crisis psychotherapy by year[28-29]*




***The Statewide Crisis Continuum of Care***

In addition, there are several crisis programs offered to youth in Oregon. These three programs serve individuals regardless of insurance and are not fully captured in the data above, because the data above only includes individuals with Medicaid and the programs below are funded separately by OHA.

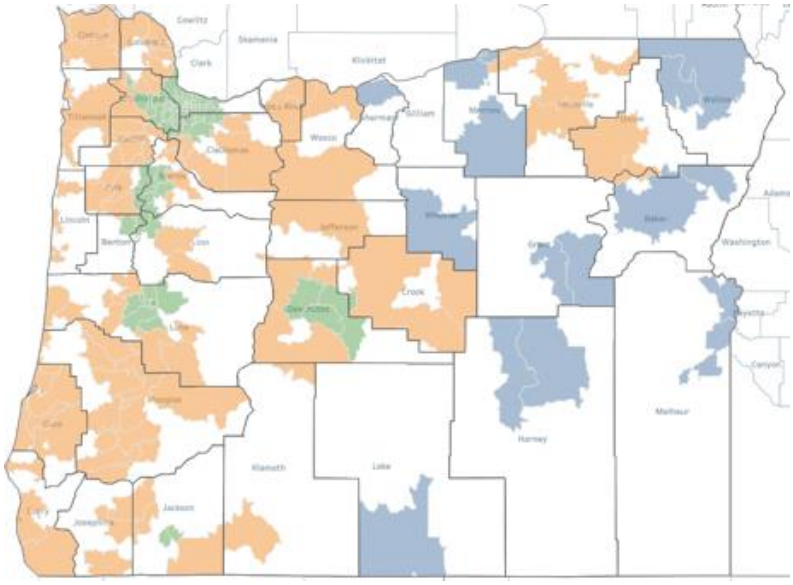
988 Suicide & Crisis Lifeline

988 is the national Suicide & Crisis Lifeline; in Oregon, it is operated by Lines for Life and Northwest Human Services. This service is available free of charge. 988 is available 24/7; if Oregon operators are not available, the call is routed to partner agencies in other states. Operators are trained to provide emotional support and crisis de-escalation with the caller. Since it launched in July 2022, Oregon's 988 has completed over 14 thousand calls with youth ages 20 and under.[229] Almost 97% of all 988 calls in Oregon are resolved over the phone (OHA); however, if an in-person response is needed, Mobile Crisis Intervention Teams are requested to respond.[230]

## Mobile Crisis Intervention Teams (MCIT)

MCITs are mental health teams that respond to crises in the community and other settings. Teams are operated by CMHPs and funded by OHA (this program is also referred to as Mobile Crisis Intervention Services, or MCIS). MCITs are available in every county in Oregon; most have 24-hour coverage. Mobile dispatches are available for free to all individuals who need in-person crisis intervention. Requests for dispatches can come from 988 or 911 operators, law enforcement, emergency medical services personnel, schools or from the youth or family. Statewide data collection for this program began in early 2023; from April to December 2023, MCIT was dispatched 4,553 times for individuals under 26 years old (2,541 times for youth ages 0 to 17; 787 times for ages 18 to 20; 1,223 times for ages 21 to 24).[231] MCITs are most likely to respond to private residences (39%), followed by community/public settings (22%) and emergency departments (19%).[231] A majority of youth remain in the community (63%) after the encounter, while a smaller number are routed to an emergency department (17%) or other setting, such as respite (2%), arrest/jail (2%), sobering/detox facility (1%) or crisis center (1%).[231] If a youth needs short-term stabilization services and support, they can be connected to Mobile Response and Stabilization Services, if available.

*Figure 6.5. Map of Mobile Crisis Intervention Team dispatch locations in 2023*[231]



*Zip Code Geographic Designation:* ***Urban*** ***Rural*** ***Frontier*** *(white = no dispatches)*

## Mobile Response and Stabilization Services (MRSS)

MRSS is an extension of the mobile crisis service for individuals ages 0 to 20 (see above for the number of MCIS dispatches for youth in this age group). The program provides intensive care coordination, mental health treatment, skills training, crisis response and peer support for up to eight weeks. While MRSS is required in statute to be available in every county, only 15 counties are reporting data at the time of this report: Baker, Benton, Clackamas, Coos, Curry, Deschutes,

Douglas, Harney, Josephine, Lane, Linn, Malheur, Marion, Multnomah and Washington. Data collection for this program began in early 2023. From April to December 2023, there were 209 youth enrolled in MRSS programs across the state.[37] Most referrals came from MCITs (45%), EDs/hospitals (30%) and crisis centers/walk-in clinics (22%).[37] Some programs have a discrete number of program slots that limit referrals into the program; data on referrals made to the program is not available, only data on enrolled youth is collected.

The average age of youth enrolled was 15 years old, with most being between 11 and 19 years old. The program served more female (48%) and male (44%) youth and fewer nonbinary or transgender (6%) youth.[37] Most youth identified as White (64%), Hispanic or Latino (11%) or American Indian/Alaska Native (8%).[37] The most common presenting issues were suicidality (56%), mental health concerns (46%) and/or needing connection to resources, services and supports (32%). More than half (62%) of youth enrolled had a trauma history.[37]

At the end of MRSS, most youth are connected to longer-term support (66%) or are discharged from the program because the family is stable and no longer in need of services (16%), stops engaging in services (10%) or moves out of the service area (8%).[37]

**What community-based behavioral health programs and treatments are available, and for each, what is the eligibility, regional availability, capacity/waitlist, population served, cross-system involvement, services provided, utilization rate and program outcomes?**

OHA outlines a variety of home- and community-based behavioral health programs and treatments that are available throughout Oregon, including outpatient treatment, intensive services and multilevel care management.[232] Data on specific program eligibility, regional availability, capacity/waitlist, population served, cross-system involvement, services provided, utilization rate and program outcomes is available to varying degrees; available data is presented below.

### *Outpatient*

Outpatient therapy

Outpatient therapy can be accessed through a variety of settings, which makes it difficult to assess capacity and access across the state. Many youth access services through their regional CMHP, large health care systems (like OHSU or Providence), Certified Community Behavioral Health Clinics (CCBCHs), private community-based agencies (like Catholic Community Services or Youth Villages) or individuals in private practice. The SOC dashboard estimates that the number of youth receiving outpatient mental health care has increased over time (Table 6.6).

*Table 6.6. Individuals with the Oregon Health Plan receiving mental health outpatient care[6]*

| | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| Individuals Receiving Mental Health Outpatient Care | n | n | n | n |
| Ages 0 to 17 | 48,338 | 49,400 | 52,124 | 54,574 |
| Ages 18 to 25 | 22,311 | 26,202 | 27,802 | 29,203 |

Outpatient substance use disorder services

Outpatient SUD treatment is the most common SUD treatment accessed by youth.[233] The number of youth receiving SUD outpatient treatment is presented in Table 6.7.

*Table 6.7. Individuals with the Oregon Health Plan receiving substance use disorder outpatient care[6]*

| | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| Individuals Receiving Substance Use Disorder Outpatient Care | n | n | n | n |
| Ages 0 to 17 | 738 | 432 | 467 | 507 |
| Ages 18 to 25 | 1,603 | 1,445 | 1,262 | 1,168 |

The CCO Quality Metrics Dashboard reports rates of SUD treatment initiation and engagement for youth ages 13 to 17 with a newly diagnosed SUD (Table 6.8).[179] Statewide, rates are low; Advanced Health, Eastern Oregon CCO, Jackson Care Connect and Trillium South have the lowest rates.

Recovery high schools are state-funded schools that provide additional community-based education and support to youth in recovery from SUD and with other co-occurring disorders. There are currently (as of January 2025) two recovery high schools in Oregon: Harmony Academy in Lake Oswego and Rivercrest Academy in Portland. One additional school, the Discovery Academy in Salem, is on track to open in mid-2025. *The Oregonian* reports that these schools enroll between 30 and 50 students each with flexible, fluctuating enrollment.[234] Recovery high schools offer substance use education, behavioral health treatment and coping skill development; additionally, they foster a sense of community among peers.

*Table 6.8. Substance use disorder treatment initiation and engagement for youth ages 13 to 17*[179]

| | 2021 | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|
| Coordinated Care Organization | % Initiation* | % Engagement** | % Initiation* | % Engagement** | % Initiation* | % Engagement** |
| Statewide | 30.5% | 15.8% | 36.7% | 20.3% | 38.5% | 22.3% |
| Advanced Health | 30.8% | 0.0% | 17.6% | 5.9% | 20.0% | 10.9% |
| AllCare CCO | 26.3% | 15.8% | 35.5% | 21.1% | 41.8% | 15.2% |
| Cascade Health Alliance | 35.7% | 17.9% | 34.0% | 28.3% | 44.1% | 42.4% |
| Columbia Pacific | 17.9% | 0.0% | 52.8% | 33.3% | 36.5% | 15.4% |
| Eastern Oregon CCO | 25.4% | 15.9% | 29.9% | 11.1% | 39.4% | 15.7% |
| Health Share of Oregon | 30.6% | 15.1% | 38.9% | 19.5% | 35.4% | 21.4% |
| InterCommunity Health Network | 26.9% | 19.2% | 29.9% | 20.1% | 39.1% | 23.7% |
| Jackson Care Connect | 36.2% | 12.8% | 26.7% | 16.0% | 25.0% | 13.5% |
| PacificSource Central | 25.3% | 11.5% | 36.5% | 20.3% | 43.6% | 26.2% |
| PacificSource Gorge | 12.5% | 0.0% | 46.2% | 30.8% | 22.2% | 16.7% |
| PacificSource Lane | 32.1% | 8.9% | 44.1% | 17.6% | 41.4% | 22.1% |
| PacificSource Marion Polk | 36.7% | 22.9% | 35.1% | 22.2% | 44.6% | 31.3% |
| Trillium North | | | 30.0% | 30.0% | 45.8% | 33.3% |
| Trillium South | 44.0% | 32.0% | 29.5% | 15.9% | 44.1% | 11.8% |
| Umpqua Health Alliance | 33.3% | 26.2% | 51.3% | 33.8% | 41.8% | 20.9% |
| Yamhill Community Care Organization | 33.3% | 20.8% | 35.5% | 23.7% | 46.6% | 23.9% |

**Initiation is the percentage of new SUD diagnoses that received follow-up treatment within 14 days of initial diagnosis. **Engagement is the percentage of new SUD diagnoses followed up with at least two engagement visits or medication treatments within 34 days of initial treatment.*

## Integrated treatment for co-occurring disorders

Co-occurring disorders (COD) is defined as having more than one mental health, I/DD, SUD and/or problem gambling diagnosis. OHA has several initiatives aimed at improving treatment for youth with COD. First, it reimburses COD treatment at an enhanced rate based on the complexity of the youth's presentation and the education level of the provider. Additionally, OHA provides start-up funding for integrated co-occurring disorder (ICD) programs to incentivize agencies to offer these services. As of January 2025, 28 out of Oregon's 36 counties had at least one ICD program (counties without programs include Clatsop, Columbia, Hood River, Lake, Polk, Sherman, Tillamook and Wallowa counties).[235] The Health Policy and Analytics Division at OHA reports that they are still developing mechanisms to pull utilization data on these programs.

***Intensive Services***

Intensive In-Home Behavioral Health Treatment (IIBHT)

IIBHT is an intensive level of care for those with Medicaid that offers home-based mental health therapy, peer support, skills training and psychiatric care to youth with complex mental health needs. The program is meant to be accessible to youth with co-occurring disorders and/or have cross-system involvement. IIBHT services can be provided wherever the youth is living, which may be at home with parents or in a foster home, group home, shelter care or behavioral rehabilitation services placement.

IIBHT was launched in 2021 and served a total of 446 youth in the first three years of implementation (Table 6.9).[36] In 2023, the average age of youth served was 13 years old, with most being between 9 and 15 years old. [36] At intake, a striking percentage of youth in IIBHT had a trauma history (87%) and/or a history of suicidality (76%); many had an attention disorder (52%), trauma and stressor-related disorder (48%), depressive disorder (36%) and/or anxiety disorder (34%).[36]

The program is mandated in rule and every CCO is required to offer this service; as of December 2024, IIBHT was available in every county except for Curry, Gilliam, Sherman and Wheeler counties. In the counties where it is available, there are often waitlists for accessing the program. The average wait from referral to program intake was 19 days in 2021, 56 days in 2022 and 49 days in 2023.[36]

*Table 6.9. Number of youth enrolled in Intensive In-Home Behavioral Health Treatment (IIBHT), data from OHSU REDCap*[36]

| | 2021 | 2022 | 2023 |
|---|---|---|---|
| Number of youth enrolled in IIBHT | 63 | 160 | 223 |

The 2023 IIBHT Annual Report highlights several key program outcomes:

- Youth show statistically significant improvement on standardized assessment measures over the course of the program, specifically in hopefulness, problem severity, functioning and treatment satisfaction.[236]
- Around half (47-54%) discharge from the program because they are ready to transition to a lower level of care; some youth need to transition to a higher level of care (9-19%) and others stop engaging in services for a variety of reasons (19-23%).[236]
- Approximately a quarter (24%) of youth go to an ED or are admitted to a psychiatric inpatient level of care during the program; however, recidivism after IIBHT discharge is lower, with 7% of youth going to an ED or inpatient unit in the month following discharge.[236]

Intensive Outpatient Services and Supports (IOSS) and Intensive Outpatient Services (IOS)

In addition to IIBHT, several organizations offer IOSS, which provide crisis and safety planning, skill development, professional and natural supports[237], or IOS. There is no centralized list of

organizations offering these services; however they vary in regional availability, services provided, range of intensity and insurance accepted. More specific information on statewide intensive outpatient services would require a specific Medicaid analysis.

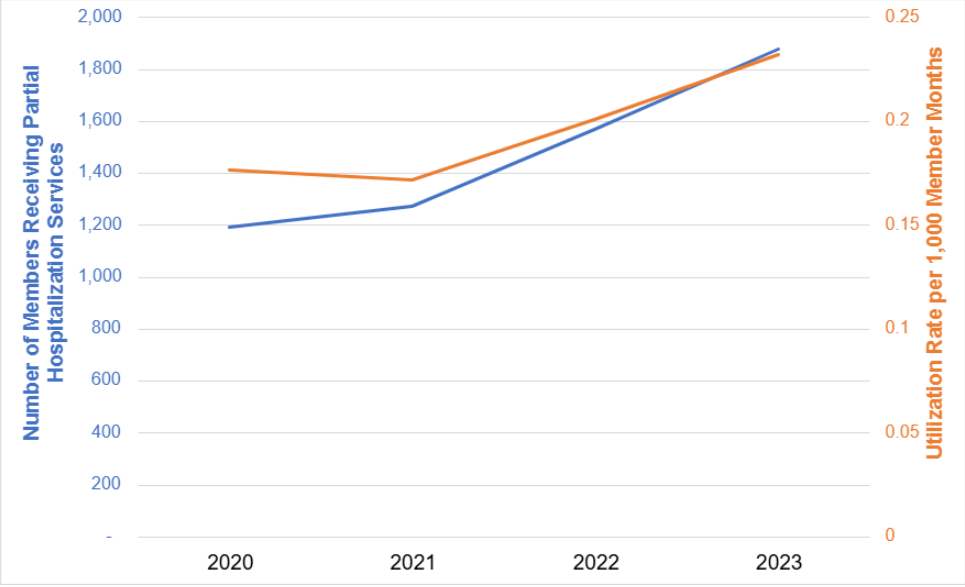
Charlie Health is a virtual care provider that offers intensive outpatient services to youth in Oregon.[238] Services include virtual individual, family and group therapy in addition to psychiatry. Charlie Health accepts most major commercial carriers and Medicaid.

Psychiatric day treatment

Partial hospitalization programs, also known as day treatment programs, provide intensive care to youth with behavioral health challenges. These programs are essential in providing care to youth who need more than traditional outpatient services, but don't need or are not able to be admitted to an inpatient level of care. Additionally, education services are often offered in tandem with mental health treatment, allowing youth to receive services while remaining in school. The rate of individuals receiving partial hospitalization services statewide increased from 2020 to 2023 (Figure 6.6).

In Oregon, there are eight partial hospitalization programs for youth under 18 and eight for transition-age youth (Table 6.10). Most programs require a psychiatric diagnosis and significant impact on daily functioning to be considered for admission (additional population eligibility criteria is presented in Table 6.10). Referrals for partial hospitalization come from both hospital and community levels of care (although some programs only accept referrals from hospitals). Capacity, waitlist and program outcome data are not collected by OHA.

*Table 6.6. Number of individuals ages 0 to 26 receiving partial hospitalization services and utilization rate per 1,000 member months* [28-29]




*Partial hospitalization is defined as procedure codes G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484 and S9485* ***or*** *revenue code 0905, 0907, 0912 and 0913* ***or*** *procedure code in HEDIS Visit Setting Unspecified Value Set combined with place of service code 52.*
*Utilization is calculated by dividing the number of members receiving services by the total number of member months for individuals 0-26, then multiplying by 1,000.*

*Table 6.10. Partial hospitalization/day treatment programs in Oregon*

| Program | Location | Population Served |
|---|---|---|
| **Serving Children and Adolescents** | | |
| Discovery Mood and Anxiety [239] | Portland | Ages 11 to 17, commercial insurance only |
| Kartini Clinic [240] | Portland | Ages 18 and under with eating disorders |
| Lifeworks NW [241] | Portland | Ages 5 to 18 |
| Providence St. Vincent [242] | Portland | Adolescents |
| Providence Adolescent Eating Disorders | Portland | Adolescents ages 13-18 with eating disorders |
| Providence Willamette Falls [243] | Oregon City | Adolescents |
| Rainrock Treatment Center (Monte Nido) [244] | Springfield | Adolescents and adults with eating disorders |
| Riverview Center for Growth [245] | Springfield | K-12 age students |
| Trillium Family Services [246] | Bend, Corvallis, Keizer, Portland, The Dalles | Ages 5 to 17 |
| **Serving Transition-Age Youth** | | |
| Good Samaritan Hospital [247] | Corvallis | Adults |
| Madrone Mental Health Services [248] | Eugene | Adults |
| Odyssey Complete [249] | Salem | Adults |
| PeaceHealth Sacred Health Medical Center [250] | Eugene | Adults |
| Rainrock Treatment Center (Monte Nido) [244] | Springfield | Adolescents and adults with eating disorders |
| Salem Hospital [251] | Salem | Adults |
| Sober Living Oregon Recovery Center [252] | Portland | Adults |
| Cedar Hills Hospital [253] | Portland | Adults |

### *Multilevel Care Management*

Fidelity Wraparound

Wraparound is a team-based planning and care coordination approach that aims to support multisystem-involved youth. Programs are available in every county in Oregon. The Child and Adolescent Needs and Strengths (CANS) tool is used to measure progress over time. The 2023 Wraparound Annual Report outlines trends for 1,839 youth with CANS data during 2022 and 2023. The average length of services was 427 days.[40] Youth show statistically significant improvement on both strength development and needs reduction from enrollment to discharge. The CANS strengths-based items with the greatest improvement from enrollment to discharge included *Coping and Savoring Skills*, *Education Setting* and *Resilience*. Needs-based items with the greatest improvement included *Anger Control*, *Depression and Anxiety* and *Decision Making*.[40]

> **It was appreciated when the traditional system was able to be flexible to accommodate our child's needs related to her disability. We've had a wonderful experience with the Wrap[around] program.**
>
> *– Parent describing their experience with the behavioral health system*[5]

**What types of community-based behavioral health programs and treatments are not available in Oregon that youth, families or providers have expressed a need for?**

Family representatives of the Oregon Children's System Advisory Council (CSAC) expressed the need for several community-based services that either don't exist, are too difficult to access or are not widely available. The CSAC Family Representative Recommendations[225] were compiled for use in the implementation of the OHA's Child and Family Behavioral Health Program's Policy Vision[226] and workplan for 2021-2025. The recommendations include:

- More respite services
- More family support before, during and after behavioral health treatment
- More community- and home-based alternatives to hospital-based services
- Expanded clinical and peer services to reduce system gaps
- Shortened wait times for services
- More coordinated service plans across systems
- More family- and youth-driven treatment plans

> **It has been challenging to find the right level of care, and to get services in a timely manner.**
>
> *– Parent describing their experience seeking behavioral health services*[5]

> **Mental health services need to be available more for children. It should not be so hard to get a counselor for a child who needs it.**
>
> *– Parent describing their experience seeking behavioral health services*[5]

**How many youth are accessing emergency departments with behavioral health presentations and what systems are these youth involved with? What is the prevalence/length of stay of emergency department boarding and how does that differ across demographics, regions and hospitals?**

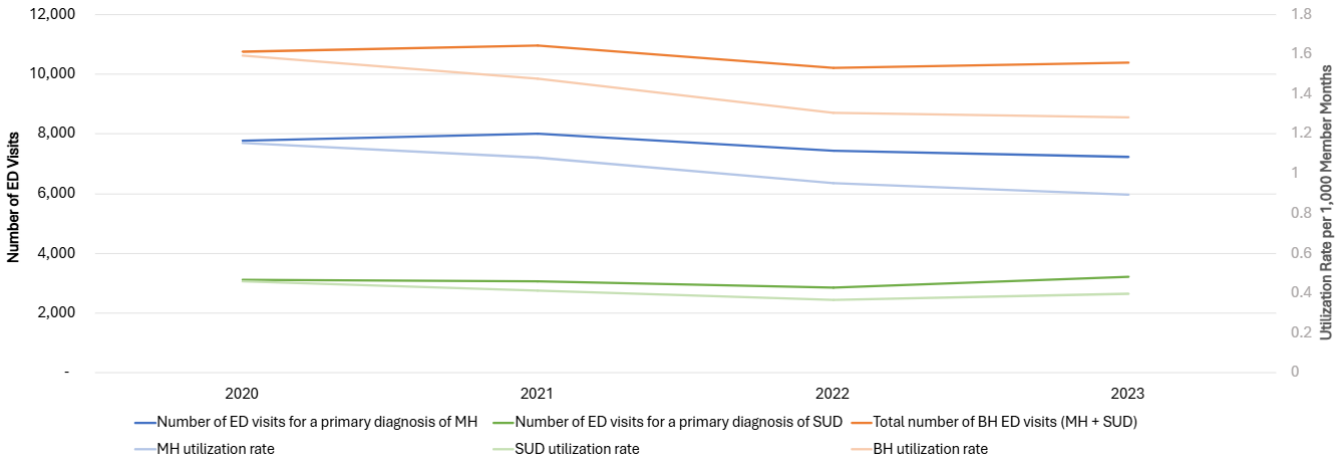
Youth who are experiencing a mental health crisis often rely on emergency departments (EDs) to access urgently needed care. Due to the large volume of youth needing services, boarding has become a widespread issue in the state. Boarding is defined as a youth staying in the ED longer than medically necessary while they wait for a psychiatric bed placement or other necessary aftercare. Boarding is not only potentially traumatizing and minimally therapeutic for youth and families, but it also places stress on the hospital system.

In 2023, there were 10,380 statewide ED visits for behavioral health presentations for individuals ages 0 to 26 with OHP (Figure 6.7).[28-29] Of those, 7,235 visits had a mental health diagnosis and 3,228 had a substance use diagnosis (some were in both categories). A study completed by OHSU found that there are seasonal trends in behavioral health ED visit volume; higher volume is more common in January, April, May, October and November.[254]

Data from the Hospital and Emergency Department Discharge dataset, which includes youth with all insurance (public and private), provides additional insight into ED utilization and boarding (complete data for 2023 was not available at the time of this report) (Table 6.11).[28-29] When stratifying the most recent data (2022) by several key factors, the following emerged:

- **County:** Individuals that resided in Douglas County were significantly more likely to experience boarding (38% of total presentations) than the statewide average (11%)
- **Race:** Native Hawaiian / Pacific Islander (16%) and Black / African American (15%) individuals were more likely to board than the statewide average (11%).
- **Ethnicity:** Hispanic/Latino individuals (9%) were less likely to board than non-Hispanic/Latino individuals (12%).
- **Facility:** Unity Center for Behavioral Health (54%) and Mercy Medical Center (40%) experience the highest boarding rates.
- **Insurance:** Individuals with Medicaid (12%) were more likely to board than individuals with commercial insurance (10%).
- **Sex:** No significant differences observed.

*Figure 6.7. Number of emergency department visits for individuals ages 0 to 26 for primary behavioral health concerns and utilization rate per 1,000 member months[28-29]*




*Emergency department visits are defined as procedure codes 99281, 99282, 99283, 99284 and 99285* ***and*** *place of service code 23* ***or*** *revenue codes 0450, 0451, 0452, 0459 and 0981.*
*Utilization is calculated by dividing the number of members receiving services by the total number of member months for individuals 0-26, then multiplying by 1,000.*
*Behavioral health (BH) is defined as combined mental health and SUD; all ICD-10 diagnosis codes starting with F but excluding codes starting with F17 (nicotine).*
*Mental health (MH) is defined as all ICD-10 diagnosis codes starting with F, but excluding codes starting with F1.*
*Substance use disorder (SUD) is defined as all ICD-10 diagnosis codes starting with F1, but excluding codes starting with F17 (nicotine).*

*Table 6.11. Discharges that resulted in boarding over 24 hours for individuals 0 to 26 years old*[28-29]

| | Year | Total Number of Discharges | Number of Discharges Boarded | % of Total Boarded | Mean Length of Stay (hours) | Median Length of Stay (hours) |
|---|---|---|---|---|---|---|
| Behavioral health* | 2020 | 12,358 | 1,226 | 9.9% | 62.4 | 45 |
| | 2021 | 12,432 | 1,375 | 11.1% | 72.1 | 48 |
| | 2022 | 10,795 | 1,214 | 11.3% | 66.9 | 46 |
| Mental health** | 2020 | 8,756 | 1,117 | 12.8% | 64.3 | 46 |
| | 2021 | 8,899 | 1,243 | 14.0% | 74.5 | 50 |
| | 2022 | 7,606 | 1,095 | 14.4% | 69 | 47 |
| Substance use disorder*** | 2020 | 3,602 | 109 | 3.0% | 43.2 | 31 |
| | 2021 | 3,533 | 132 | 3.7% | 49.5 | 35.5 |
| | 2022 | 3,189 | 119 | 3.7% | 47.6 | 37 |

**Behavioral health (BH) is defined as combined mental health and SUD; all ICD-10 diagnosis codes starting with F but excluding codes starting with F17 (nicotine).*
***Mental health (MH) is defined as all ICD-10 diagnosis codes starting with F, but excluding codes starting with F1.*
****Substance use disorder (SUD) is defined as all ICD-10 diagnosis codes starting with F1, but excluding codes starting with F17 (nicotine).*

> **The ER doc said that our kid was too unpredictable to admit and needed acute care; when acute care turned [my child] down, the hospital told us we'd be fine and insisted on discharging right away. They seemed not to care at all when we said we definitely were not fine.**
>
> *– Parent describing their experience with the behavioral health system*[5]

**How many psychiatric residential, subacute and acute inpatient beds are in Oregon? How does this compare to other states with similar population levels and geography? How does bed availability fluctuate over time? For the programs, what is the regional availability, admission criteria, referral process, capacity, waitlist, utilization rate and program outcomes?**

When community-based services can no longer meet the needs of youth ages 0 to 17, higher levels of care may be pursued. Out-of-home psychiatric care is divided into three levels:

- **Psychiatric residential treatment facilities:** Non-hospital, 24-hour treatment facilities that provide intensive therapy and psychiatric care.
- **Subacute psychiatric inpatient:** Non-hospital, 24-hour treatment facilities that treat youth with more complex and intensive needs for a shorter duration than residential treatment; there is typically more access to child psychiatry and nursing.
- **Acute psychiatric inpatient:** Hospital-based, 24-hour psychiatric treatment that treat the highest acuity youth with the most complex or severe needs.

A research study of 2017-2020 data found that Oregon had fewer pediatric psychiatric beds per capita than most other states (Figure 6.8); this trend was apparent throughout the West Coast.[255] At the time of this report, there are 12 facilities offering psychiatric inpatient care in Oregon (Table 6.12).[255] There are only two facilities that offer acute psychiatric inpatient care.

*Figure 6.8. Pediatric inpatient psychiatric beds per 100,000 children in 2020, from the Journal of the American Medical Association*[255]

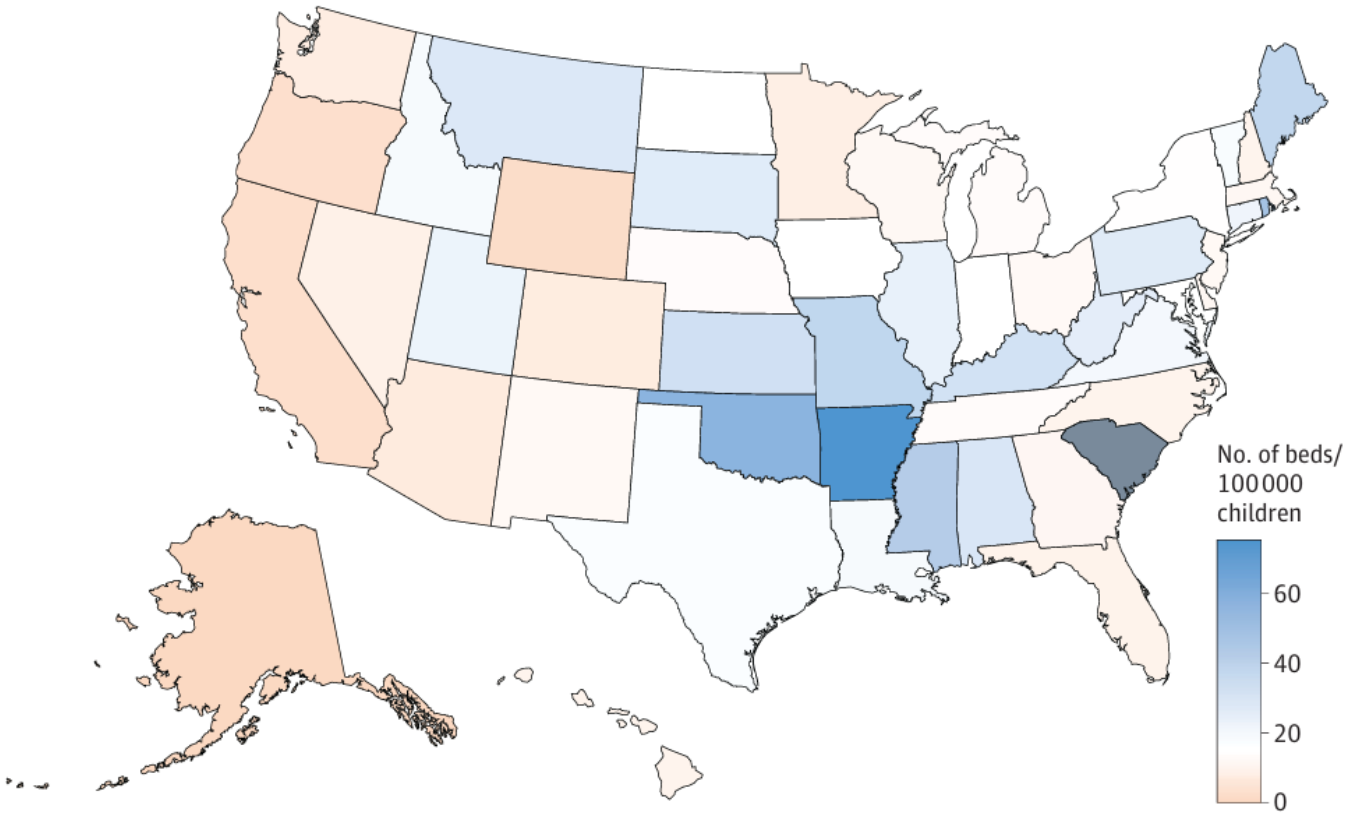


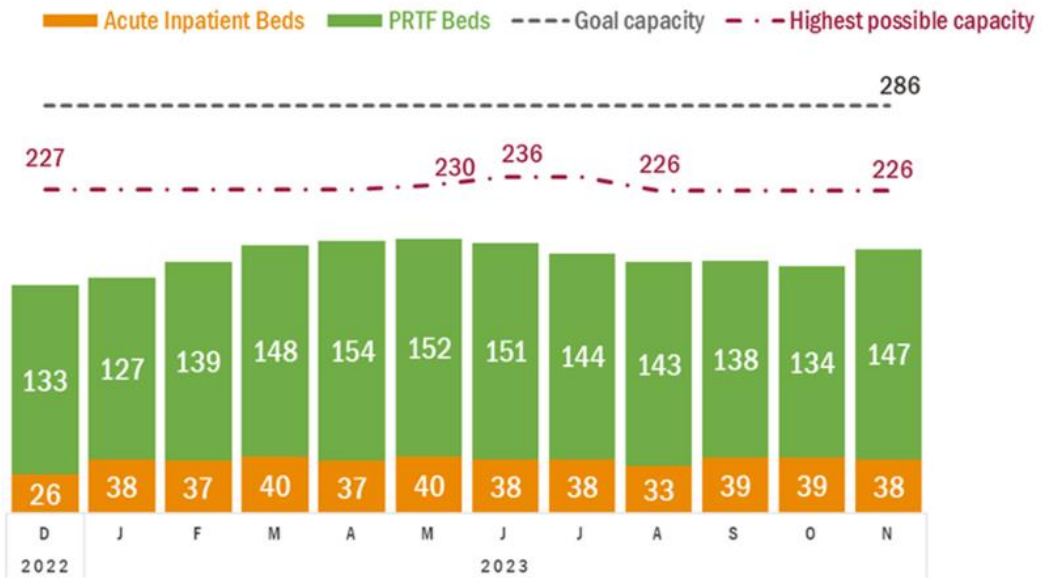

*Table 6.12. Psychiatric inpatient facilities for youth up to age 18 in Oregon*

| Program | Location | Programs Offered and Population Served |
|---|---|---|
| Albertina Kerr[256] | Portland | Subacute; ages 5 to 17, all genders |
| Clementine[257] | West Linn | Residential; adolescent, females only, eating disorder diagnosis |
| Embark[258] | Bend | Residential; ages 10 to 14, all genders |
| Jasper Mountain[259] | Jasper | Residential; ages 4 to 13, all genders |
| Looking Glass[260] | Eugene (2 facilities) | Residential, Subacute; ages 12 to 18, all genders, only youth involved with ODHS |
| Madrona Recovery[261] | Tigard | Residential; dually licensed to provide psychiatric and SUD residential; ages 13 to 17, all genders |
| Nexus Family Healing[262] | Portland | Residential; youth with behavioral health needs and I/DD involved with the JJ system |
| Providence Willamette Falls[263] | Oregon City | Acute; ages up to 18, all genders |
| Trillium Family Services[264] | Portland, Corvallis | Residential, subacute; ages 5 to 17 (Portland) and 12 to 17 (Corvallis), all genders |
| Unity Center for Behavioral Health[265] | Portland | Acute; ages 9-17, all genders |

Data from OHA indicates that there were 147 residential and 38 acute inpatient beds operational at the end of 2023 (Figure 6.9). In 2019, OHA in partnership with ODHS set a goal to increase statewide youth psychiatric residential bed capacity to 286 beds; however, Oregon is still significantly below that capacity.[266] Operational beds reflect the functionally available beds that have adequate staffing and resources to be utilized, while maximum capacity is how many licensed beds there are in the state.[266] Residential and subacute programs can be accessed from emergency departments and hospitals, or by outpatient clinicians and crisis response teams. Acute inpatient referrals can only come from emergency departments and hospitals.

In January 2024, Governor Kotek announced a partnership with CCOs to invest an additional $25 million in expanding residential beds to Trillium Family Services, Adapt, Looking Glass and Community Counseling Solutions.

*Figure 6.9. Psychiatric residential & acute inpatient beds, December 2022 – November 2023, from the Oregon Health Authority*[267]




**The gray line on the chart represents the capacity goal set in 2019 by ODHS and OHA.*
**The red line shows the highest possible (functional) capacity, which refers to the number of available beds that month, given full staffing and without high acuity concerns among a given milieu in any facilities.*
**The columns represent the actual beds used or open for use (operational) each month.*

Data on individual program waitlists, utilization rates and outcomes is unable to be included in this report, as it was not tracked in a systematic way during the report time frame. However, OHA launched the Referral and Capacity Management (RCM) System in late 2024, which tracks statewide referrals, admission and outcomes data. RCM is still in its early stages and not all providers have been onboarded. The RCM team plans to coordinate with the OHSU Oregon Behavioral Health Coordination Center (OBCC), a program funded by the state legislature to coordinate adult and youth behavioral health referrals and beds, to more effectively track data on referrals, beds and waiting times.

The National Alliance on Mental Illness (NAMI) surveyed and interviewed youth who had received facility-based psychiatric treatment.[268] While the sample size is small (25 parent/caregiver responses and three youth responses), results highlighted important equity considerations. The three main themes that emerged from this report are that BIPOC youth and their families:

- Feel like their voice is not considered in treatment, from intake to discharge
- Experience forcefulness, coercion and insensitivity from staff that impacts the well-being of youth in their care
- Feel frustrated that there are inadequate feedback mechanisms in place

> **It is widely accepted that each of Oregon's residential service options has limited capacity to meet the needs of Oregon's youth overall, let alone the culturally specific needs of Oregon's BIPOC youth.**
>
> *– Parent describing their experience with residential treatment*[268]

Adult facilities

Individuals ages 18-25 are served by the adult system for facility-based psychiatric care. Oregon State Hospital is Oregon's public mental health inpatient facility for adults who are committed to the state's care. Admission rates are presented in Table 6.13. Data on other facilities, which OHA reports are usually not appropriate for transition-aged youth, are not included in this report.

*Table 6.13. Number of admissions for individuals ages 18 to 25 at the Oregon State Hospital*[269]

| | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| Number of individuals ages 18 to 25 admitted | 113 | 130 | 122 | 176 |
| Percentage of total admissions | 15% | 14% | 12% | 14% |

**How many substance use disorder residential beds are available in Oregon? What are programs' regional availability, admission criteria, referral processes, capacities, waitlists, utilization rates and program outcomes?**

Residential SUD facilities offer 24-hour support for youth with substance use disorder and may be required when a youth needs more intensive SUD treatment than is available in the community. Treatment typically includes individual and group therapy, psychoeducation about the impacts of substance use and alternatives to substance use.[233]

At the time of this report publication, there are four facilities offering residential treatment for youth with SUD (Table 6.14).

*Table 6.14. Substance use disorder residential treatment facilities*

| Program | Location | Population Served |
|---|---|---|
| Adapt Deer Creek[270] | Roseburg | 13 to 17 years old, SUD and co-occurring mental health, public and private insurance |
| Madrona Recovery[261] | Tigard | 13 to 17 years old, co-occurring SUD and mental health diagnosis, public and private insurance |
| Native American Rehabilitation Association (NARA)[271] | Gresham | 12 to 17 years old, SUD, focus on Native American / Alaska Native youth, public and private insurance |
| Rimrock Trails[272] | Prineville | 12 to 17 years old, co-occurring SUD and mental health diagnosis, public and private insurance |

Data from OHA indicates that there were 42 operational SUD beds at the end of 2023, which indicates that Oregon is operating at 61% of maximum capacity (Figure 6.10). Operational beds reflect the functionally available beds that have adequate staffing and resources to be utilized, while maximum capacity is how many licensed beds there are in the state.[266] Programs can be accessed from the community or from emergency departments and hospitals. Treatment utilization rates among individuals ages 0 to 26 peaked in 2020 and has since declined (Figure 6.11) (OHA data tables). The Youth and Young Adult Substance Use Prevention, Treatment, and Recovery report (2023) states that in Oregon, more than 5% of youth ages 12-17 who needed facility-based SUD treatment do not receive it, compared to 4% nationally.[233]

*Figure 6.10. Substance use disorder residential beds, maximum capacity compared to highest possible capacity, 2023, from Oregon Health Authority*[266]

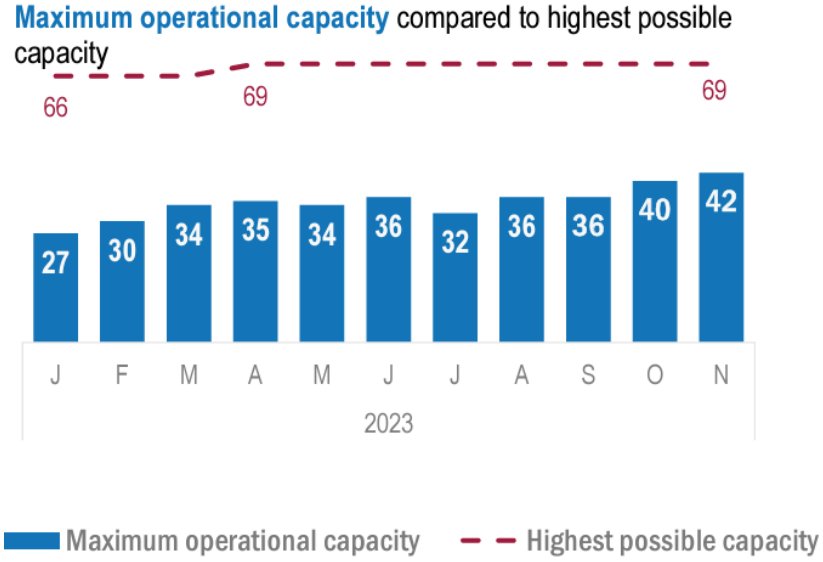
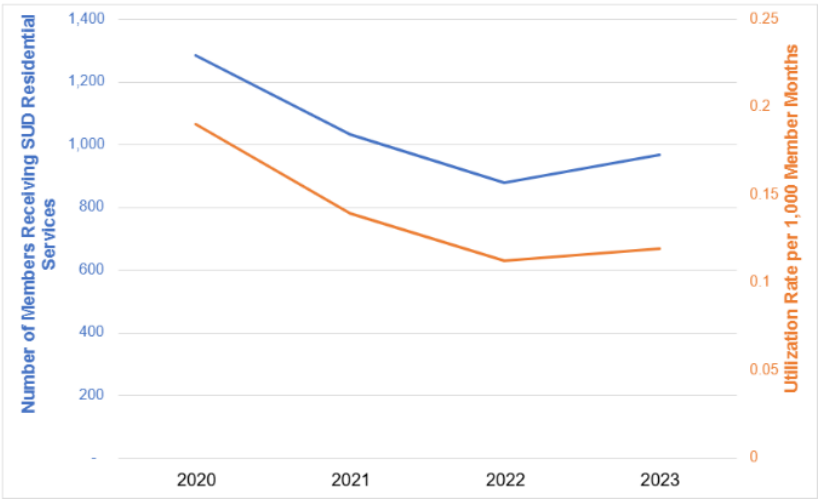


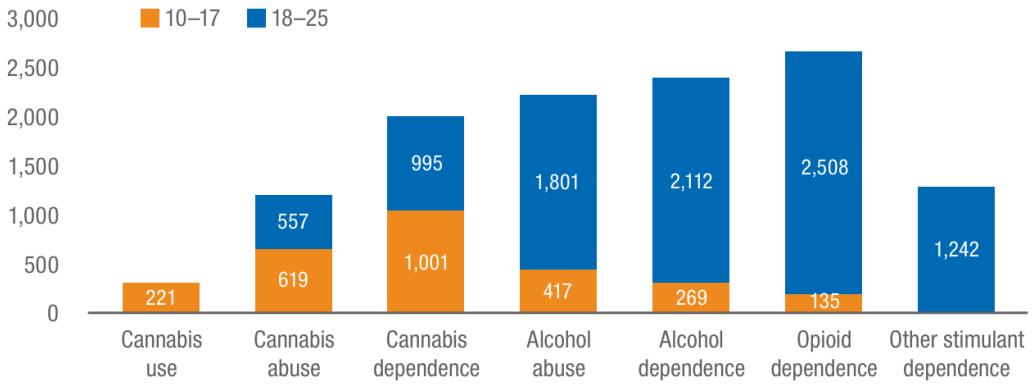

*Figure 6.11. Number of individuals ages 0 to 26 receiving substance use disorder residential treatment and utilization rate per 1,000 member months*[28-29]




[1]*Substance use residential is defined as procedure codes H0018 and H0019.*
[2]*Utilization is calculated by dividing the number of members receiving services by the total number of member months for individuals 0-26, then multiplying by 1,000.*

Figure 6.12 shows SUD diagnoses by age at admission; cannabis dependence and abuse are the most common diagnoses for youth ages 10 to 17 and opioid and alcohol dependence are the most common diagnoses for adults 18 to 25.[233] The average length of stay in 2022 ranged from 50 days to 270 days.[233]

*Figure 6.12. Top 6 SUD diagnoses of admitted youth for each age group for 2022, from the Youth and Young Adult Substance Use Prevention, Treatment, and Recovery Report*[233]




*Ages 0-9 are not included because of the low counts
Source: Generated from the Medicaid Management Information System (MMIS/Data Support/Surveillance and Utilization Review System (DSSURS).

**How many behavior rehabilitation services beds are in Oregon? How does this compare to other states with similar population levels and geography? How does bed availability fluctuate over time? What are the regional availability, admission criteria, referral process, capacity, waitlist, utilization rate and program outcomes?**

Behavior residential services (BRS) provide behavioral intervention, counseling and skills training to youth in the child welfare and juvenile justice systems. OHA, Oregon Department of Human Services (ODHS) and the Oregon Youth Authority (OYA) partner with BRS providers for a range of services in various settings, including family "proctor," residential and qualified residential treatment programs (QRTPs). Referrals can occur from ODHS Child Welfare, OYA or county probation officers. Table 6.15 outlines the availability of BRS programs through ODHS and OYA. At the time of this report, ODHS has a total of 207 beds and OYA has a total of 255 beds.[273] Admission criteria is outlined in Table 6.16.

Figure 6.13 shows how ODHS bed capacity fluctuates over time. There has been a notable decrease in BRS facility bed capacity since 2020. ODHS currently has formal solicitations open to increase bed capacity across the state.[274] From 2022 to 2025, 43% of referrals to BRS and other child-caring agencies contracted with ODHS (including community-based shelters, transitional living programs and psychiatric residential treatment facilities) were not accepted.[273] Denial reasons are outlined in Figure 6.14. The team was unable to locate data on BRS waitlists or program outcomes.

Only two other states, Washington and Connecticut, have BRS beds. Between January 2021 and January 2023, Washington had between 256 and 338 beds.[275]

*Table 6.15. Oregon behavior rehabilitation services programs*[273,276]

| Provider | Location | Services | Beds | Ages | Gender |
|---|---|---|---|---|---|
| Oregon Department of Human Services | | | | | |
| Boys and Girls Aid | Portland | BRS Proctor & Behavioral Health Treatment Foster Care | 14 | 5+ | All |
| Clarvida (formerly Maple Star) | Portland | BRS Proctor | 7 | 6+ | All |
| Connections 365 | Salem | BRS Proctor & Behavioral Health Treatment Foster Care | 4 | 9+ | All |
| Family Solutions Cascade House | Medford | BRS Intensive Behavioral Support | 9 | 12+ | Female |
| Greater Oregon Behavioral Health Inc. | Various/ Statewide | BRS Proctor & Behavioral Health Treatment Foster Care | 45+ | 4+ | All |
| Janus Youth Programs – Atlas | Portland | BRS Enhanced ILP | 2 | 16+ | Male |
| Kairos | Grants Pass | BRS Proctor | 3 | 4-18 | All |
| Klamath Basin Behavioral Health – Kane St. | Klamath Falls | BRS Intensive Rehabilitation | 6 | 10-14 | All |
| Morrison Counterpoint | Portland | BRS Proctor Enhanced | 2 | 12-18 | Male |
| Multnomah A&E | Portland | BRS Assessment & Evaluation | 4 | 13+ | All |
| Next Door Inc. | Hood River | BRS Proctor Enhanced | 5 | 6-18 | All |
| Oregon Community Programs | Eugene | BRS & Behavioral Health Treatment Foster Care | 26 | 4-17 | All |
| Rising Light | Roseburg | BRS Intensive Behavioral Support | 8 | 13-17 | Female identifying |
| River Rock | Roseburg | BRS Intensive Behavioral Support | 8 | 14-17 | All |
| St. Mary's Home for Boys – Tualatin | Portland | BRS Intensive Residential | 25 | 13-17 | Male |
| Turning Point | Grants Pass | BRS Basic Residential | 1+ | 13-17 | All |
| A Village for One – Anisa's Place | Clackamas | BRS Intensive Behavioral Support | 6 | 12-17 | Female identifying |
| Youth Progress | Portland | BRS Proctor Enhanced & Behavioral Health Treatment Foster Care | 13 | 13-17 | All |
| Youth Unlimited | Portland | BRS Proctor & Behavioral Health Treatment Foster Care | 15 | 5-18 | All |

| Oregon Youth Authority | | | | | |
|---|---|---|---|---|---|
| Connections365 | Salem | Proctor Care | 2 | 12-18 | All |
| Connections365 | Salem | Short-term Stabilization | 5 | 12-18 | Male |
| Connections365 | Salem | Intensive Behavioral Support | 4 | 14-19 | Male |
| Homestead | Pendleton | Basic Residential | 15 | 14-17 | Male |
| Homestead | Pendleton | Enhanced Structure ILP | 5 | 17.5+ | Male |
| J Bar J – Ranch | Bend | Basic Residential | 25 | 13-19 | Male |
| J Bar J – J5 | Bend | Short-term Stabilization | 20 | 13-24 | Male |
| J Bar J – Loft | Bend | ILP | 3 | 17.5+ | Female |
| J Bar J – Grandma's House | Bend | ILP | 1 | 12 - 20 | All |
| J Bar J – Apartment | Bend | ILP | 3 | 17.5+ | Male |
| Janus – Atlas | Portland | Enhanced Structure ILP | 6 | 16 - 21 | Male |
| Janus – Cordero | Tigard | Basic Residential | 13 | 14-19 | Male |
| Janus – Buckman | Portland | ILP | 4 | 17-24 | Male |
| Janus - Buckman | Portland | Enhanced Structure ILP | 12 | 17-24 | Male |
| Josephine – Turning Point | Grants Pass | Basic Residential | 5 | 13-17 | All |
| Klamath – Crimson Rose | Klamath Falls | Short-term Stabilization | 9 | 13-20 | Female |
| Morrison | Portland | Proctor Enhanced Services | 13 | 13-18 | Male |
| Multnomah A&E | Portland | Assessment and Evaluation | 2 | 13-18 | All |
| Northwest Youth Discovery | Bend | Basic Residential | 10 | 13-17 | Female |
| Oregon Community Programs | Euguene | Proctor Care & Behavioral Health Treatment Foster Care | 10 | 12-18 | All |
| Parrott Creek | Oregon City | Basic Residential | 17 | 14-18 | Male |
| Polk | Dallas | Proctor Care | 10 | 12-18 | Male |
| St. Mary's | Beaverton | Intensive Residential | 30 | 13-17 | Male |
| The Next Door | The Dalles | Basic Residential | 10 | 13-17 | Male |
| The Next Door | Hood River | Proctor Enhanced Services | 5 | 13-17 | Male |
| Youth Progress Association College and Career Attainment Program | Portland | ILP | 4 | 17.5+ | Male |
| Youth Progress Association College and Career Attainment Program | Portland | Proctor Enhanced Services | 8 | 17.5+ | Male |
| Youth Unlimited, Inc. | Gresham | Proctor Care & Behavioral Health Treatment Foster Care | 4 | 12-20 | All |

*Table 6.16. Behavior rehabilitation services (BRS) admission criteria*[277]

| **BRS Admission Criteria from the Oregon Administrative Rules**[277] |
|---|
| Has a primary mental, emotional or behavioral disorder or developmental disability that prevents the individual from functioning at a developmentally appropriate level in the individual's home, school or community. Requires out-of-home behavioral rehabilitation treatment to restore or develop the individual's appropriate functioning at a developmentally appropriate level in the individual's home, school or community. |
| Demonstrates severe emotional, social and behavioral problems, including but not limited to drug and alcohol abuse; antisocial behaviors requiring close supervision, intervention and structure; sexual behavioral problems; or behavioral disturbances |
| Requires out-of-home behavioral rehabilitation treatment to restore or develop the individual's appropriate functioning at a developmentally appropriate level in the individual's home, school or community |
| Is able to benefit from the BRS program at a developmentally appropriate level |
| Does not have active suicidal, homicidal or serious aggressive behaviors |
| Does not have active psychosis or psychiatric instability |

*Figure 6.13. Oregon Department of Human Services Child Welfare treatment services placements over time, from Child Welfare*[273]

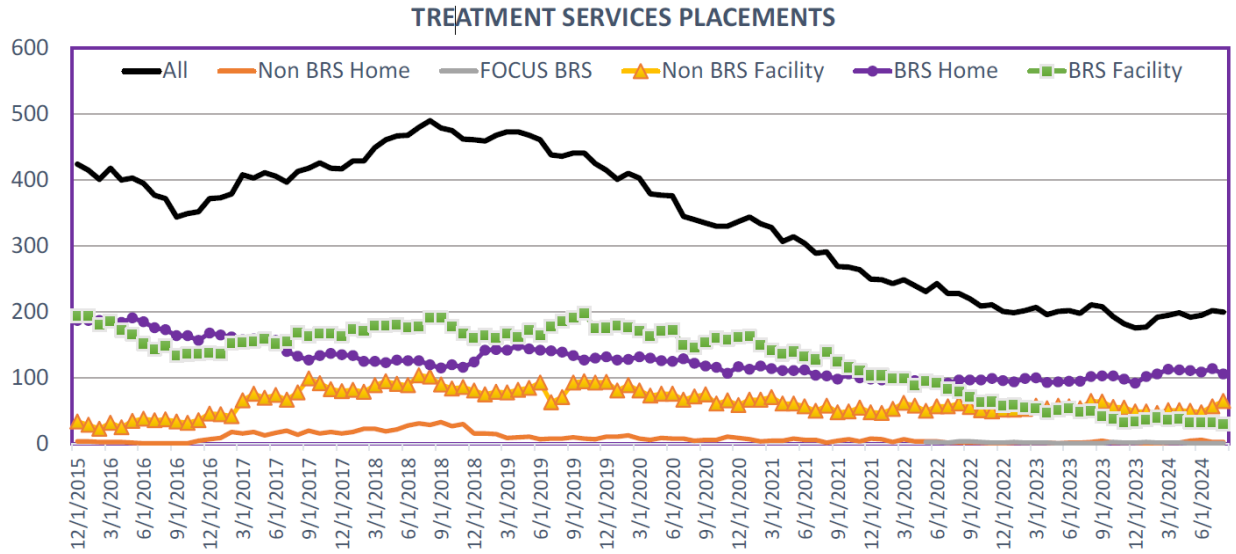
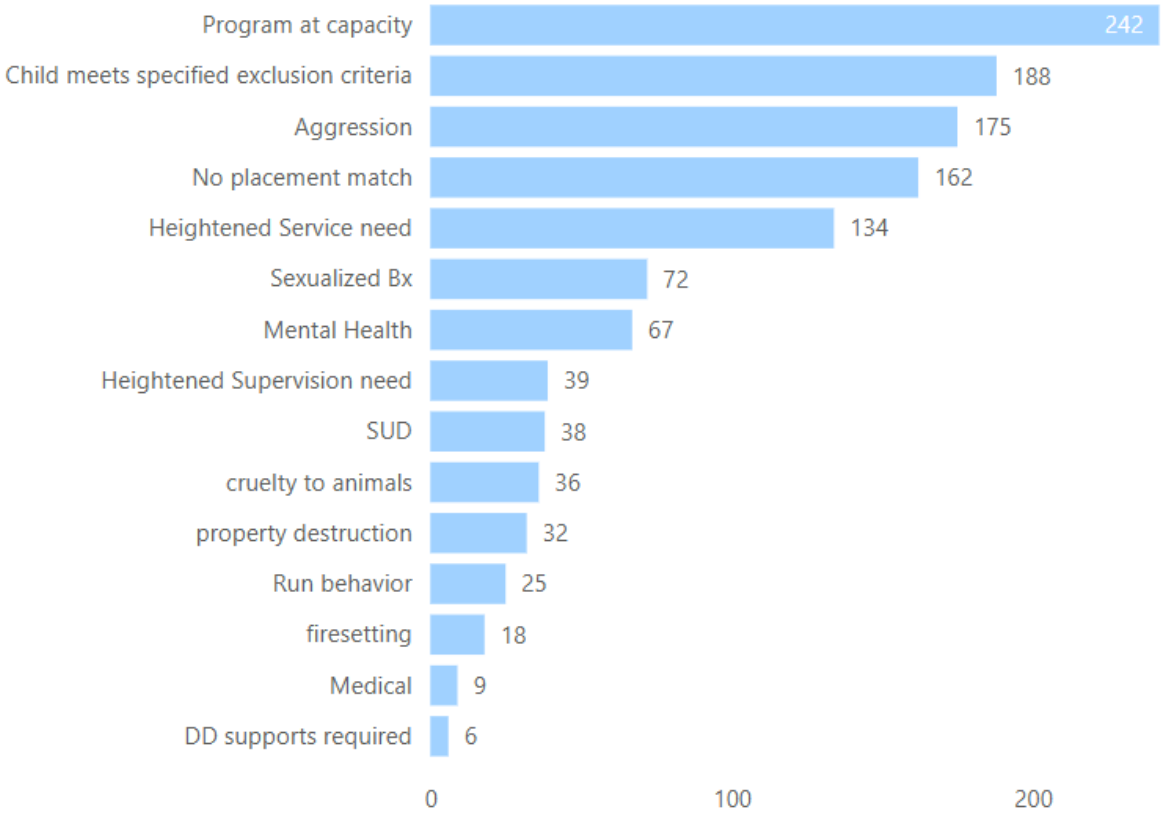



*Figure 6.14. Number of referrals by denial reason for child-caring agencies contracted with Oregon Department of Human Services Child Welfare, from Child Welfare*[45]



**What barriers do families face when moving through levels of care?**

This question will be addressed in the Care Pathways Analysis, which is scheduled to be completed in 2025. This analysis could not be completed in the time frame of this report due to issues outlined in the Limitations section.

**What are some barriers to treatment for youth with medical comorbidities/complex medical issues?**

OHA has been gathering community feedback on this topic and plans to release a report in Q2 2025.

# INTELLECTUAL AND DEVELOPMENTAL DISABILITIES SYSTEM

## CHAPTER INTRODUCTION

This chapter focuses on services and supports provided by the Office of Developmental Disability Services (ODDS). ODDS is a division of the Oregon Department of Human Services (ODHS) and serves youth diagnosed with intellectual and developmental disabilities (I/DD). Intellectual disability is characterized by an IQ of 70 or lower and significant difficulties with adaptive behavior, such as challenges in communication and self-care, that emerge before age 18. Individuals with an IQ between 71 and 75 may also be diagnosed with intellectual disability if they exhibit substantial impairment in adaptive behavior.[278] Developmental disability refers to severe mental or physical impairments, or a combination of both, that begin before the age of 22, affect the brain and are expected to be lifelong. It affects essential daily living skills, including communication, self-care, safety and social interaction. I/DD is a combined term which stands for intellectual and developmental disabilities. ODDS services and supports include service coordination, family support, in-home supports, host homes and residential care.[278] The Children's Intensive In-Home Services (CIIS) programs and Children's Extraordinary Needs (CEN) programs also provide specialized care to youth with I/DD and medical needs. These programs were not identified as specific research topics by SOCAC; however, utilization data is captured in the overall utilization rates presented in the chapter. Because these two programs are important to youth involved in the SOC, more focused evaluation of these programs should be included in future efforts.

## KEY TAKEAWAYS

Oregon youth receive more I/DD in-home support than other states and less early intervention support.

Half of families feel that I/DD workers are available when needed to help support their child's needs, which is lower than the national average.

Although the family is involved in developing their youth's Individual Support Plan (ISP) at a higher rate than in the rest of the U.S., less than 1% of youth ages 0 to 25 receive the full hours of support listed on their ISP.

Through the National Core Indicators (NCI) survey for youth with I/DD, approximately one-third of families report that their youth receive behavioral health supports when needed. Over three-fourths of families report that their providers always or usually understand their youth's needs related to their disability.

**How many youth are eligible for intellectual and developmental disability services and how many are receiving services? Are there groups that are disproportionately represented in either category?**

In Oregon, Community Developmental Disabilities Programs (CDDPs) determine eligibility for I/DD services through ODDS. CDDP staff help families obtain necessary forms and assist with the eligibility process. Eligibility requirements for qualifying disabilities are outlined in the Oregon Administrative Rules.[279] The specific services that a youth is eligible for are determined via their Oregon Needs Assessment (ONA) and subsequent service group determination. Additional information on the ONA and service levels is presented in the following question.

Table 7.1 shows the number of youth eligible for I/DD services and those receiving services. The number of youth who are authorized and receiving services from ODDS has increased each year since 2020. Table 7.2 shows a breakdown of this data stratified by demographic groups from 2020 to 2023.

*Table 7.1. Oregon Department of Disability Services eligibility, authorization and service utilization rates, 2020-2023*[28, 30]

| | 2020 | | 2021 | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | n | *% of eligible* | n | *% of eligible* | n | *% of eligible* | n | *% of eligible* |
| Eligible to receive services | 18,131 | *N/A* | 19,093 | *N/A* | 19,531 | *N/A* | 20,875 | *N/A* |
| Authorized to receive services | 17,448 | *96.2%* | 18,361 | *96.2%* | 18,770 | *96.1%* | 20,160 | *96.6%* |
| Received services* | 11,936 | *65.8%* | 11,506 | *60.3%* | 12,171 | *62.3%* | 13,911 | *66.6%* |

Individual service-type data was not provided by ODDS; however, the National Core Indicators – Intellectual and Developmental Disabilities (NCI-IDD) Child Family Survey collects service information from families of youth (up to age 22) with I/DD. Nine states completed the survey in 2022; national data comparisons present a weighted average of these states. The survey found that Oregon youth receive much more in-home support than other states and less early intervention support (Table 7.3).[280]

*Table 7.2. Service eligibility, authorization and utilization among youth with IDD stratified by race/ethnicity, 2020-2023*[28, 30]

| | 2020 | | | | | | 2021 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Eligible N = 18,131 | | Authorized N = 17,448 | | Received Services N =11,936 | | Eligible N = 19,093 | | Authorized N = 18,361 | | Received Services N = 11,506 | |
| Race/Ethnicity | n | % | n | % | n | % | n | % | n | % | n | % |
| American Indian/ Alaska Native | 353 | *1.9 %* | 341 | *2.0%* | 245 | *2.1%* | 387 | *2.0%* | 373 | *2.0%* | 241 | *2.1%* |
| Asian | 442 | *2.4%* | 446 | *2.6%* | 305 | *2.6%* | 491 | *2.6%* | 491 | *2.7%* | 310 | *2.7%* |
| Black | 640 | *3.5%* | 629 | *3.6%* | 461 | *3.9%* | 685 | *3.6%* | 669 | *3.6%* | 442 | *3.8%* |
| Hispanic or Latino/a/x/e | 1,389 | *7.7%* | 1,367 | *7.8%* | 884 | *7.4%* | 1,523 | *8.0%* | 1,501 | *8.2%* | 834 | *7.2%* |
| Native Hawaiian / Pacific Islander | 88 | *0.5%* | 85 | *0.5%* | 52 | *0.4%* | 95 | *0.5%* | 91 | *0.5%* | 52 | *0.5%* |
| Other race or ethnicity | 44 | *0.2%* | 47 | *0.3%* | 30 | *0.3%* | 59 | *0.3%* | 62 | *0.3%* | 32 | *0.3%* |
| Two+ race/ethnicities | 377 | *2.1%* | 367 | *2.1%* | 238 | *2.0%* | 430 | *2.3%* | 417 | *2.3%* | 247 | *2.1%* |
| Unknown | 6,486 | *35.8%* | 5,981 | *34.3%* | 3,749 | *31.4%* | 6,792 | *35.6%* | 6,257 | *34.1%* | 3,534 | *30.7%* |
| White | 8,312 | *45.8%* | 8,185 | *46.9%* | 5,972 | *50.0%* | 8,631 | *45.2%* | 8,500 | *46.3%* | 5,814 | *50.5%* |

| | 2022 | | | | | | 2023 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Eligible N = 19,532 | | Authorized N = 18,770 | | Received Services N = 12,171 | | Eligible N = 20,876 | | Authorized N = 20,160 | | Received Services N = 13,911 | |
| Race/Ethnicity | n | % | n | % | n | % | n | % | n | % | n | % |
| American Indian / Alaska Native | 414 | *2.1%* | 399 | *2.1%* | 260 | *2.1%* | 445 | *2.1%* | 427 | *2.1%* | 300 | *2.2%* |
| Asian | 519 | *2.7%* | 520 | *2.8%* | 355 | *2.9%* | 574 | *2.7%* | 575 | *2.9%* | 411 | *3.0%* |
| Black | 736 | *3.8%* | 723 | *3.9%* | 481 | *4.0%* | 824 | *3.9%* | 811 | *4.0%* | 573 | *4.1%* |
| Hispanic or Latino/a/x/e | 1,621 | *8.3%* | 1,599 | *8.5%* | 931 | *7.6%* | 1,867 | *8.9%* | 1,851 | *9.2%* | 1,177 | *8.5%* |
| Native Hawaiian / Pacific Islander | 107 | *0.5%* | 104 | *0.6%* | 56 | *0.5%* | 136 | *0.7%* | 135 | *0.7%* | 71 | *0.5%* |
| Other race or ethnicity | 63 | *0.3%* | 63 | *0.3%* | 40 | *0.3%* | 63 | *0.3%* | 64 | *0.3%* | 46 | *0.3%* |
| Two+ races/ethnicities | 501 | *2.6%* | 492 | *2.6%* | 298 | *2.4%* | 628 | *3.0%* | 622 | *3.1%* | 405 | *2.9%* |
| Unknown | 6,697 | *34.3%* | 6,110 | *32.6%* | 3,587 | *29.5%* | 6,766 | *32.4%* | 6,214 | *30.8%* | 3,923 | *28.2%* |
| White | 8,874 | *45.4%* | 8,760 | *46.7%* | 6,163 | *50.6%* | 9,573 | *45.9%* | 9,461 | *46.9%* | 7,005 | *50.4%* |

*Table 7.3. Services and supports received from the state, 2022-2023*[280]

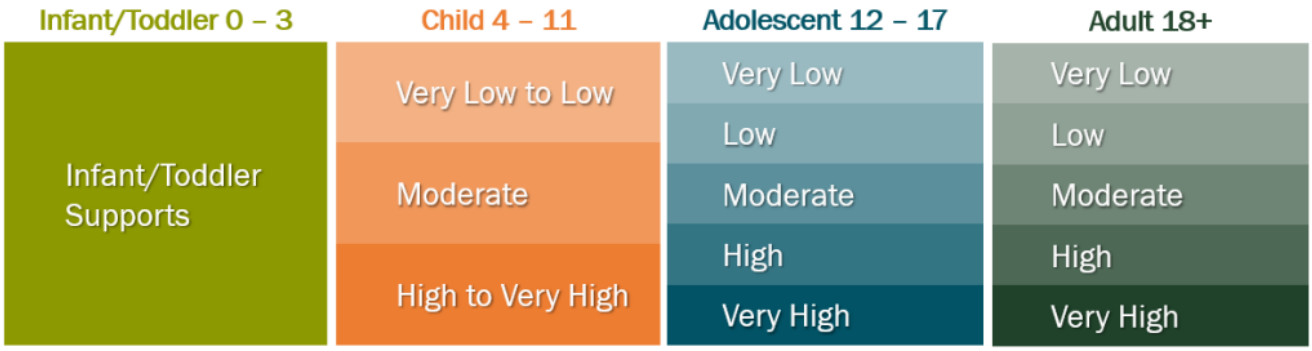
| | Oregon | United States |
|---|---|---|
| Services and Supports | % received | % received |
| Financial support | 17% | 20% |
| In-home support | 76% | 48% |
| Out-of-home respite care | 33% | 25% |
| Early intervention | 9% | 17% |
| Transportation | 23% | 15% |
| Mental or behavioral health care or other treatments or therapies | 74% | 77% |
| Self-direction or fiscal intermediary services | 67% | 48% |

**What is the distribution of needs assessment levels and how does this relate to services received? Are there groups that are disproportionately represented in any needs assessment level? Is there equity between needs assessment level and services received?**

The Oregon Needs Assessment (ONA) evaluates the functional needs of individuals with I/DD to ensure they receive appropriate services. The type and intensity of service provided to individuals is dependent on their needs assessment level determined through the ONA. This assessment helps the agency create service groups, develop Individual Support Plans (ISPs) and determine eligibility for things like the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IDD) level of care or an Enhanced status for those supported by in-home care workers.[281]

Youth are categorized by their age and needs assessment level; ODDS refers to this categorization as service groups. The number of service groups varies based on age. As shown in Figure 7.1, youth 0 to 3 years of age only have one service group, children ages 4 to 11 have three service groups and youth aged 12 to 17 and 18 to 25 each have five.[282]

*Figure 7.1. Oregon Department of Disability Services needs assessment levels by age, from the Office of Developmental Disability Services*[282]



***Service Group Determination***

ODDS publishes service group handbooks for each age range that describe what a service group is, how it is determined and what parents should do if they disagree with their child's service group designation. These service group handbooks are publicly available and can be found on the ODDS website.[283]

ODDS creates service groups based on responses to the Oregon Needs Assessment which are grouped into seven categories[282]:

- General support need (GSN) score
- Medical support need (MSN) score
- Support person performs score (this means the support person performs the task for the person with I/DD)
- Behavior support need (BSN) score
- Behavior intervention/management frequency score
- Positive behavior support plan (PBSP) score
- Emergency/crisis services score

Each category is assigned a numerical value, and the scores are summed to determine a total. This total score then corresponds to a specific needs assessment level, which is based on the youth's age.[282]

Table 7.4 shows the distribution of service level groups for all individuals 25 and under served by ODDS.[28, 30] Table 7.5 shows the breakdown of service group by age. More 0- to 3-year-olds were in the supports service group than in the "no assessment" group. Among children 4 to 11 years of age, most were in the moderate service group, followed by the group with high to very high support needed. This trend was similar for youth 12 to 17 and 18 to 25 years of age.

ODDS collects data on service groups for youth stratified by race/ethnicity. The moderate-needs service group was the most common among White, Black and American Indian / Alaska Native youth. The high-needs service group was most common among Asian, Hispanic/Latino and multiracial youth. For Native Hawaiian / Pacific Islander youth, the high- and very-high-needs service groups were the most prevalent.

*Table 7.4. Service-level groups identified for all individuals 25 and under authorized for Oregon Department of Disability Services[28, 30]*

| **Service Group** | **2020** N = 17,448 | | **2021** N = 18,361 | | **2022** N = 18,770 | | **2023** N = 20,160 | |
|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % |
| No Assessment Yet | 2,976 | *17.1%* | 2,745 | *15.0%* | 2,430 | *12.9%* | 2,557 | *12.7%* |
| Very Low | 483 | *2.8%* | 397 | *2.2%* | 328 | *1.7%* | 283 | *1.4%* |
| Low | 1,971 | *24.8%* | 1,946 | *10.6%* | 1,828 | *9.7%* | 1,744 | *8.7%* |
| Moderate | 4,325 | *2.4%* | 4,889 | *26.6%* | 5,232 | *27.9%* | 5,784 | *28.7%* |
| High to Very High | 4,286 | *24.6%* | 4,760 | *25.9%* | 5,028 | *26.8%* | 5,477 | *27.2%* |
| Very High | 3,407 | *19.5%* | 3,624 | *19.7%* | 3,924 | *20.9%* | 4,315 | *21.4%* |

*Table 7.5. Service level groups identified for individuals 25 and under authorized for Oregon Department of Disability Services, by age*[28, 30]

| Service Group | 2020 | | 2021 | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | n | *% of age group* | n | *% of age group* | n | *% of age group* | n | *% of age group* |
| 0-3 Years old* | N = 560 | | N = 463 | | N = 491 | | N = 599 | |
| No Assessment Yet | 220 | *39.2%* | 180 | *38.9%* | 170 | *34.6%* | 191 | *31.9%* |
| Infant/Toddler Supports | 340 | *60.7%* | 283 | *61.1%* | 321 | *65.4%* | 408 | *68.1%* |
| 4 to 11 years old | N = 4,759 | | N = 4,958 | | N = 4,961 | | N = 5,303 | |
| No Assessment Yet | 970 | *20.4%* | 896 | *18.1%* | 728 | *14.7%* | 807 | *15.2%* |
| Very Low to Low | 268 | *5.6%* | 233 | *4.7%* | 201 | *4.1%* | 205 | *3.9%* |
| Moderate | 2,453 | *51.5%* | 2,672 | *53.9%* | 2,859 | *57.6%* | 2,985 | *56.3%* |
| High to Very High | 1,068 | *22.4%* | 1,157 | *23.3%* | 1,173 | *23.6%* | 1,306 | *24.6%* |
| 12 to 17 years old | N = 4,356 | | N = 4,498 | | N = 4,610 | | N = 4,862 | |
| No Assessment Yet | 834 | *19.1%* | 698 | *15.5%* | 586 | *12.7%* | 574 | *11.8%* |
| Very Low | 31 | *0.7%* | 15 | *0.3%* | 8 | *0.2%* | 5 | *0.1%* |
| Low | 314 | *7.2%* | 230 | *5.1%* | 180 | *3.9%* | 142 | *2.9%* |
| Moderate | 1,593 | *36.6%* | 1,755 | *39.0%* | 1,867 | *40.5%* | 2,022 | *41.6%* |
| High to Very High | 766 | *17.6%* | 875 | *19.5%* | 989 | *21.5%* | 1,114 | *22.9%* |
| Very High | 818 | *18.8%* | 925 | *20.6%* | 980 | *21.3%* | 1,005 | *20.7%* |
| 18 to 25 years old | N = 6,284 | | N = 6,544 | | N = 6,690 | | N = 6,979 | |
| No Assessment Yet | 847 | *13.5%* | 786 | *12.0%* | 686 | *10.3%* | 635 | *9.1%* |
| Very Low | 383 | *6.1%* | 332 | *5.1%* | 245 | *3.7%* | 220 | *3.2%* |
| Low | 1,447 | *23.0%* | 1,493 | *22.8%* | 1,389 | *20.8%* | 1,319 | *18.9%* |
| Moderate | 2,023 | *32.2%* | 2,264 | *34.6%* | 2,575 | *38.5%* | 2,839 | *40.7%* |
| High to Very High | 654 | *10.4%* | 709 | *10.8%* | 772 | *11.5%* | 826 | *11.8%* |
| Very High | 930 | *14.8%* | 960 | *14.7%* | 1,023 | *15.3%* | 1,140 | *16.3%* |

**How many youth are accessing the full hours of support services per their Individualized Support Plan? Are there certain groups accessing more services through their Individual Service Plan?**

An Individual Support Plan (ISP) is a document for individuals with I/DD that outlines the person's needs and goals, and the services and support they need to achieve them.[284] ISPs should be guided by the youth and family and what is important to them. Data from ODDS indicates that on average, less than 1% of youth ages 0 to 25 receive the full hours of support listed on their ISP (Table 7.6). Note: In-home services are the only services included in this calculation, as they

are the only services that use service hours as a measure. Additionally, ODDS provided aggregate numbers and the team could not assess for disparities.

*Table 7.6. In-home services* utilization and service hours on the Individual Support Plan, data from ODHS[28,30]*

| | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| Number of individuals eligible to receive services | 12,827 | 12,882 | 13,503 | 14,597 |
| Number of individuals receiving services | 8,662 | 8,958 | 9,477 | 10,577 |
| Average number of service hours authorized on ISP (annual) | 1,781 | 1,883 | 1,929 | 1,940 |
| Average number of service hours received on ISP (annual) | 1,359 | 1,452 | 1,472 | 1,445 |
| Percentage of individuals receiving full hours authorized on ISP | 0.6% | 1.1% | 0.8% | 0.7% |

**In-home services include the Children's Intensive In-Home Services (CIIS) and the Children's Extraordinary Needs (CEN) programs*

The 2022-2023 NCI-IDD Core Indicators report highlights better rates of engagement in ISP development in Oregon than other comparison states (Table 7.7). The rate of youth receiving all the services outlined on their ISP is lower in Oregon than the national average.

*Table 7.7. Family-reported development and utilization of service plans, 2022-2023[280]*

| | Oregon | United States |
|---|---|---|
| | % | % |
| Child has a service plan | 83% | 71% |
| Service plan includes all the services and supports needed | 84% | 84% |
| Someone in the family (aside from identified youth) helped make the service plan | 93% | 88% |
| Child helped make the service plan | 25% | 19% |
| Family feels they had enough input in making the service plan | 92% | 91% |
| Child gets all the services listed in the ISP | 77% | 82% |

**How many youth/families have personal support workers and/or direct support professionals? Do certain families lack access to these professionals in their communities?**

Some individuals with I/DD utilize direct support professionals (DSPs) and personal support workers (PSWs) for daily support in areas such as independent living, health and social involvement. PSWs provide support for activities of daily living, such as personal hygiene, meal preparation and housekeeping. They can be an individual of the youth and family's choice, are

hired directly by the family and can be parents or caregivers.[285] DSPs are employed by certified agency providers contracted with ODHS. They must complete certification training through the agency where they are employed.[286] More detailed information about this workforce can be found in the System Workforce chapter of this report.

ODDS collects information on the number of youth receiving in-home services by a PSW or a DSP, as shown in Table 7.8. This number has increased from 7,610 youth served in 2020 to 9,157 youth served in 2023.[28, 30]

*Table 7.8. Youth who have received in-home services by a PSW or DSP, from ODDS[28, 30]*

| | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| Number of youth | 7,610 | 7,882 | 8,182 | 9,157 |

### *Barriers to Accessing PSWs and DSPs*

Key takeaways from Oregon's results on the NCI-IDD survey include[287]:

- **36%** of families report that there is too much turnover of support workers working with their child, which is comparable to the national average (37%).
- **52%** said there is always a staff person available to provide support when needed, which is less than the national average (72%) (Figure 7.2).
- **79%** said that support workers always or usually have the right information and skills to meet their family's needs, which are comparable, though slightly lower, than national averages (83%).
- **78%** of families with a child who does not communicate verbally reported that there were always or usually support workers who could communicate with their child, which is better than national averages (54%) (Figure 7.3).

*Figure 7.2. Percentage of families that feel that staff are available to meet their child's needs, from 2021-22 OR Child Family Survey State Report[280]*

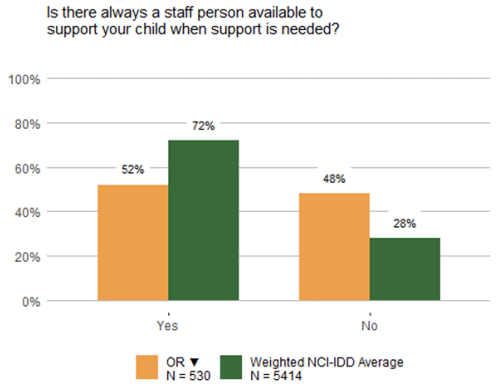
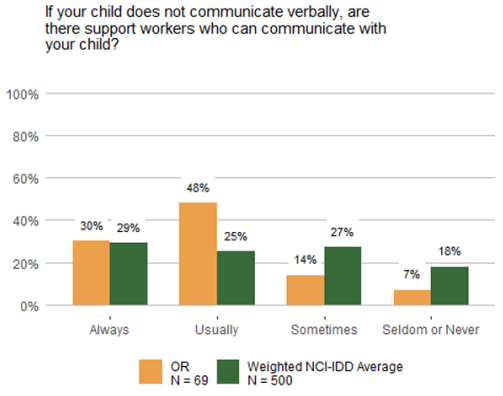



*Figure 7.3. Percentage of families that feel that staff can communicate with their nonverbal child, from 2021-22 OR Child Family Survey State Report[280]*



**What behavioral health services are provided to youth with intellectual and developmental disabilities? Are there groups that have more/less access to these supports?**

Behavioral health services, which include mental health and/or substance use treatment, are not provided to youth through ODDS. ODDS case managers help families and guardians navigate the behavioral health system by informing them about local mental health resources and helping individuals with their intake paperwork. For youth in out-of-home placements, their residential providers can enroll them in mental health services, such as counseling, within their local communities.[286]

The NCI-IDD indicates that Oregon youth with I/DD have less access to mental health treatment and providers who adequately understand their unique needs related to their disability (Table 7.9).[280]

*Table 7.9. Services and supports received from the state, 2022-2023*[280]

| | Oregon | United States |
|---|---|---|
| | % | % |
| Child gets mental or behavioral health supports (like a therapist or group counseling) when needed | 33% | 44% |
| Mental health providers always or usually understand child's needs related to their disability | 79% | 84% |

ODDS does not collect data on gaps in behavioral health services provided to youth with I/DD. OHA does collect data on this, although it was not able to be obtained within the time frame of this report. However, data specific to I/DD youth who have accessed services through community-based behavioral health programs provide some information about services received. These community-based programs are In-Home Intensive Behavioral Health Treatment (IIBHT), Mobile Crisis Intervention Services (MCIS) and Mobile Response and Stabilization Services (MRSS) for youth up to age 25.

Youth insurance influences the BH services they can access. For example, Oregon Health Plan (OHP) members can access behavioral health services as a co-occurring need with I/DD through IIBHT. Individuals can access MCIS for crisis intervention and MRSS for crisis and stabilization services regardless of insurance, although MRSS is not available in all counties currently, and some counties have a limited number of spots.

### *Intensive Behavioral Health Treatment (IIBHT)*

IIBHT is an intensive behavioral health program that provides in-home therapy, skills training, peer support and crisis support to youth with OHP (for more information on this program, see

the Behavioral Health Care System chapter). From 2021 to 2023, IIBHT served 455 youth, 36 of whom (7.9%) had an I/DD.[36] Race/ethnicity and gender data reflected the I/DD population demographics in Oregon. Of the 36 youth with I/DD served through IIBHT, the majority were White youth, followed by Hispanic/Latino youth. Asian and American Indian/Alaskan Native youth were the least represented. Males made up the largest gender group.[36] Of these youth, 56% identified as straight, while 25% identified as LGBTQ+.[36] Most of the I/DD youth served by IIBHT lived in private residences, though a significant portion were currently or formerly in foster care, with about 28% having been adopted.[36]

***Mobile Crisis Intervention Services (MCIS)***

MCIS is the statewide mobile crisis response system that serves individuals of all ages regardless of insurance (for more information, see the Behavioral Health Care System chapter). In 2023, MCIS served a total of 3,330 youth ages 0-20 years; 243 (about 7%) of those served were youth with I/DD.[231] A higher proportion of youth with I/DD aged 18 or older were served compared to those aged 0 to 17.[231] White youth with I/DD were the most represented in MCIS, while Asian youth were the least. Additionally, more males than females were served, which aligns with the general trend of a higher prevalence of I/DD in males.[231]

***Mobile Response and Stabilization Services (MRSS)***

MRSS is an extension of the MCIS program. It offers short-term stabilization services, like mental health assessment and treatment, after an initial crisis encounter with MCIS (for more information about MRSS, see the Behavioral Health Care System chapter). In 2023, MRSS served 21 youth with I/DD, representing 10% of the total youth served.[37] Similar to MCIS, MRSS also served more White youth with I/DD than other races/ethnicities, and more males than females, as is representative of the I/DD population in Oregon.[37] However, in contrast to MCIS, most youth served through MRSS were 12 years of age or younger.[37]

**Are behavioral health services for youth with intellectual and developmental disabilities restricted or limited due to office policy, insurance, lack of provider ability or willingness to accept and treat youth with intellectual and developmental disabilities? Are there any disparities in who experiences this?**

While youth with I/DD have higher rates of mental health needs compared to non-I/DD youth, they also face many challenges in accessing this care.[288] In Oregon, legislation passed in 2024 (SB 1557) mandates that no community mental health program, licensed medical provider or other certified or licensed practitioner, education provider or coordinated care organization may deny any individual under the age of 21 years access to mental health assessment, treatment or services on the basis that the individual also has an I/DD.[289]

ODDS does not collect information on restrictions and limitations in accessing mental health services. This data is mostly available through qualitative feedback received from families. In 2023, OHA identified several key barriers to accessing behavioral health care in Oregon for individuals with I/DD, including[290]:

- A lack of knowledge and communication about available services
- Workforce challenges
- Issues with case management, service coordination and care coordination
- Difficulties in addressing the needs of people with complex conditions and integrating health services
- Limited access to and availability of necessary services
- Ambiguities around roles, referrals and responsibilities for providing services
- Inequities in service delivery and the need for culturally and linguistically appropriate services
- Insufficient provider capacity
- Provider reluctance
- Discriminatory practices
- Lack of accommodations

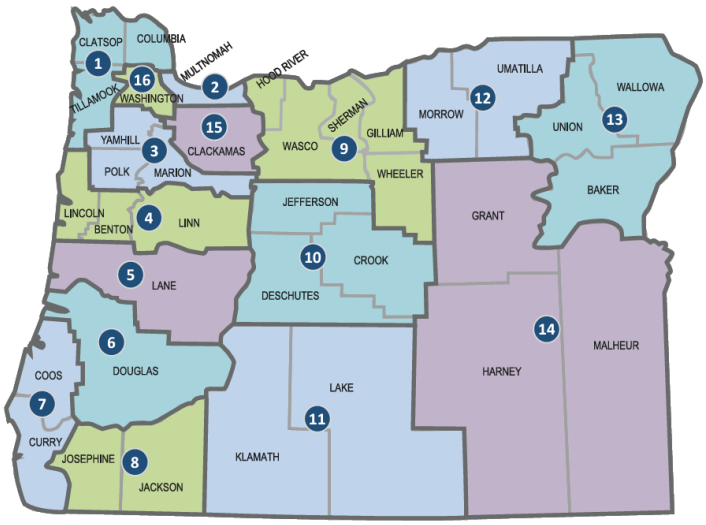
> **"We are very grateful for the ODDS program and recognize the progress made with KPlan. However, it's clear that ODDS is presenting an image of support for disabled children in Oregon that doesn't fully match the reality. Caregivers are reaching a breaking point — working tirelessly, grappling with rising inflation and often unable to return to work — while ODDS has yet to provide a plan that enables families to achieve a sustainable living situation, beyond merely scraping by.**
>
> **Having caregivers who are stressed, financially strained and unsupported is ultimately detrimental to the children in Oregon who deserve so much more.**
>
> *– Parent describing their experience with the Oregon Department of Disability Services[5]*

> **Our experiences reflect the larger, systemic issues in Oregon, where families like ours are forced to confront these unnecessary barriers in the mental health and developmental service fields. Outdated diagnostic approaches and a lack of comprehensive support for children with complex needs only add to the trauma and hardship…**
>
> **It is essential for Oregon's mental health and developmental services to adopt modern, inclusive approaches that can support children with autism, trauma and other co-occurring conditions without making families choose between inadequate local resources and uprooting their lives to seek the right care elsewhere."**
>
> *– Parent describing their experience with the I/DD and behavioral health systems[5]*

## CHAPTER INTRODUCTION

The Child Welfare division of the Oregon Department of Human Services (ODHS) oversees the state's Adoption and Guardianship, Child Safety, and Foster Care programs.[291] Sixteen regional Child Welfare districts operate independently while being united by the vision, goals, practice and data of the state-level division (Figure 8.1).[292]

*Figure 8.1. Child welfare districts in Oregon, from the Oregon Department of Human Services*[292]




District 1: Clatsop, Columbia, Tillamook
District 2: Multnomah
District 3: Marion, Polk, Yamhill
District 4: Benton, Lincoln, Linn
District 5: Lane
District 6: Douglas
District 7: Coos, Curry
District 8: Jackson, Josephine
District 9: Gilliam, Sherman, Wasco, Wheeler
District 10: Crook, Deschutes, Jefferson
District 11: Klamath, Lake
District 12: Morrow, Umatilla
District 13: Baker, Union, Wallowa
District 14: Grant, Harney, Malheur
District 15: Clackamas
District 16: Washington

## KEY TAKEAWAYS

Over 25,000 youth were served by Child Welfare from 2020 to 2023. Oregon has higher rates of referrals, investigations and founded abuse claims than rates across the United States as a whole; rates for entry into foster care are similar.

Native American / Alaska Native and Black / African American youth are disproportionately represented in the child welfare system.

Oregon's child welfare system has less placement stability than the national standard, which means that youth move placements more often than recommended while in Child Welfare custody.

Oregon's Child Welfare has higher rates of youth victimization while in foster care than the national standard.

**What are the different levels of involvement and their prevalence, including abuse calls, Child Protective Services contacts/screens/removal from home, In-Home Family Services, Foster Care and the Adoption & Guardianship Program? Are there groups that are disproportionately represented in the different levels of involvement? How does this compare to other states?**

When there are concerns about youth maltreatment, Child Welfare may become involved through different stages of investigations and determinations about the case. The following section describes the different ways CW may be involved.

### *Child Protective Services Referrals, Investigations, Founded Claims and Removals*

The Oregon Child Abuse Hotline (ORCAH) receives and screens reports of child maltreatment. An ORCAH screener determines if a caller's allegations meet the definition of abuse or neglect. If they do, the case is assigned to a caseworker in Child Protective Services (CPS), who investigates the allegation. A case is considered "founded" if evidence supports the allegation. Resulting actions range from providing voluntary services to placement in foster care.

Oregon has higher rates of referrals, investigations, and founded abuse claims than the United States as a whole; however, rates for entry into foster care are similar (Table 8.1).[293] National data suggests that "racial disparities occur at nearly every major decision-making point along the child welfare continuum," with Native American / Alaska Native and Black / African American youth often disproportionately overrepresented; this trend is also evident in Oregon (Table 8.2).[13]

Note: Child Welfare representatives report that Oregon has one of the lowest thresholds for substantiating abuse / neglect in the county, which may account for some of the differences presented in Table 8.2.

Tables 8.3 and 8.4 show the annual number of referrals, investigations, and founded claims in Oregon.[45] On average, around 57% of referrals are assigned for CPS investigation and 19.2% of the children who are named as alleged victims have founded abuse.

*Table 8.1. Oregon and United States rate per 1,000 youth of child abuse referrals, investigations, founded claims, and entry into foster care*[293]

| | 2020 | | 2021 | | 2022 | |
|---|---|---|---|---|---|---|
| Rate per 1,000 Youth | OR | U.S. | OR | U.S. | OR | U.S. |
| Child abuse/neglect referrals | 81.9 | 45.0 | 78.2 | 44.4 | 86.6 | 48.6 |
| Investigations | * | * | * | * | * | * |
| Maltreated children (founded) | 13.1 | 8.3 | 12.2 | 8.1 | 12.3 | 7.6 |
| Entry into foster care | 3.2 | 2.9 | 2.8 | 2.8 | N/A | N/A |

**Data by year is not available; however, a 2019-2022 total is available: Oregon had an investigation rate of 54.4 per 1,000 children and the United States had a rate of 41.7 per 1,000 children.*

*Table 8.2. Race and ethnicity of victims of child abuse, adapted from the Child Welfare Data Book*[294]

| | FFY 2021 | | FFY 2022 | | FFY 2023 | |
|---|---|---|---|---|---|---|
| Race/Ethnicity | % | DI* | % | DI* | % | DI* |
| Black / African American | *4.6%* | 1.2 | *4.7%* | 1.3 | *4.6%* | 1.2 |
| Asian / Pacific Islander | *1.6%* | 0.3 | *1.6%* | 0.3 | *1.6%* | 0.3 |
| White | *58.0%* | 0.9 | *58.3%* | 0.9 | *53.4%* | 0.8 |
| Hispanic (any race) | *12.4%* | 0.5 | *13.1%* | 0.6 | *12.6%* | 0.6 |
| American Indian / Alaska Native | *3.7%* | 2.6 | *3.9%* | 2.5 | *2.8%* | 1.9 |
| Unable to determine | *19.7%* | N/A | *18.4%* | N/A | *24.9%* | N/A |

**Disproportionality index (DI) is calculated by taking the percentage by race of victims of child abuse and dividing it by the percentage by race in Oregon's child population. Values less than 1 mean underrepresentation. Values greater than 1 mean overrepresentation.*

*Table 8.3. Child Protective Services referrals and investigations*[45]

| | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| Total child abuse/neglect referrals | 106,358 | 112,506 | 117,538 | 113,447 |
| Total referrals assigned for CPS investigation | 60,235 | 66,338 | 66,558 | 64,026 |
| Number of youth named on investigations | 58,726 | 63,673 | 64,048 | 61,704 |

*Table 8.4. Type of abuse among Child Protective Services investigations and founded cases*[45]

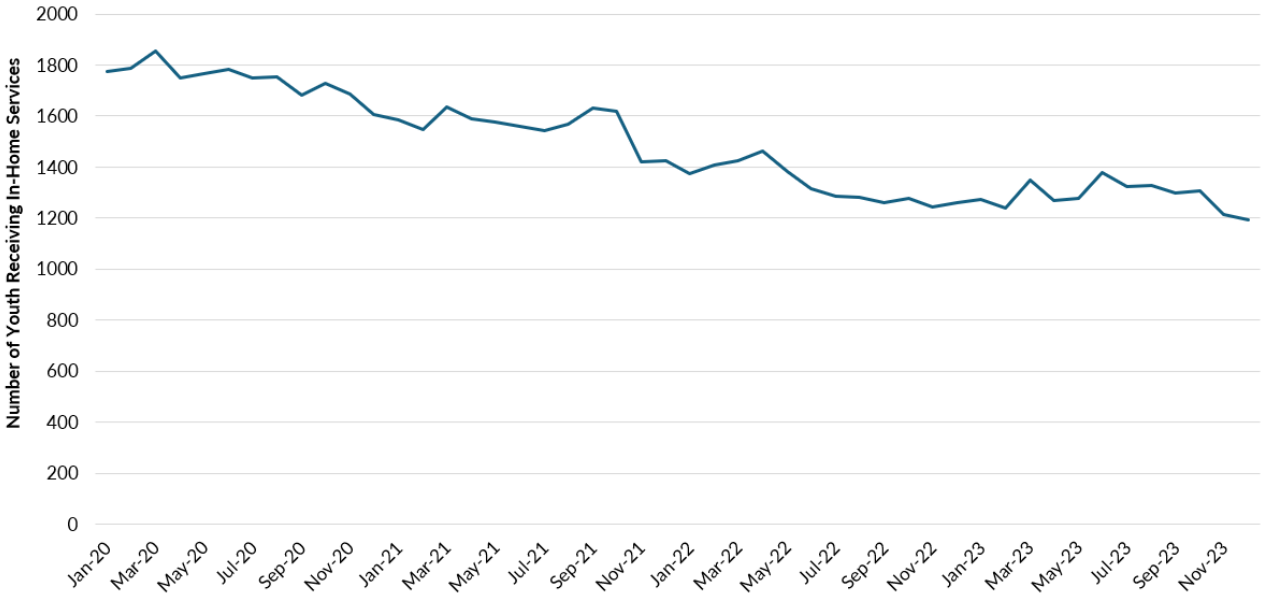
| | 2020 | | 2021 | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % |
| Number of Youth Assigned for Investigation* | N = 58,726 | | N = 63,673 | | N = 64,048 | | N = 61,704 | |
| Physical abuse | 10,778 | *18.4%* | 11,520 | *18.1%* | 12,990 | *20.3%* | 13,581 | *22.0%* |
| Sexual abuse | 2,804 | *4.8%* | 5,079 | *8.0%* | 5,464 | *8.5%* | 6,006 | *9.7%* |
| Threat of harm | 26,315 | *44.8%* | 31,031 | *48.7%* | 29,770 | *46.4%* | 29,611 | *48.0%* |
| Neglect | 31,224 | *53.2%* | 29,470 | *46.3%* | 26,635 | *41.6%* | 20,597 | *33.4%* |
| Mental injury | 1,404 | *2.4%* | 1,415 | *2.2%* | 2,110 | *3.3%* | 3,185 | *5.2%* |
| Number of Youth with Founded Abuse* | N = 9,724 | | N = 12,272 | | N = 13,011 | | N = 12,702 | |
| Physical abuse | 1,920 | *19.7%* | 2,239 | *18.2%* | 2,422 | *18.8%* | 2,597 | *20.4%* |
| Sexual abuse | 1,520 | *15.6%* | 2,162 | *17.6%* | 2,479 | *19.1%* | 2,527 | *19.9%* |
| Threat of harm | 5,615 | *57.7%* | 7,382 | *60.2%* | 7,678 | *59.0%* | 7,820 | *61.6%* |
| Neglect | 5,118 | *52.6%* | 5,607 | *45.7%* | 5,648 | *43.4%* | 4,785 | *37.7%* |
| Mental injury | 1,152 | *11.8%* | 1,201 | *9.8%* | 1,278 | *9.8%* | 1,417 | *11.2%* |

**Youth may fall into more than one category; totals will exceed 100%.*

### *In-Home Family Services*

In-home family services may be provided to families when CPS has determined that a youth can safely remain in the home with support. This may include services through the In-Home Safety and Reunification Services (ISRS) or Strengthening, Preserving and Reunifying Families (SPRF) programs (as of 2022, the program is also referred to as the Family Preservation program). These programs connect families with community resources and provide stabilization and safety interventions that focus on "managing the safety threats within the family to prevent removal" (ORRAI).[295] The average number of youth receiving family services per month decreased from 1,742 in 2020 to 1,288 in 2023 (Figure 8.2).[45] Consistent with other areas of child welfare, Black / African American youth and American Indian / Alaska Native youth are disproportionately represented in those receiving in-home family services (ORRAI).[295]

*Figure 8.2. Number of youth receiving in-home family services over time*[45]




### *Foster Care*

From 2020 to 2023, there were 15,850 unique youth who spent at least one day in foster care.[296] The annual number of youth in foster care has steadily been declining (Figure 8.3).[296] Consistent with national trends, Oregon has disproportionate representation of American Indian / Alaska Native and Black / African American youth in foster care (Table 8.5); this trend has persisted for almost 20 years.[13, 296-297]

*Figure 8.3. The total number of youth who spent at least one day in foster care by year*[296]

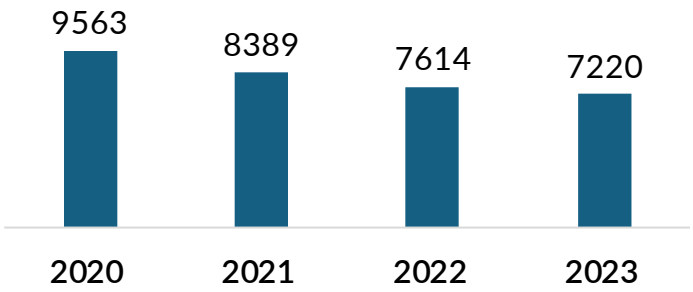


*Table 8.5. Race and ethnicity of youth in foster care, adapted from the Child Welfare Data Book*[294]

| | FFY 2021 | | FFY 2022 | | FFY 2023 | |
|---|---|---|---|---|---|---|
| Race/Ethnicity | % | DI* | % | DI* | % | DI* |
| Black / African American | *7.1%* | 1.9 | *7.4%* | 2.0 | *7.6%* | 2.0 |
| Asian / Pacific Islander | *1.5%* | 0.3 | *1.7%* | 0.3 | *1.7%* | 0.3 |
| White | *65.4%* | 1.0 | *63.9%* | 1.0 | *64.1%* | 1.0 |
| Hispanic (any race) | *18.6%* | 0.8 | *19.0%* | 0.8 | *18.0%* | 0.8 |
| American Indian / Alaska Native | *4.7%* | 3.3 | *4.7%* | 3.2 | *4.6%* | 3.2 |
| Unable to determine | *2.7%* | N/A | *3.2%* | N/A | *4.0%* | N/A |

**Disproportionality index (DI) is calculated by taking the percentage of race of victims of child abuse and dividing it by the percentage of race in Oregon's child population. Values less than 1 mean underrepresentation; values over 1 mean overrepresentation.*

Placement types

In addition to foster homes, youth may also be placed in a variety of settings, including psychiatric hospitals, residential treatment homes and independent living (Table 8.6).

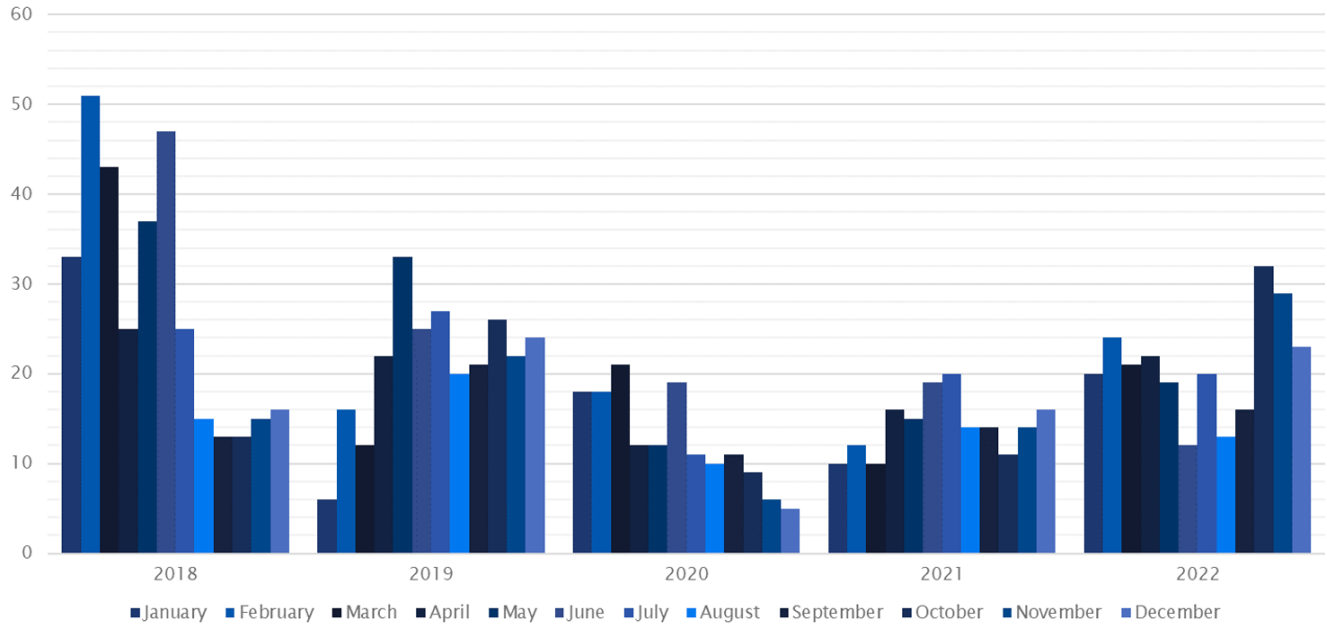
*Table 8.6. Average distribution of youth in Child Welfare placements*[45]

| | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| Child Welfare Placements | % | % | % | % |
| Foster care (non-relative) | 37% | 36% | 35% | 35% |
| Foster care (relative) | 30% | 32% | 32% | 33% |
| Group home | 1% | 1% | 1% | 2% |
| Hospitalization | 1% | 1% | 1% | <1% |
| Incarceration | <1% | 1% | <1% | <1% |
| Independent living | 3% | 3% | 3% | 2% |
| Juvenile justice facility | <1% | <1% | <1% | 1% |
| Left placement without permission | 2% | 2% | 2% | 3% |
| Medical or rehabilitative facility | <1% | <1% | <1% | <1% |
| Non-certified care | <1% | 1% | 1% | 1% |
| Pre-adoptive home | 9% | 8% | 8% | 6% |
| Psychiatric hospital | <1% | <1% | <1% | 1% |
| Residential treatment facility | 4% | 3% | 3% | 2% |
| Residential treatment home | 2% | 2% | 2% | 2% |
| Trial Reunification | 11% | 11% | 11% | 11% |

One placement that is of concern to system consumers and advocates is temporary lodging (under the noncertified care category), which is the use of hotels or other emergency accommodations when a youth is experiencing a placement crisis and there is no other safe

placement available.[298] Child Welfare aims to avoid the use of temporary lodging when possible.[299] A 2023 assessment found that very few youth were placed in temporary lodging: at its peak in 2018, the percentage of youth in care who experienced temporary lodging was < 1% (Figure 8.4).[299] From 2020 to 2022, the average number of youth in temporary lodging per month increased (12.7 in 2020, 14.3 in 2021, 20.9 in 2022).

*Figure 8.4. Number of children or young adults with at least one day in temporary lodging during the month, from Public Knowledge*[299]




## Placement stability

Placement stability (number of moves per 1,000 days in foster care) is consistently higher than the national standard, which indicates that Oregon youth have less placement stability than what is federally recommended (Figure 8.5).

When looking at this data by county, only 10 out of Oregon's 36 counties meet the federal standard (Figure 8.6).

*Figure 8.5. Child welfare placement stability (average moves per 1,000 days in care) in Oregon compared to the federal standard*[300]

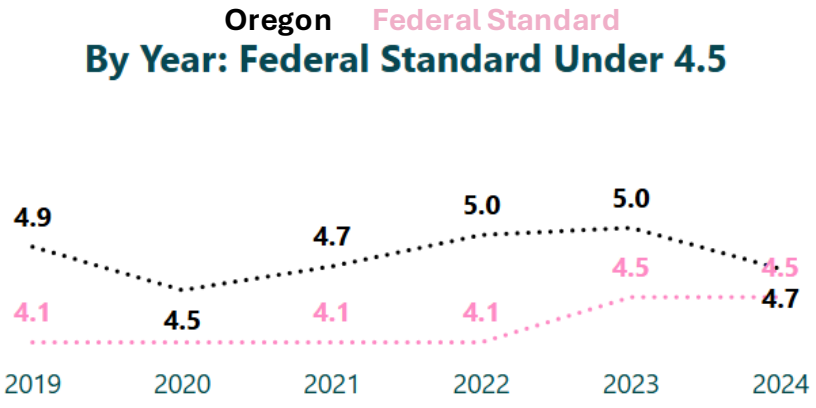
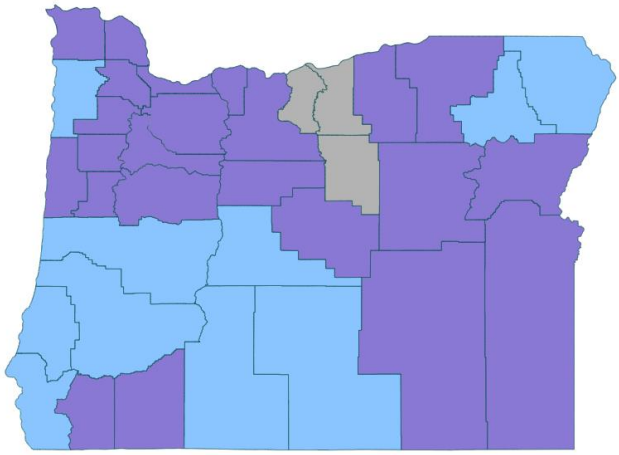


*Figure 8.6. Child Welfare placement stability (average moves / 1,000 days) in 2023*[300]



**Counties Meeting National Standards**

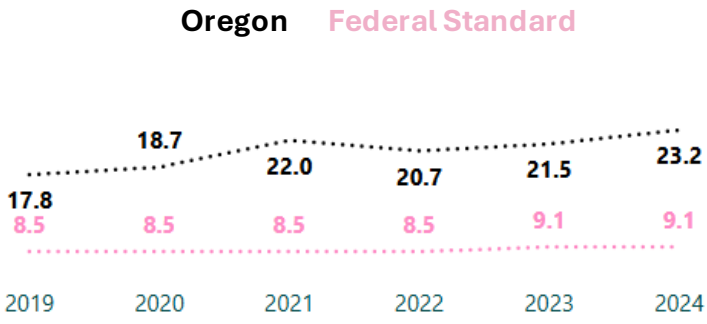
| | |
|---|---|
| Met | 10 |
| Not Met | 23 |
| No Score | 3 |
| Total | 36 |

Of note, Child Welfare is piloting two initiatives aimed at improving placement stability: the Response and Support Network (RSN) and Child Specific Caregiver Supports (CSCS). RSN provides "immediate response and individualized supports to resource and post-adoptive parents to help address challenges and connect them to longer term resources."[301] The program is currently available in the tri-county area; ODHS is currently advocating for statewide expansion. CSCS is currently available in eight counties (Clackamas, Lane, Linn, Marion, Multnomah, Polk, Washington and Yamhill) and provides in-home and community-based care tailored to the youth's specific needs. Both programs are aimed at keeping youth in their current placements.

## Maltreatment in foster care

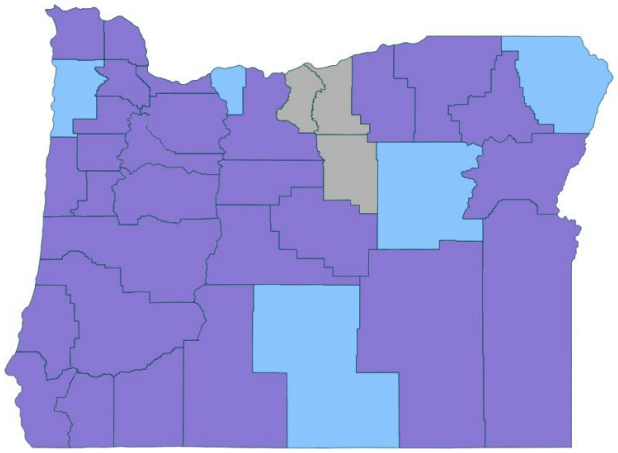
Youth in foster care in Oregon experience higher rates of maltreatment while in foster care than the national standard (Figure 8.7). These elevated rates are observed across all racial groups. When looking at this data by county, only five out of Oregon's 36 counties meet the federal standard (Figure 8.8). As stated previously, Oregon has one of the lowest thresholds for what constitutes maltreatment.

*Figure 8.7. Rate of maltreatment* during foster care in Oregon compared to the federal standard*[300]




**Rate = # of substantiated reports / # of days in care * 100,000*

*Figure 8.8. Rate of maltreatment in foster care in Oregon in 2023*[300]



| Counties Meeting National Standards | |
|---|---|
| Met | 5 |
| Not Met | 28 |
| No Score | 3 |
| Total | 36 |

*Rate = # of substantiated reports / # of days in care * 100,000

### *Adoption and Guardianship Program*

When ODHS has determined that it is no longer in the child's best interest to return to the care of their parents, the ODHS Permanency Program works with local foster care branches to secure adoptions and guardianship for youth. Around one-third of youth achieve permanency within the first 12 months of entering foster care and around 60% achieve permanency within 24 months (Table 8.7).

Adoption terminates parental rights and grants full custody of the youth to the adoptive parent(s).[302] Guardianship does not terminate parental rights and instead provides the youth with a legal guardian while the parents may continue to be involved.[302] Adoption and guardianship rates are presented in Table 8.8. One notable trend is that as age increases, youth are less likely to be adopted and more likely to be under guardianship. Additionally, American Indian / Alaska Native youth are more likely to be placed in guardianship, whereas White youth are more likely to be adopted.[303]

*Table 8.7. Youth who achieved permanency within 12 and 24 months of foster care entry*[303]

| | 2020* | | 2021* | | 2022* | | 2023* | |
|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % |
| Within 12 Months of Entry | | | | | | | | |
| Entries to foster care | 3,336 | N/A | 2,675 | N/A | 2,337 | N/A | 2,354 | N/A |
| Achieved permanency | 1,139 | 34.1% | 939 | 35.1% | 754 | 32.3% | 811 | 34.5% |
| Within 24 Months of Entry | | | | | | | | |
| Entries to foster care | 3,486 | N/A | 3,336 | N/A | 2,675 | N/A | 2,337 | N/A |
| Achieved permanency | 2,091 | 60.0% | 2,033 | 60.9% | 1,563 | 58.4% | 1,397 | 59.8% |

*Review period for enrollment is 12 or 24 months prior to year presented. For example, the review period for the percentage of individuals who achieved permanency within 12 months for 2020 looks at youth who entered foster care in 2019.

*Table 8.8. Number of youth discharged from foster care to adoption and guardianship*[45]

| | 2020 | | | | 2021 | | | | 2022 | | | | 2023 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Adoption N = 849 | | Guardianship N = 373 | | Adoption N = 572 | | Guardianship N = 418 | | Adoption N = 568 | | Guardianship N = 404 | | Adoption N = 530 | | Guardianship N = 463 | |
| | n | % | n | % | n | % | n | % | n | % | n | % | n | % | n | % |
| Age | | | | | | | | | | | | | | | | |
| 2 and under | 178 | 21% | 25 | 7% | 139 | 24% | 24 | 6% | 149 | 26% | 42 | 10% | 168 | 32% | 50 | 11% |
| 3 to 5 | 261 | 31% | 49 | 13% | 180 | 31% | 76 | 18% | 169 | 30% | 65 | 16% | 160 | 30% | 100 | 22% |
| 6 to 8 | 191 | 22% | 47 | 13% | 95 | 17% | 66 | 16% | 111 | 20% | 74 | 18% | 95 | 18% | 93 | 20% |
| 9 to 11 | 117 | 14% | 68 | 18% | 76 | 13% | 79 | 19% | 69 | 12% | 76 | 19% | 44 | 8% | 74 | 16% |
| 12 to 14 | 61 | 7% | 94 | 25% | 50 | 9% | 90 | 22% | 52 | 9% | 74 | 18% | 40 | 8% | 64 | 14% |
| 15 + | 41 | 5% | 90 | 24% | 32 | 6% | 83 | 20% | 18 | 3% | 73 | 18% | 23 | 4% | 82 | 18% |
| Sex | | | | | | | | | | | | | | | | |
| Female | 410 | 48% | 180 | 48% | 285 | 50% | 206 | 49% | 269 | 47% | 205 | 51% | 258 | 49% | 227 | 49% |
| Male | 439 | 52% | 193 | 52% | 287 | 50% | 212 | 51% | 299 | 53% | 199 | 49% | 272 | 51% | 236 | 51% |
| Race | | | | | | | | | | | | | | | | |
| American Indian / Alaskan Native | 20 | 2% | 40 | 11% | 13 | 2% | 65 | 16% | 12 | 2% | 47 | 12% | 19 | 4% | 59 | 13% |
| Asian | 4 | <1% | 2 | <1% | 3 | <1% | 4 | <1% | 1 | <1% | 4 | <1% | 4 | <1% | 2 | <1% |
| Black or African American | 41 | 5% | 19 | 5% | 28 | 5% | 18 | 4% | 43 | 8% | 12 | 3% | 37 | 7% | 21 | 5% |
| Hispanic, any race | 126 | 15% | 77 | 21% | 106 | 19% | 76 | 18% | 121 | 21% | 90 | 22% | 82 | 15% | 77 | 17% |
| Native Hawaiian / Pacific Islander | 1 | <1% | 6 | 2% | 2 | <1% | 2 | <1% | 8 | 1% | 8 | 2% | 13 | 2% | 0 | 0% |
| Unable to determine | 6 | 2% | 6 | 2% | 6 | 1% | 3 | <1% | 7 | 1% | 3 | <1% | 2 | <1% | 8 | 2% |
| White | 651 | 77% | 223 | 60% | 414 | 72% | 250 | 60% | 376 | 66% | 240 | 59% | 373 | 70% | 296 | 64% |

**What factors are associated with Child Welfare involvement? Are there groups disproportionately at risk of becoming involved with Child Welfare?**

In addition to the demographic factors outlined so far, there are several risk factors that are associated with child maltreatment and involvement with the Oregon child welfare system. Family stressors most commonly present for families in child welfare are parent/caregiver substance use and domestic violence (Table 8.9).[48]

*Table 8.9. Percentage of family stress factors present when abuse is founded, adapted from the 2020-2023 Child Welfare Data Books*[48]

| | FY 2020 | FY 2021 | FY 2022 | FY 2023 |
|---|---|---|---|---|
| Stress Factor | | | | |
| Parent/caregiver substance use | 41.0% | 42.3% | 40.2% | 40.7% |
| Domestic violence | 31.7% | 32.5% | 31.0% | 31.3% |
| Parent/caregiver involvement with law enforcement | 20.1% | 19.7% | 17.5% | 14.1% |
| Parent/caregiver mental illness | 13.7% | 14.2% | 12.7% | 12.8% |
| Child mental/physical/behavior disability | 12.1% | 12.6% | 11.5% | 4.2% |
| Parent/caregiver history of abuse as a child | 10.9% | 11.2% | 11.1% | 14.1% |
| Family financial distress | 10.4% | 8.2% | 8.2% | 9.5% |
| New baby/pregnancy | 5.7% | 6.9% | 6.2% | 5.4% |
| Inadequate housing | 6.8% | 6.1% | 6.0% | 6.4% |
| Head of household unemployed | 5.7% | 5.1% | 4.5% | 4.5% |
| Child developmental disability | 2.5% | 2.5% | 2.7% | 4.9% |
| Social isolation | 1.9% | 2.3% | 2.5% | 2.3% |
| Parent developmental disability | 1.6% | 1.7% | 1.3% | 1.9% |
| Heavy childcare responsibility | 1.5% | 1.5% | 1.3% | 2.8% |

*Note: Categories are not mutually exclusive, percentages will add up to over 100%.*

**How many parents have had to relinquish rights in order for their youth to receive services? How many parents have had their rights reinstated once services transitioned? What is the process to reinstate parental rights once services transition? Are parents engaged in the process of their youth receiving services even if they relinquished their rights?**

In some circumstances, parents may seek to relinquish their custodial rights to their children to ODHS in order to access services such as a higher level of behavioral health services.

ODHS keeps limited data regarding these cases. It reports that from 2020 to 2023, a total of 161 youth had a voluntary custody/placement.[306] Table 8.10 shows which districts these placements

occurred in (see Figure 8.1 in chapter introduction). It is unknown how many of these cases occurred as a result of parents seeking services for their children, as this information is not tracked, and it is not known how many parents had rights reinstated after services transitioned. The average length of time for youth in these placements was 20.3 months.[306]

In early 2025, ODHS is initiating a voluntary services case review, to examine qualitative data regarding the services and supports DHS was able to provide to a youth and family, and whether these services and supports were helpful to the youth and family. These reviews will provide additional information about the circumstances around voluntary relinquishment of rights and the outcomes of these relinquishments.

*Table 8.10. Number of youth with voluntary custody/placements in Child Welfare, 2020-2023*[306]

| District | # of Youth |
|---|---|
| 1 | 6 |
| 2 | 19 |
| 3 | 10 |
| 4 | 34 |
| 5 | 35 |
| 6 | 9 |

| District | # of Youth |
|---|---|
| 7 | 5 |
| 8 | 15 |
| 9 | < 5 |
| 10 | < 5 |
| 11 | 6 |
| 12 | < 5 |

| District | # of Youth |
|---|---|
| 13 | < 5 |
| 14 | < 5 |
| 15 | 9 |
| 16 | 7 |

# JUVENILE JUSTICE SYSTEM

## CHAPTER INTRODUCTION

The juvenile justice system is responsible for holding youth accountable for illegal actions and providing them with opportunities for reformation.[307] This chapter provides an overview of the ways youth become involved in the justice system and the factors that put certain youth at elevated risk of system involvement.

The juvenile justice system is organized at the county and state level. County-level juvenile departments provide sanctions and services to youth ages 12 to 17. Youth are referred to county systems from law enforcement, schools, parents, the community and other government agencies.[308] County juvenile departments conduct intake assessments and determine dispositions for cases referred.[307] Dispositions range from informal diversion, adjudication through juvenile court or referral to adult court.[307]

When youth are unsuccessful at the county level, need more services than the county can provide, commit very serious offenses and/or are a serious risk to the community, the court can commit them to the custody of the Oregon Youth Authority.[309] OYA is the state-level agency responsible for these youth who are ages 12 to 24 who commit crimes prior to age 18.[309] OYA provides youth with "treatment, education, and other guidance to help them take responsibility for their behavior and learn how to act differently in the future."[309] As a subsection of the JJ system, OYA manages youth both in close custody (secure youth correctional facilities) and in the community (transition programs, foster care, residential treatment).[307]

## KEY TAKEAWAYS

From 2020 to 2023, over 16,000 youth and young adults were served by county juvenile departments and the Oregon Youth Authority. The number of youth in county juvenile departments fluctuated over the time period while the number of youth under OYA commitment slightly declined.

Oregon ranks second in the nation for the number of committed youth.

American Indian / Alaska Native and Black / African American youth are overrepresented at almost every decision point in the JJ system, including at referral into the system, diversion, pretrial detention and placement in secure confinement at Oregon Youth Authority facilities.

Almost all youth in OYA custody have a trauma history and a large majority of youth have current or previous substance use.

**How many youth are involved in the juvenile justice system who are not committed to Oregon Youth Authority? Are there groups disproportionately represented?**

Of the 16,682 individuals up to age 24 served by juvenile justice from January 2020 to December 2023, 92% were supervised by county juvenile justice departments and 12.4% were supervised by OYA.[6] Since some of these youth were served by both county juvenile justice departments and by OYA, the total percentage is greater than 100. The average number of youth per month who were served by county JJ departments is displayed in Table 9.1. There was a peak in the number served in 2020; numbers reduced in 2021 and steadily increased during 2022 and 2023 (Figure 9.1). For broad information about disproportionality, see the Population Description chapter.

*Figure 9.1. Number of youth served by county juvenile departments, from the System of Care Data Dashboard[6]*

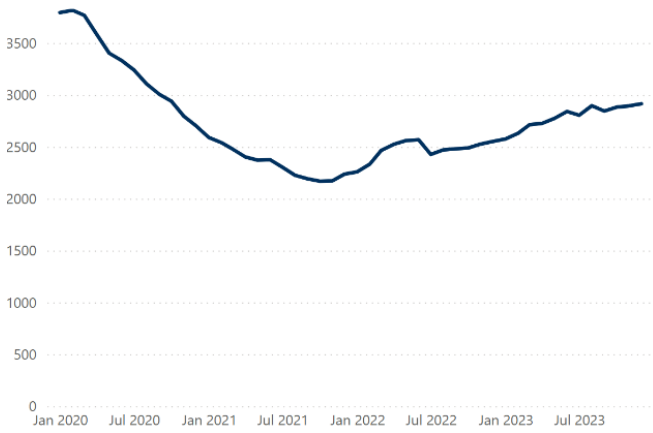



*Table 9.1. Average number of youth served by county juvenile departments per month (table adapted from the System of Care Dashboard[6]*

| | 2020 | 2021 | 2022 | 2023 | Average |
|---|---|---|---|---|---|
| Average number of youth* | 3,289 | 2,337 | 2,471 | 2,791 | **2,722** |

**Youth served by county juvenile departments for multiple years may have been counted twice.*

Compared to the general Oregon youth population (see Population Description chapter), dispositions for youth in the juvenile justice department show the following trends (Table 9.2):

- Males are overrepresented throughout the system, but more so for cases that are adjudicated or transferred to adult court.
- Younger youth are more likely to have cases reviewed and closed or receive diversion or other informal dispositions.
- African American youth are overrepresented in general, but particularly for having cases dismissed or reviewed and closed.
- White youth are overrepresented in plea bargains or alternative processes.
- Native American youth are overrepresented in adjudication and diversion or other informal dispositions

*Table 9.2. County juvenile dispositions in 2023 by demographics*[310]

| | **Review & Close** N = 3,625 | | **Diversion/ Informal** N = 2,588 | | **Dismissed** N = 308 | | **Alternative** N = 142 | | **Adjudicate** N = 1,660 | | **Adult Court** N = 27 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Demographic | n | % | n | % | n | % | n | % | n | % | n | % |
| Gender | | | | | | | | | | | | |
| Female | 1,447 | *39.9%* | 939 | *36.3%* | 87 | *28.2%* | 38 | *26.8%* | 409 | *24.6%* | 4 | *14.8%* |
| Male | 2,122 | *58.5%* | 1,629 | *62.9%* | 219 | *71.1%* | 102 | *71.8%* | 1,240 | *74.7%* | 23 | *85.2%* |
| Unknown | 56 | *1.5%* | 20 | *0.8%* | 2 | *0.6%* | 2 | *1.4%* | 11 | *0.7%* | 0 | *0.0%* |
| Age | | | | | | | | | | | | |
| 12 and under | 367 | *10.1%* | 203 | *7.8%* | 8 | *2.6%* | 4 | *2.8%* | 31 | *1.9%* | 0 | *0.0%* |
| 13 to 15 | 1,669 | *46.0%* | 1,283 | *49.6%* | 112 | *36.4%* | 50 | *35.2%* | 713 | *43.0%* | 1 | *3.7%* |
| 16 and older | 1,589 | *43.8%* | 1,102 | *42.6%* | 188 | *61.0%* | 88 | *62.0%* | 916 | *55.2%* | 26 | *96.3%* |
| Race/Ethnicity | | | | | | | | | | | | |
| African American | 323 | *8.9%* | 141 | *5.4%* | 39 | *12.7%* | 6 | *4.2%* | 127 | *7.7%* | 1 | *3.7%* |
| Asian | 65 | *1.8%* | 50 | *1.9%* | 4 | *1.3%* | 1 | *0.7%* | 25 | *1.5%* | 0 | *0.0%* |
| Hispanic | 700 | *19.3%* | 603 | *23.3%* | 58 | *18.8%* | 26 | *18.3%* | 451 | *27.2%* | 8 | *29.6%* |
| Native American | 70 | *1.9%* | 62 | *2.4%* | 4 | *1.3%* | 2 | *1.4%* | 62 | *3.7%* | 0 | *0.0%* |
| Other/Unknown | 474 | *13.1%* | 291 | *11.2%* | 47 | *15.3%* | 19 | *13.4%* | 128 | *7.7%* | 5 | *18.5%* |
| White | 1,993 | *55.0%* | 1,441 | *55.7%* | 156 | *50.6%* | 88 | *62.0%* | 867 | *52.2%* | 13 | *48.1%* |

*Review and Close: no jurisdiction, referred to another agency, case reviewed and closed, warning, diversion and close, intake contact and close, rejected by district attorney / juvenile department, alternative process.*
*Diversion/Informal: diversion supervision, youth court or traffic/municipal court, informal sanctions/supervision, formal accountability agreement.*
*Dismissed: case dismissed.*
*Alternative process: plea bargain or alternative process.*
*Adjudicated: formal sanction, probation, commit/custody to non-OYA agency, probation and commit/custody to non-OYA agency, probation and OYA commitment for community placement, OYA commitment for YFC.*
*Adult Court: waived/transfer, adult sentence.*

There were 2,582 detention admissions in 2023 (Table 9.3). For those discharged, the average length of stay was 13.8 days with a range of seven to 323 days. Similar to overall trends in justice system involvement, males, older adolescents, African American and Native American youth are overrepresented in detention admissions.

*Table 9.3. County detention admissions in 2023 by demographics*[311]

| **Demographic** | **Number of County Admissions N = 2,582** | |
|---|---|---|
| Demographic | n | % |
| Gender | | |
| Female | 653 | 25% |
| Male | 1,910 | 74% |
| Unknown | 19 | 1% |
| Age | | |
| 11 and under | 5 | <1% |
| 12 to 14 | 792 | 31% |
| 15 to 17 | 1,698 | 66% |
| 18 and over | 87 | 3% |
| Race/Ethnicity | | |
| African American | 258 | 10% |
| Asian | 31 | 1% |
| Hispanic | 643 | 25% |
| Native American | 104 | 4% |
| Other/Unknown | 204 | 8% |
| White | 1,342 | 52% |

**How many youth are committed and under the guardianship of the Oregon Youth Authority? How does this compare to other states? Are there groups that are disproportionately represented?**

In 2021, Oregon was ranked the second highest in the nation for number of committed youth (Figure 9.2).[312] From 2020-2023, OYA served a total of 4,204 youth (Table 9.4):

- **2,529 (60%) were served in the community**, which includes parole and probation.
- **1,675 (40%) youth were in close custody**, which includes commitments for juveniles and 18-year-olds.

*Figure 9.2. Number of committed youth in 2021, from the Office of Juvenile Justice and Delinquency Prevention*[312]

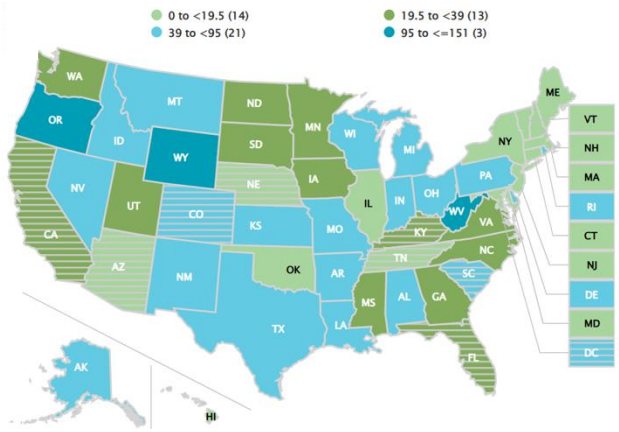



*Table 9.4. Youth in the custody of the Oregon Youth Authority adapted from the Oregon Youth Authority*[313-316]

| | **2020** N = 1,173 | | **2021** N = 1,112 | | **2022** N = 1,008 | | **2023** N = 911 | |
|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % |
| Community Total | 684 | *58%* | 694 | *62%* | 608 | *60%* | 543 | *60%* |
| Youth on OYA parole | 316 | *27%* | 326 | *29%* | 283 | *28%* | 261 | *27%* |
| Youth on OYA probation | 368 | *31%* | 368 | *33%* | 325 | *32%* | 282 | *31%* |
| Close Custody Total | 489 | *42%* | 418 | *38%* | 400 | *40%* | 368 | *40%* |
| Juvenile commitments | 303 | *26%* | 267 | *24%* | 301 | *30%* | 321 | *35%* |
| Adult commitments | 186 | *16%* | 151 | *14%* | 99 | *10%* | 47 | *5%* |

The Oregon commitment and detention rates are 121 per 100,000 and 23 per 100,000 respectively (Table 9.5); these are higher than U.S. averages. Committed youth includes those who are "awaiting adjudication, disposition, or placement elsewhere"; detained youth includes those who are "held as part of a court ordered disposition."[317] Native American / Alaska Native and Black / African American youth are disproportionately represented in placement in secure OYA custody.[313-316]

*Table 9.5. Commitment and detention rates per 100,000 youth in 2021, adapted from Office of Juvenile Justice and Delinquency Prevention*[317]

| | **Oregon** | **United States** |
|---|---|---|
| Commitment rate per 100,000 youth | 121 | 39 |
| Detention rate per 100,000 youth | 23 | 33 |

**What risk factors are associated with delinquent behavior, charges, etc.? Are there groups disproportionately at risk?**

There are many risk factors associated with delinquent behaviors and subsequent charges. Having more than one risk factor can compound the risk of delinquent behaviors. The Office of Juvenile Justice and Delinquency Prevention (OJJDP) found that risk factors can be individual level, family level, peer-related, school-related and community level (Figure 9.3).

An additional analysis by the Oregon Child Integrated Dataset identified two major risk factors for students who had contact with the juvenile justice system[318]:

- Male students who had contact with the juvenile justice department were more likely to have a disability (as measured by ever having an Individualized Education Plan, 41%) than male students without juvenile justice involvement (29%).
- American Indian / Alaska Native youth living in rural areas (20%) and Black / African American youth living in urban areas (22%) had the highest rates of contact with the juvenile justice department.

*Figure 9.3. Risk factors for delinquency, adapted from the Office of Juvenile Justice and Delinquency Prevention[319]*

**Individual-Level Risk Factors**

- Antisocial behavior and alienation
- Gun possession (illegal gun ownership or carrying a gun)
- Favorable attitudes toward drug use, early onset of substance use
- Early onset of aggression or violence or other problem behaviors
- Violent victimization and children exposed to violence
- Cognitive and neurological deficits, mental/behavioral health disorders

**Family-Level Risk Factors**

- Family history of problem behavior / parent criminality
- Family management problem / poor parental supervision and monitoring
- Poor family attachment/bonding, pattern of high family conflict and/or violence
- Child victimization and maltreatment
- Parental use of physical punishment / harsh and erratic discipline practices
- Low parental education level

**Community-Level Risk Factors**

- Availability of alcohol and other drugs
- Availability of firearms
- Community crime / high crime neighborhood
- Community instability
- Economic deprivation / poverty / residence in a disadvantaged neighborhood
- Social and physical disorder / disorganized neighborhood / feeling unsafe in the neighborhood

**Peer-Related Risk Factors**

- Gang involvement or gang membership
- Peer alcohol and drug use
- Association with delinquent or aggressive peers

**School-Related Risk Factors**

- Low academic achievement / academic failure
- Negative attitude toward school / low bonding, low school attachment and commitment
- Inadequate school climate / poorly organized and functioning schools / negative labeling
- School dropout

**How many youth are receiving restorative services and what is the average length of time and outcome of these services? Are there inequities in who is determined to be "fit to proceed"? How many youth are under jurisdiction of the Psychiatric Services Review Board?**

Oregon Health Authority (OHA) offers restorative services to youth in the juvenile justice system who are involved with the court system. The goal of restorative services is to educate youth in court proceedings to become "fit to proceed."[320] Case management, skills training and evaluation are offered in 90-day community-based episodes. OHA defines a youth as being "fit to proceed" if they can "understand the nature of the court proceedings, assist and cooperate with [their] attorney, and participate in his or her own defense."[320] There are three outcomes that can occur after a youth receives restorative services (Table 9.6) [320]:

- Fit to proceed / adjudicative competency: The youth understands court proceedings and can move forward with their case in the juvenile justice system.
- Unable to be restored / unlikely to become fit to proceed: The youth is unable to become competent in court proceedings and is referred to other programs to receive services they require.
- Other: In this case, usually the court decides to dismiss the case.

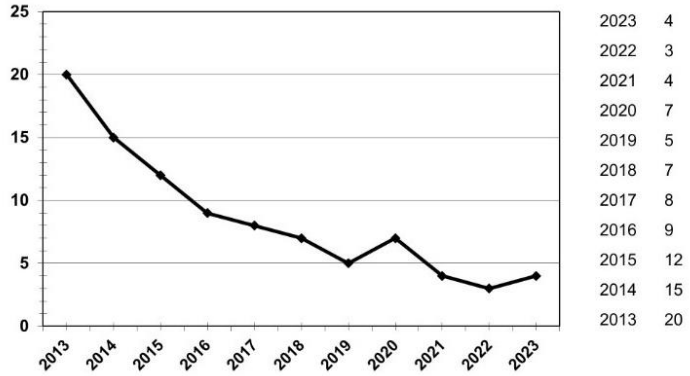
The team was unable to find demographic information regarding youth in restorative services.

*Table 9.6. Outcomes of youth in restorative services from 2020*[320]

| | **2020** N = 30 | | **2021** N = 23 | | **2022** N = 36 | | **2023** N = 38 | |
|---|---|---|---|---|---|---|---|---|
| Outcome | n | % | n | % | n | % | n | % |
| Fit to proceed | 20 | *66.7%* | 14 | *60.9%* | 24 | *66.7%* | 24 | *63.2%* |
| Unable to be restored | 8 | *26.7%* | 8 | *34.8%* | 12 | *33.3%* | 11 | *28.9%* |
| Other | < 5 | *N/A* | < 5 | *N/A* | < 5 | *N/A* | < 5 | *N/A* |

Oregon's Psychiatric Security Review Board (PSRB) oversees youth that are not criminally responsible for their actions due to a successful insanity plea known as Responsible Except for Insanity (REI).[321] Since the juvenile PSRB program, which is called Responsible Except for Insanity (REI), was launched in 2007, 32 youth have been served.[322] As of December 2024, the

*Figure 9.4. Responsible Except for Insanity clients under the jurisdiction of the Psychiatric Security Review Board*[323]



PSRB has five youth under its jurisdiction.[323] Due to small sample sizes, demographic stratification could not be completed.

**How many youth are accessing behavioral health services through the juvenile justice system and what services are they accessing? Are there inequities in access to care?**

Many youth in the juvenile justice system have untreated behavioral health needs. Providing access to treatment can help prevent recidivism, improve rehabilitation outcomes and address the root causes of their actions rather than simply punishing them. Both county juvenile departments and OYA offer behavioral health programs and services to youth, including:

- **Mental health services:** treatment for mental health diagnoses.
- **Substance abuse services:** services that help prevent substance abuse in juveniles through education, interventions, support groups and outpatient treatment, while assisting youth in avoiding substance use.
- **Co-occurring diagnosis services:** services for youth with dual diagnoses of mental health and substance use.
- **Family education and counseling:** family & parent training and education services, family mental health programs and multidimensional family services like family counseling, multisystemic therapy & functional family therapy.

Services may be accessed through internal department therapists, while others may be referred out and treated by community providers. This combination of service providers makes it difficult to track utilization. The Juvenile Justice Information System (JJIS) collects data on behavioral health programs and services offered to youth within both the Oregon Youth Authority (OYA) and county juvenile departments. While utilization and demographic data on these programs are publicly available,[324] juvenile justice leadership has advised the OHSU team to not include the data due to reporting inaccuracies.

SYSTEM WORKFORCE

## CHAPTER INTRODUCTION

Oregon has a variety of individuals in the workforce who serve youth and families; these include behavioral health providers, intellectual / developmental disability providers, traditional health workers, primary care and other health care providers, educators and school staff, and juvenile justice and child welfare workers.

The questions posed in this chapter of the report ask for information specifically about mental health professionals, traditional health workers (specifically family support specialists and youth peer support specialists), primary care providers and specialized intellectual and developmental workers. Information focused on these workers details the numbers, distribution and whether there are disparities in access. Additionally, it discusses statewide efforts related to workforce diversity, safety, recruitment and retention. Because there were no questions posed about education, juvenile justice or child welfare system workforces, these workforces are not included in this report and it is recommended that they be evaluated in future efforts.

## KEY TAKEAWAYS

Oregon is facing a statewide behavioral health provider shortage. Providers are clustered around the Portland metro area and along the I-5 corridor; the eastern and coastal areas are severely understaffed. Statewide, the number of providers decreases with increasing education and training requirements.

Oregon has the third lowest provider-to-population ratio nationally, indicating that there are more providers per capita in Oregon than most other states.

In 2021, most family and youth peer providers reported working for nonprofits in the Portland metro area and along the I-5 corridor with fewer working in the rural areas of the state.

In 2023, CCO reporting on Family and Youth PSS indicated that 64% were employed in the service areas of three CCOs (EOCCO, HealthShare and PacificSource Lane), while the remaining 36% were employed across the remaining 13 CCO regions.

The behavioral health workforce is less racially and ethnically diverse than the population in Oregon and the national behavioral health workforce.

Burnout, low wages / poor economic return, administrative burden, lack of mentorship / support and absence of career growth opportunities for non-licensed providers are all contributing to Oregon's challenges with developing a culturally diverse and robustly staffed workforce.

**How many behavioral health professionals does Oregon currently have who serve youth and families? What is the distribution of providers and where are they working? Are there any disparities related to where providers are available?**

In this report, *behavioral health providers* include those who are licensed or credentialed to diagnose and/or treat mental health and/or substance use conditions. Education, experience, licensure and overseeing regulatory body vary by provider type:

- Certified Alcohol and Drug Counselor (CADC) [325]: Counselors who complete education and supervised experience hours, pass a national competency examination and specialize in providing substance use disorder treatment.
- Child & Adolescent Psychiatrist (M.D. or D.O.) [326]: Medical doctors with specialized training in evaluating, diagnosing and treating youth with psychiatric disorders.
- Licensed Clinical Social Worker (LCSW) [327]: Clinicians with a master's degree in social work and specialized experience in diagnosing and providing clinical care.
- Licensed Professional Counselor (LPC) & Licensed Professional Marriage & Family Therapists (LMFT)[328]: Master's-level clinicians who can diagnose and treat mental health conditions.
- Psychiatric Nurse Practitioner (PNP) [329]: Registered nurses with advanced training to diagnose and treat mental health conditions.
- Psychologist (Ph.D. or Psy.D.): Doctorate-level clinicians who can evaluate, diagnose and treat mental and behavioral health conditions.
- Qualified Mental Health Associate (QMHA) [325]: Bachelor's-level associates who complete 1,000 hours of supervised experience and pass a state competency exam; provide case management and treatment services under the supervision of a QMHP; many QMHA providers fill the role of skills trainer.
- Qualified Mental Health Professional (QMHP) [325]: Master's-level professionals who complete 1,000 hours of supervised experience and pass a state competency exam; conduct mental status exams, mental health assessment, write and supervise treatment plan, provide mental health therapy.
- Skills Trainer[332]: In Oregon, QMHAs provide skills training to youth, focusing on skill development strategies, often as part of a team. Individual agencies may provide specific staff training to provide skills training to youth.

Additional bachelor's- and master's-level professionals who complete agency-specific training and supervision may be certified with QMHA and QMHP through employers with a Certificate of Approval (COA) to provide Medicaid-funded services in Oregon, such as Youth Villages, Morrison Center, LifeWorks, Trillium and Options Counseling. COAs are issued by the Oregon Health Authority. These certifications are not portable. If the staff leave that employer, they are no longer certified and must either follow a similar process with another employer with a COA or get certified independently through state regulatory bodies. Employer-certified staff are not reflected in this report.

### *Total Providers in Oregon*

An estimated 25,000 mental health providers serve Oregonians (Table 10.1); it is unknown what percentage serve youth and families (except for child & adolescent psychiatrists, who are specifically licensed to provide care to youth). The following are key points:

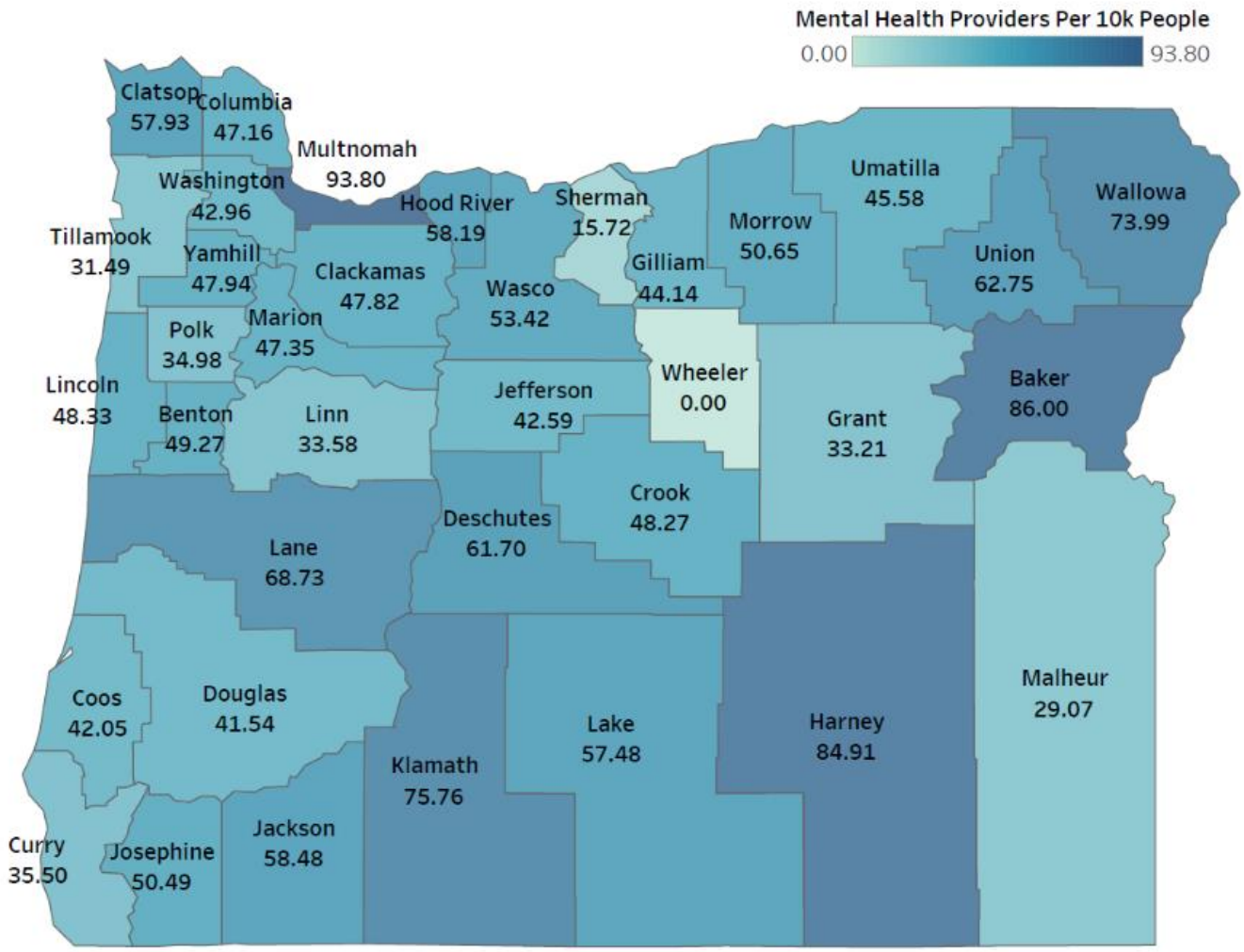
- **Some counties have extreme shortages of mental health providers.** Wheeler County does not have any registered mental health providers. Sherman and Gilliam counties both have fewer than 10 total providers.
- **Statewide, the number of providers decreases with increasing education and training requirements**: CADCs and QMHAs are the most prevalent while PNPs and child & adolescent psychiatrists are the least prevalent.
- **There are more providers in the Portland Metro Area and along the I-5 corridor.** This includes CADCs and QMHAs, who are heavily utilized by community mental health programs, and master's- and doctorate-level professionals (QMHP, LCSW, LPC, LMFT, Ph.D, Psy.D), who work in a variety of settings, including hospitals, community mental health centers and private practice.
- **PNPs and child & adolescent psychiatrists (CAPs) are not distributed evenly across the state.** Multnomah County includes over half of statewide child and adolescent psychiatrists, while more than half of Oregon counties do not have a child & adolescent psychiatrist. Many of these providers work in hospital settings or private practice; they are often equipped to provide telehealth care or consultation.
- Information about the settings where mental health providers work, such as community-based, inpatient or residential centers could not be found.
- **Mental health services are also offered in school-based settings.** More information on School-Based Mental Health (SBMH) services can be found in the Education System Chapter of this report.

### *Provider-to-Population Ratio*

To better allow comparison across counties with varying populations, the number of providers per 10,000 people in the population is also presented (Figure 10.1). Even when accounting for population differences, Sherman and Wheeler County remain severely understaffed, while Gilliam County is more aligned with the rest of the state. Surprisingly, some rural and frontier areas have the highest population-to-provider ratios (behind urban Multnomah County), including Baker, Harney, Klamath, Wallowa and Lane counties.

When comparing to the rest of the United States, Oregon has the third lowest provider-to-population ratio, indicating that there are more providers per capita in Oregon than most other states.[335]

*Figure 10.1. Number of mental health providers per 10,000 people by county[335]*




***Demand for Mental Health Providers***

Health Professional Shortage Areas (HPSAs) are federally recognized regions with a shortage of health professionals. HPSA designations consider how demand is related to the number of providers available, using a complex scoring mechanism that includes population-to-provider ratio, poverty level, age of population, alcohol and substance abuse prevalence and travel time to nearest source of care.[336] In Oregon, HPSAs are observed in almost every region for mental health professionals.

In the Behavioral Health Care System chapter presented earlier in this report, data shows Oregon's higher prevalence of mental health disorders is accompanied by lower rates of access to behavioral health services, with more youth struggling to access services than the national average. This may serve as one proxy for looking at the behavioral health shortage in the state.

*Table 10.1. Number of mental health providers by profession and county[325,337-339]*

| | CADC[325] | CAP[337] | LCSW[325] | LPC/LMFT[337] | PNP[339] | Ph.D. Psy.D.[338] | QMHA[325] | QMHP[325] | Total | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| County | # providers | # providers | # providers | # providers | # providers | # providers | # providers | # providers | # providers | population |
| Baker | 62 | 0 | 18 | 14 | 3 | 2 | 37 | 9 | 145 | 16,860 |
| Benton | 74 | 13 | 103 | 105 | 10 | 62 | 70 | 26 | 463 | 93,976 |
| Clackamas | 428 | 14 | 392 | 433 | 86 | 187 | 333 | 161 | 2,034 | 425,316 |
| Clatsop | 81 | 0 | 39 | 35 | 9 | 4 | 54 | 18 | 240 | 41,428 |
| Columbia | 91 | 1 | 21 | 24 | 1 | 2 | 93 | 17 | 250 | 53,014 |
| Coos | 62 | 0 | 31 | 44 | 10 | 2 | 87 | 38 | 274 | 65,154 |
| Crook | 39 | 0 | 6 | 23 | 3 | 2 | 41 | 9 | 123 | 25,482 |
| Curry | 16 | 0 | 5 | 9 | 2 | 7 | 34 | 11 | 84 | 23,662 |
| Deschutes | 283 | 7 | 228 | 357 | 49 | 77 | 170 | 84 | 1,255 | 203,390 |
| Douglas | 139 | 1 | 79 | 57 | 13 | 15 | 125 | 35 | 464 | 111,694 |
| Gilliam | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 9 | 2,039 |
| Grant | 0 | 0 | 1 | 2 | 0 | 0 | 15 | 6 | 24 | 7,226 |
| Harney | 21 | 0 | 4 | 6 | 1 | 0 | 29 | 3 | 64 | 7,537 |
| Hood River | 19 | 0 | 34 | 20 | 4 | 10 | 32 | 20 | 139 | 23,888 |
| Jackson | 286 | 1 | 201 | 271 | 32 | 69 | 341 | 108 | 1,309 | 223,827 |
| Jefferson | 49 | 0 | 9 | 12 | 2 | 2 | 23 | 9 | 106 | 24,889 |
| Josephine | 114 | 2 | 43 | 73 | 7 | 7 | 166 | 36 | 448 | 88,728 |
| Klamath | 139 | 1 | 36 | 39 | 8 | 4 | 234 | 68 | 529 | 69,822 |
| Lake | 15 | 0 | 3 | 5 | 2 | 1 | 19 | 2 | 47 | 8,177 |
| Lane | 567 | 7 | 416 | 468 | 59 | 233 | 636 | 244 | 2,630 | 382,647 |
| Lincoln | 62 | 0 | 34 | 54 | 11 | 9 | 54 | 22 | 246 | 50,903 |
| Linn | 139 | 3 | 63 | 59 | 10 | 18 | 114 | 32 | 438 | 130,440 |
| Malheur | 19 | 0 | 14 | 11 | 4 | 2 | 38 | 5 | 93 | 31,995 |
| Marion | 390 | 4 | 294 | 366 | 63 | 152 | 275 | 100 | 1,644 | 347,182 |
| Morrow | 11 | 0 | 8 | 2 | 0 | 0 | 30 | 13 | 64 | 12,635 |
| Multnomah | 1,365 | 75 | 1,823 | 1,570 | 270 | 786 | 1,204 | 605 | 7,698 | 820,672 |
| Polk | 91 | 0 | 27 | 44 | 18 | 15 | 85 | 31 | 311 | 88,916 |
| Sherman | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 2 | 3 | 1,908 |

| | CADC[325] | CAP[337] | LCSW[325] | LPC/LMFT[337] | PNP[339] | Ph.D. Psy.D.[338] | QMHA[325] | QMHP[325] | Total | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| County | # providers | # providers | # providers | # providers | # providers | # providers | # providers | # providers | # providers | Population |
| Tillamook | 27 | 1 | 26 | 18 | 0 | 1 | 8 | 6 | 87 | 27,628 |
| Umatilla | 120 | 1 | 37 | 23 | 9 | 9 | 128 | 40 | 367 | 80,523 |
| Union | 64 | 1 | 23 | 14 | 4 | 3 | 40 | 16 | 165 | 26,295 |
| Wallowa | 10 | 0 | 4 | 5 | 2 | 2 | 22 | 10 | 55 | 7,433 |
| Wasco | 22 | 0 | 26 | 18 | 4 | 4 | 56 | 12 | 142 | 26,581 |
| Washington | 460 | 13 | 463 | 540 | 108 | 255 | 448 | 312 | 2,599 | 605,036 |
| Wheeler | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,456 |
| Yamhill | 149 | 2 | 54 | 80 | 10 | 56 | 120 | 48 | 519 | 108,261 |
| **Total** | **6,002** | **147** | **4,565** | **4,802** | **814** | **1,998** | **5,587** | **2,568** | **25,068** | **426,662** |

***Telehealth and Virtual Care Benefits***

Telehealth services were a necessity for providing services during the COVID-19 pandemic and many providers and insurers continue to make these available. As telehealth options expand, it is difficult to assess capacity. In many areas, CCOs contract with telehealth providers, such as Charlie Health, to fill gaps in local, in-person services, but there is no comprehensive data from CCOs reporting access to these services or which specific services are provided.

According to an inquiry with OHA, they are aware of some contracts that CCOs have with virtual providers, but there is not a complete picture.[340] Psychiatry, intensive outpatient therapy for eating disorders (through Monte Nido), outpatient mental health treatment (through Charlie Health) and peer support (through Flourish Labs) are examples of virtual services contracted by some CCOs. While these offerings may expand access to these services for those who have adequate internet access, they also change the landscape for tracking access. A survey of CCOs would be helpful in this effort.

**How many traditional health workers does Oregon currently have who serve youth and families? What is the distribution of workers and where are they working? Where are there gaps in the availability of traditional health workers?**

Peer-delivered services are a foundational element in the system of care. Unfortunately, programs report that the number of registered peers in Oregon is inadequate and many experience challenges in hiring for available positions.

There are six main types of traditional health workers (THWs) in Oregon: peer support specialists (PSS), peer wellness specialists (PWS), community health workers (CHW), personal health navigators (NAV), birth doulas and tribal traditional health workers.[341] OHA's Equity and Inclusion Division is the regulatory oversight body for THWs. Youth and families in the system of care usually interact with sub-specialties of PSS — specifically family support specialists and youth peer support specialists. This section focuses on those THWs (Table 10.2).

*Table 10.2. Sub-types of peer support specialists and peer wellness specialists*[341]

| Provider Type | Sub-Specialties |
|---|---|
| Peer Support Specialists | Adult Addictions, Adult Mental Health, Family Support, Youth Support |
| Peer Wellness Specialists | Adult Addictions, Adult Mental Health, Adult Addictions & Mental Health, Family Support, Youth Support |

While the PWS designation of sub-specialties for family and youth peer support is included in the registry, there is only one state-approved training program for PWS and it does not specialize in the youth or family sub-specialties; this may indicate an inaccuracy in those sub-specialty designations.

***Peer Support Specialist (PSS)***

PSSs are required to complete an OHA-approved 40+ hour training program, an OHA-approved oral health training and an application through the state Traditional Health Workers Registry to be certified and accepted into the state registry.[342] A PSS uses their lived/living experiences to provide guidance and support to a youth or family member with similar lived/living experiences. As of September 2024, there were 570 registered PSSs designated in sub-specialties serving youth and families (286 family peers, 284 youth peers).[343]

As of January 2025, there are four state-approved training programs in the THW Training Programs directory for youth support specialists (Adulting IRL, Connected Lane County, Mental Health & Addiction Association of Oregon, Youth ERA) and two state-approved training programs for family support specialists (Oregon Family Support Network, Yellowhawk Tribal Health Center).

### *Peer Wellness Specialist (PWS)*

PWSs are required to complete an OHA-approved 80-hour training program, an OHA-approved oral health training and an application through the state Traditional Health Workers Registry to be certified and accepted into the state registry.[342] The PWS role serves members of coordinated care organizations in the following ways: assessing mental health and substance use disorder service and support needs, assisting members with recovery and wellness, helping to access services and resources, and providing education and information.[344]

While adult addictions and adult mental health are the only specialties indicated in the PWS description, the THW registry indicates five registered PWSs designated in sub-specialties serving youth and families (four family support specialists, one youth support specialist) as of January 2025.[343]

### *Distribution of Family and Youth Peers*

When individuals apply for THW registration, they indicate the counties where they are available to work. This self-reporting shows that peers are spread throughout the state; the location individuals self-reported on their applications is presented in Table 10.3.

Being certified as a traditional health worker (PSS or PWS) and included in the registry for any of the sub-specialties does not mean that the individual is actively employed in these roles or locations.

Two data sources were identified that provide insight into where some youth and family PSSs are employed and working: a survey of the workforce and reports from CCOs.

*Table 10.3. Primary location of registered youth- and family-serving PSWs and PSSs in Oregon, adapted from THW Registry*[343]

| **Primary County of Service** | **Number of Registered Youth and Family Peers** N = 575 | |
|---|---|---|
| | n | % |
| Baker | 11 | *1.9%* |
| Benton | 37 | *6.4%* |
| Clackamas | 93 | *16.2%* |
| Clatsop | 7 | *1.2%* |
| Columbia | 13 | *2.3%* |
| Coos | 22 | *3.8%* |
| Crook | 16 | *2.8%* |
| Curry | 4 | *0.7%* |
| Deschutes | 9 | *1.6%* |
| Douglas | 14 | *2.4%* |
| Gilliam | 4 | *0.7%* |
| Grant | 3 | *0.5%* |
| Harney | 3 | *0.5%* |
| Hood River | 11 | *1.9%* |
| Jackson | 28 | *4.9%* |
| Jefferson | 1 | *0.2%* |
| Klamath | 17 | *3.0%* |
| Lake | 4 | *0.7%* |
| Lane | 74 | *12.9%* |
| Lincoln | 6 | *1.0%* |
| Linn | 4 | *0.7%* |
| Malheur | 9 | *1.6%* |
| Marion | 44 | *7.7%* |
| Morrow | 6 | *1.0%* |
| Multnomah | 22 | *3.8%* |
| Polk | 1 | *0.2%* |
| Tillamook | 3 | *0.5%* |
| Umatilla | 21 | *3.7%* |
| Union | 2 | *0.3%* |
| Wallowa | 3 | *0.5%* |
| Washington | 7 | *1.2%* |
| Yamhill | 2 | *0.3%* |
| Statewide | 55 | *9.6%* |
| Missing | 19 | *3.3%* |

### *Workforce Survey*

The 2021 workforce survey by OHA's Health Care Workforce Reporting Program estimated the geographical location, setting and employment status of registered peer providers.[345] Sixty family and youth peer providers responded, with 87% reporting that they were actively working in Oregon at the time of the survey. Most reported their employers were nonprofit organizations (62%) or government agencies (15%).[345] Most commonly, family and youth peer providers practice in the following settings: the home of the individual/family (77%), in the community (58%) and at community-based organizations (39%).[345]

Since 2021, there has been a shift in the workforce in which community mental health programs and other organizations that deliver intensive and crisis services have begun to hire peers directly, rather than subcontracting with nonprofits. More current data is not available to reflect this.

### *CCO Reporting on FSS and YSS Employment*

THW integration and utilization data reported by CCOs shows that compared to adult-serving PSSs, there are fewer PSSs serving youth and families, as reported by CCOs and reflected in Table 10.4 below.[346] CCOs report on PSSs that are employed directly by the CCO, those employed by or within the CCO provider network and those employed in community-based or other settings through funding or payments provided by CCO (meaning not directly employed by CCO or by or within provider network). An estimated 64% of family and youth PSSs are employed in the service areas of three CCOs (Eastern Oregon CCO, HealthShare and PacificSource Lane), while the remaining 36% are employed across the remaining 13 CCO regions.

### *Family Peer Support Workforce*

In recent years, rules mandating the inclusion of the FSS role into community-based services, namely Intensive In-Home Behavioral Health Treatment (IIBHT) and Mobile Response and Stabilization Services (MRSS), indicate this sub-specialty peer role is valued. However, the role of family peers and the needs of the family peer support workforce are not universally or sufficiently understood. Individuals serving in this role report a growing gap between the professional standards and competencies of family peer support specialists and the actual utilization of the role. Additionally, while mandates for this specialty peer role expand, resources allocated to support the statewide infrastructure are not equitable.[347]

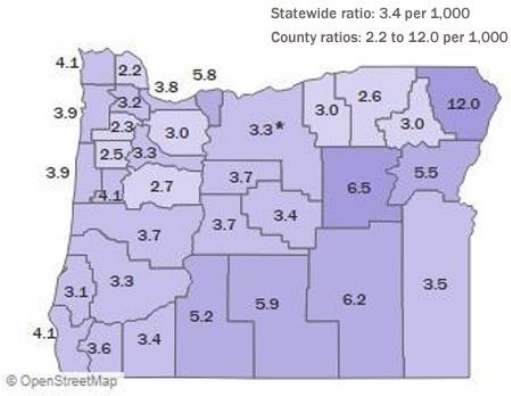
*Table 10.4. Total number of peer support specialists by coordinated care organization, 2023*[346]

| **Coordinated Care Organization** | **Adult Addiction** N = 904 | | **Adult MH** N = 507 | | **Family** N = 102 | | **Youth** N = 93 | | **Total PSS** N = 1,606 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | **n** | **%** |
| Advanced Health | 40 | *4.4%* | 10 | *2.0%* | 4 | *3.9%* | 2 | *2.2%* | **56** | ***3.5%*** |
| AllCare | 56 | *6.2%* | 65 | *12.8%* | 2 | *2.0%* | 5 | *5.4%* | **128** | ***8.0%*** |
| Cascade Health Alliance | 48 | *5.3%* | 21 | *4.1%* | 1 | *<1%* | 2 | *2.2%* | **72** | ***4.5%*** |
| Columbia Pacific CCO | 25 | *2.8%* | 16 | *3.2%* | 3 | *2.9%* | 2 | *2.2%* | **46** | ***2.9%*** |
| Eastern Oregon CCO | 41 | *4.5%* | 46 | *9.1%* | 13 | *12.7%* | 10 | *10.8%* | **110** | ***6.8%*** |
| Health Share | 132 | *14.6%* | 55 | *10.8%* | 28 | *27.5%* | 31 | *33.3%* | **246** | ***15.3%*** |
| InterCommunity Health Network | 73 | *8.1%* | 18 | *3.6%* | 4 | *3.9%* | 1 | *1.1%* | **96** | ***6.0%*** |
| Jackson Care Connect | 65 | *7.2%* | 59 | *11.6%* | 2 | *2.0%* | 3 | *3.2%* | **129** | ***8.0%*** |
| PacificSource Central Oregon | 65 | *7.2%* | 30 | *5.9%* | 2 | *2.0%* | 2 | *2.2%* | **99** | ***6.2%*** |
| PacificSource Columbia Gorge | 11 | *1.2%* | 8 | *1.6%* | 4 | *3.9%* | 1 | *1.1%* | **24** | ***1.5%*** |
| PacificSource Lane | 29 | *3.2%* | 29 | *5.7%* | 20 | *19.6%* | 22 | *23.7%* | **100** | ***6.2%*** |
| PacificSource Marion | 42 | *4.6%* | 74 | *14.6%* | 2 | *2.0%* | 3 | *3.2%* | **121** | ***7.5%*** |
| Trillium Lane | 40 | *4.4%* | 9 | *1.8%* | 6 | *5.9%* | 2 | *2.2%* | **57** | ***3.5%*** |
| Trillium Metro | 152 | *16.8%* | 4 | *<1%* | 2 | *2.0%* | 2 | *2.2%* | **160** | ***10.0%*** |
| Umpqua Health Alliance | 22 | *2.4%* | 10 | *2.0%* | 3 | *2.9%* | 1 | *1.1%* | **36** | ***2.2%*** |
| Yamhill Community Care Organization | 63 | *7.0%* | 53 | *10.5%* | 6 | *5.9%* | 4 | *4.3%* | **126** | ***7.8%*** |

**How many primary care providers does Oregon have and where do they work? What behavioral health training and continuing education is required? What knowledge do they have of behavioral health resources?**

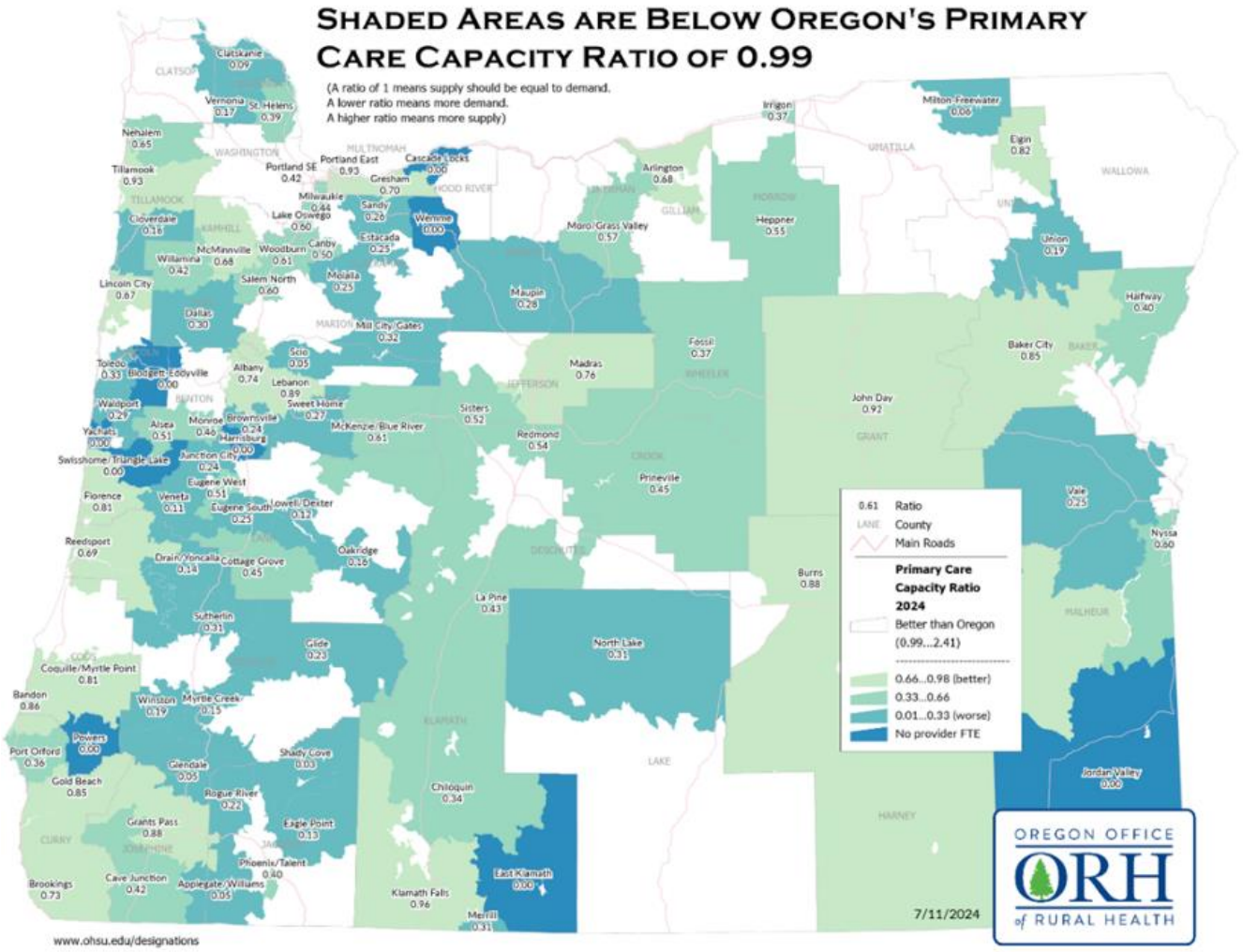
Primary care providers (PCPs) are physicians (M.D. or D.O.), nurse practitioners, physician assistants and naturopathic physicians who provide ongoing management of a youth's health, including preventive, routine and chronic care. Primary care providers are important for screening, identifying and treating behavioral health needs among youth, and making referrals to specialists when needed. In 2020, there were an estimated 3,733 PCPs actively serving youth, which is a statewide ratio of 3.4 PCPs per 1,000 youth; ratios vary by county (Figure 10.2)[348]:

*Figure 10.2. Primary care providers serving children 18 years of age and under, from the 2020 Oregon's Licensed Health Care Workforce Supply Report*[348]




- The counties with the lowest ratio of providers to youth are Yamhill, Polk, and Umatilla.
- Some of the Eastern and more rural counties (Wallowa, Grant, Harney, and Lake) have the highest provider-to-population ratios in the state, which is a departure from trends observed in other workforces.

*Figure 10.3. Primary care capacity by service area, from the 2025 Health Care Workforce Needs Assessment* [349]




### *Education and Training Requirements*

Medical schools include coursework and clinical rotations in psychiatry and behavioral health but do not require specific rotations in child psychiatry. Beginning on July 1, 2025, the Accreditation Council for Graduate Medical Education (ACGME)[350] will require pediatric residents to complete four weeks of behavioral health / mental health training during their residency. The bachelor of science in nursing (B.S.N.) degree requires coursework and clinical/simulation experience related to a category called "cognitive-behavioral health" to meet the standard, as well as coursework and clinical/simulation experience in community health, research and leadership.[350] In graduate medical and nursing education, requirements are variable based on the individual specialty. Both pediatrics and family medicine have behavioral health requirements. Beginning in July 2025, pediatric residents will be required to complete four weeks of behavioral health training during their residency.[351] Family medicine graduate education requires that behavioral health be a longitudinal part of the curriculum.[352] There are also initiatives, guidelines and opportunities for

continuing education in behavioral health. In Oregon, there is a dedicated focus on suicide-related topics:

- House Bill 2315 requires that mental-health-related professional licensing boards include mandatory continuing education related to suicide risk assessment, treatment and management. The Oregon Medical Board and Oregon State Board of Nursing are not part of this requirement; however, the statute recommends that these boards implement these guidelines as well.[353]
- The Oregon Health Authority publishes a list of suggested courses related to suicide assessment, treatment and management to support workforce training recommendations and requirements.[223]
- The Oregon Pediatric Society offers a variety of behavioral health webinars. The organization also offers Youth SAVE, a suicide screening, assessment, safety planning and intervention training program for pediatric providers.[354]

***Resources for Primary Care Providers***

Each primary care specialty can participate in medical education through their specialty's professional association. These groups offer continuing medical education opportunities through online training, in-person conferences and lectures. Examples of these opportunities include the Oregon Council Child and Adolescent Psychiatry (OCCAP) annual Children's Mental Health Conference[355], OHSU School of Medicine's Annual Pediatric Mental Health Conference[356], and Oregon ECHO Network, an educational and community-building experience for health care workers.[357]

Another resource is the Oregon Psychiatric Access Line (OPAL), which has several specialties, including OPAL-K (about kids) and OPAL-DBP (about developmental behavioral pediatrics). Provided are free, same-day psychiatric consultation to PCPs across Oregon.[202] OPAL-K completed 4,496 consultations with Oregon pediatricians from 2020-2023. Provider satisfaction surveys indicate that PCPs feel more equipped to provide mental health care due to OPAL-K.

While the above resources note what is available for providers to pursue, there is no known survey or study of what providers' knowledge is about behavioral health resources.

**How many specialized intellectual and developmental disabilities (I/DD) workers are serving youth and families and where are they working? Where are there gaps in availability?**

An array of specialized workers serves the I/DD population to meet clinical, therapeutic and personal support needs:

- **Medical:** Pediatricians, specialty medical doctors, nurses who focus on medical needs (commonly include seizures, metabolic, swallowing and respiratory problems).

- **Allied Health Professions:** Occupational therapists, speech-language pathologists, physical therapists, mental health therapists and other health care workers who provide treatment to individuals with I/DD.
- **Behavior Professionals:** Board-certified behavior analysts (BCBA), assistant behavior analysts and behavior analyst interventionists deliver applied behavior analysis to youth with autism spectrum disorder[358]; other behavior professionals utilize the Oregon Intervention System[359] to deliver positive behavior supports to youth with intellectual and developmental disabilities and provide consultation to families.[360]
- **In-Home Care Workers:** Personal support workers (PSW) and direct support professionals (DSP) help youth and families with daily activities. Assistance may include personal care, meal preparation and light housekeeping.
- **Personal Agents:** For individuals ages 18 and older with I/DD, assisting with a variety of needs to help individuals live independently in their own or their family's home in the community; provide high-level case management and support. Support services brokerages are private organizations and data on these services was not obtained.[361]

While the team was unable to obtain data on I/DD specialization within the broader medical professions (medical doctors, nurses and allied health professions), 219 behavior professionals were registered in Oregon as of December 2024.[360] Insurance coverage for these services varies by provider and the percentage of those who serve youth and families is not indicated.

Around half of all youth and young adults served by ODDS have in-home care workers, and will often have multiple DSPs and/or PSWs working with them. Payment and hiring pathways for these roles differ. PSWs are hired directly by individuals and use the ODDS billing system; therefore, ODDS has more direct data available for this worker type. DSPs are employees of in-home agencies, which are paid by ODDS to provide in-home services to individuals requesting them. It is the responsibility of the agencies to provide DSPs for individuals, bill for services rendered and handle all payments to the workers. Individuals and/or their guardian can decide whether they want a PSW or an agency to provide DSPs for their in-home care needs.

The number of individuals ages 0 to 25 who received in-home services by a PSW and/or DSP is presented below (Table 10.5).

*Table 10.5. Number of individuals ages 0-25 who received in-home services by a personal support worker (PSW) or direct support professional[28, 30]*

| | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| Individuals who received DSP or PSW services | 7,610 | 7,882 | 8,182 | 9,157 |
| % of total served by ODDS | 48% | 48% | 49% | 52% |

All PSWs must be credentialed before they can be authorized to provide services to any individual. The data in the following tables indicates how many PSWs are actively credentialed, the number of authorizations for individuals to have a PSW and the ZIP codes of those individuals, which serves as proxy for where PSWs are working.

*Table 10.6. Total number of personal support workers (PSW) with credentials and authorizations by year* [28, 30]

| | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| PSWs with active credentials through ODHS to provide in-home care | 26,251 | 24,956 | 21,401 | 19,455 |
| PSWs with an authorization to provide services to a specific individual for in-home care | 11,238 | 9,778 | 8,339 | 6,757 |

*Table 10.7. Total number of personal support workers (PSW) with individual authorizations by age group* by year* [28, 30]

| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| Age 0-17 | 6,140 | 5,104 | 4,224 | 3,257 | 2,531 |
| Age 18-25 | 5,798 | 5,236 | 4,646 | 3,878 | 3,165 |

**Individuals aging from 17 to 18 years old are counted in both age categories.*

*Table 10.8. Total number of personal support workers (PSW) working in each county, quarter 10/01/2024 –12/31/2024* [28, 30]

| County | PSWs | County | PSWs | County | PSWs | County | PSWs |
|---|---|---|---|---|---|---|---|
| Baker | 7 | Douglas | 62 | Lane | 367 | Sherman | 2 |
| Benton | 30 | Grant | 6 | Lincoln | 47 | Tillamook | 36 |
| Clackamas | 437 | Harney | 15 | Linn | 118 | Umatilla | 136 |
| Clatsop | 19 | Hood River | 26 | Malheur | 24 | Union | 38 |
| Columbia | 39 | Jackson | 73 | Marion | 375 | Wallowa | 3 |
| Coos | 72 | Jefferson | 22 | Morrow | 15 | Wasco | 37 |
| Crook | 7 | Josephine | 32 | Lake | 8 | Polk | 128 |
| Curry | 3 | Klamath | 96 | Multnomah | 799 | Washington | 377 |
| Deschutes | 83 | Lake | 8 | Polk | 128 | Yamhill | 116 |

ODDS reports that they are seeing an increase in individuals receiving in-home services, but a decrease in PSWs. They are also seeing an increase in the number of agencies with DSPs authorized to provide in-home care. This is believed to be related to PSWs moving into the role of DSPs, but there is not a way to track that change in roles.

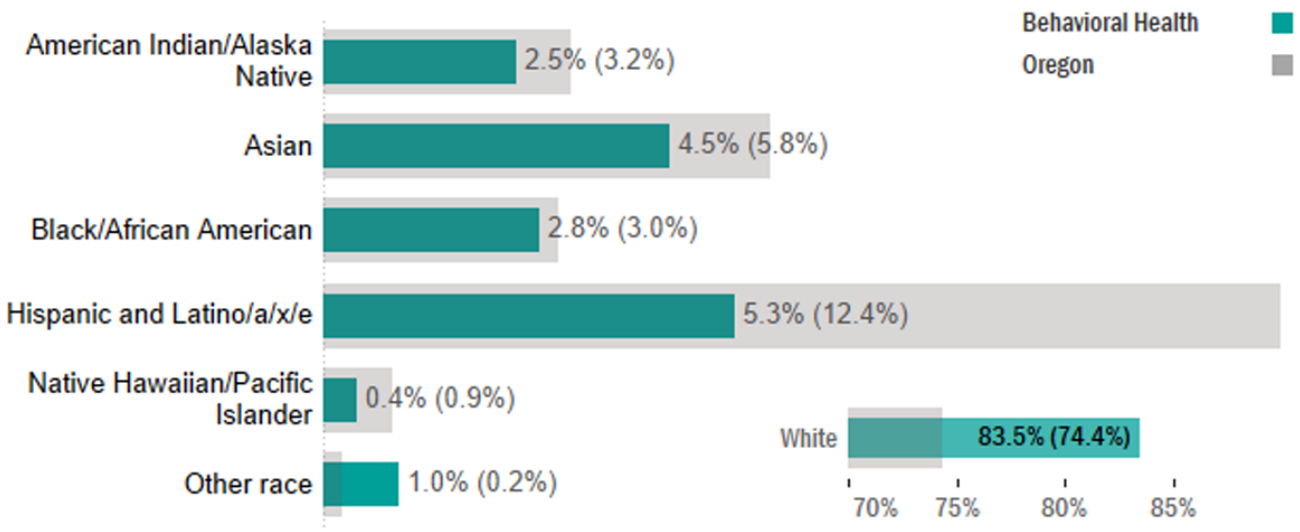
Overall, in-home care workers are often hindered by challenges such as low wages, limited benefits and high turnover, which affect the consistency and quality of care, increase the workload for remaining staff and elevate the risk of medication errors, injuries and abuse for people with I/DD.[362]

**What does cultural diversity look like in the system of care workforce? Is there an accurate representation of people of color and other minorities? Are there any underrepresented groups?**

Cultural diversity in the workforce is imperative to meeting the needs of those on the receiving end of services and supports. When the providers and staff at all levels of services are adequately trained, practice cultural humility and possess cultural similarities to those being served, it can positively impact the experiences of the youth and their families.

The Oregon Health Care Workforce Needs Assessment 2025 reports that Oregon's primary care workforce is less racially and ethnically diverse than the general population and indicates which populations are underrepresented (Figure 10.4).[349] It reflects similarly in the substance use disorder and mental health workforces.

*Figure 10.4. Race and ethnicity of the behavioral health workforce in Oregon, from the 2025 Health Care Workforce Needs Assessment* [349]




The Oregon Mental Health Regulatory Agency Diversity Study outlined several important findings related to diversity of the workforce, presented in Figure 10.5.[363] Factors that limit diversity in the workforce are presented in Figure 10.6.

*Figure 10.5. Key findings from the Oregon Mental Health Regulatory Agency Diversity Study*[363]

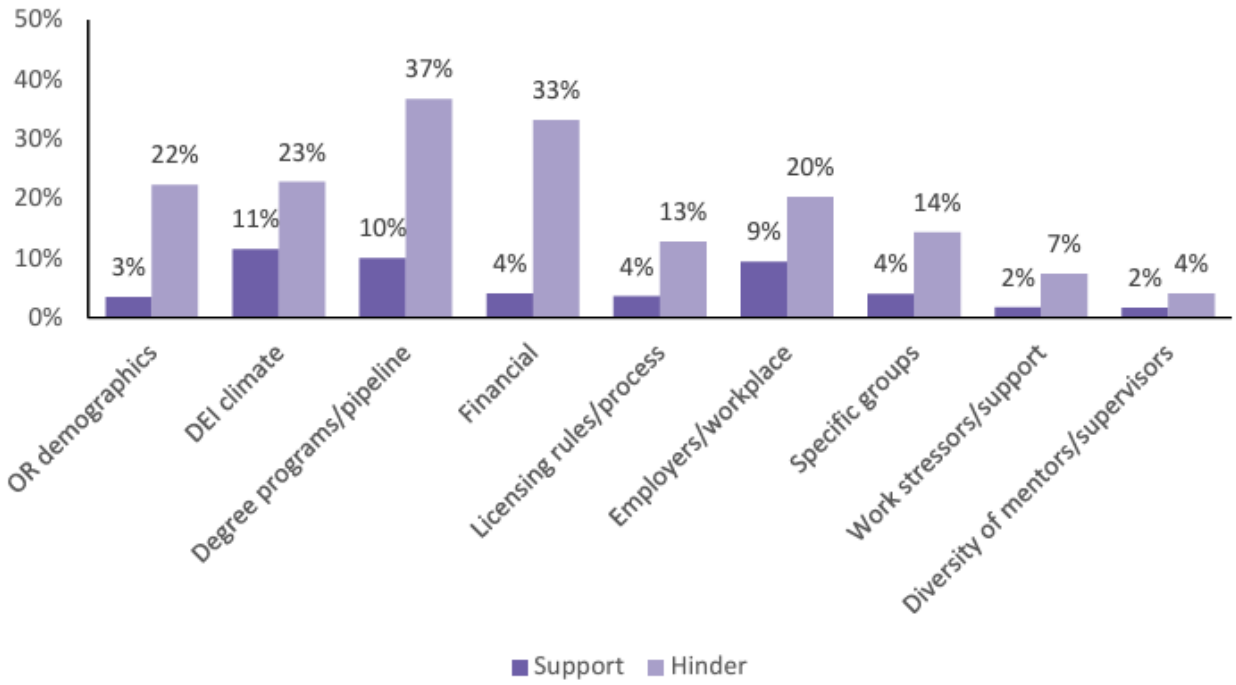
"**Mental health professionals in Oregon are less racially and ethnically diverse than the mental health professions in the nation.** About 79% of mental health professionals in the United States identify as white alone compared to 93% in Oregon. Proportionally, there are seven times as many Black mental health professionals nationally compared to in Oregon."

"**Oregon's mental health professionals are also less racially and ethnically diverse than the population of Oregon.** About 75% of Oregon residents identify as white compared to 93% of Oregon's mental health professionals. Every race and ethnicity group except white is underrepresented in the professions relative to their proportion in Oregon's population."

"**Most mental health professionals in Oregon are women (75%), which is similar to national patterns.** About half of Oregon's population is female."

"**Oregon's mental health professionals are less diverse in terms of languages spoken at home than the population of Oregon.** For example, 9% of Oregonians speak Spanish at home, but only 6% of Oregon's mental health professionals do."

*Figure 10.6. Factors that support or hinder diversity in the mental health professions, from the Oregon Mental Health Regulatory Agency Diversity Study*[363]




**Percentages represent the proportion of mental health professionals in Oregon that endorsed factors that either promote (support) or limit (hinder) diversity in the workforce.*

### *Improving Cultural Aspects of Services for BIPOC Youth and Families*

A 2022 report released by the National Alliance on Mental Illness (NAMI) Multnomah chapter outlined recommendations that youth made to improve the diversity and cultural humility/competence of staff.[268] Recommendations included diversifying the workforce by advertising outside of White communities and spaces to meet the need for more providers of color and staff with more cultural responsiveness, including religious diversity. Youth stated a desire for Black advocates who understand BIPOC struggles and providers who have a better understanding of personal needs, such as hair and skin care, hygiene and food. Parent participants in the study expressed a desire for culturally specific peer support early in the treatment process, as well as culturally specific workers on site at every point of contact, starting with intake into services, and every level of the organization, including administration.

The NAMI Multnomah report describes negative impacts of a non-diverse workforce, from not addressing racism toward BIPOC youth by other youth and staff, Black youth suffering more severe punishments for breaking rules, reduced communication and engagement from staff with youth or families whose primary language is not English, and misdiagnosis of neurodivergent BIPOC youth.[268] An appropriately diverse workforce that represents the diversity of the individuals it serves would serve as an antidote to these and other reported harms.

**What are some regulations in place regarding workplace safety? What are some resources available for burnout and stress? Are some groups unable to access resources? Are there some workplaces without safety regulations?**

Federal Occupational Safety and Health Administration (OSHA) safety regulations apply to the workforce described in this report.[364] Employees of state and local governments are not covered under the federal OSHA requirements, but Oregon's state plan extends coverage to these individuals.[365] Individual employers may have workplace safety policies in addition to the state OSHA regulations; however, identifying each agency's workplace safety staff and obtaining information from them was not feasible within the timeline of this report

The Center for Health Systems Effectiveness' (CHSE) report on Oregon's mental health workforce crisis found that providers often experience "high case burden and acuity, intensive and inflexible schedules, frequent rotations on crisis calls, and insufficient supervisory support."[366] The report further suggests that "the least-resourced settings, such as community mental health programs, often treat inappropriately high-acuity clients," leading to inexperienced clinicians working with the most complex, high-need clients.[366]

Provider-recommended strategies to help mitigate these challenges are presented in Figure 10.7. Implementation and utilization of these strategies statewide is not known.

*Figure 10.7. Strategies to mitigate burnout and improve recruitment and retention, recreated from the Center for Health Systems Effectiveness Workforce Report*[366]

**Financial incentives for recruitment and retention**

- Loan repayment options
- Tax credit programs
- Sign-on and retention bonuses
- Benefits like health care, paid leave, childcare and housing support

**Education and training programs**

- Increasing training program slots
- Increasing opportunities for culturally specific training
- Changing hiring requirements
- Education programs that are inclusive and culturally responsive
- Funding for federally qualified health centers (FQHCs) and other under-resourced settings to support internships
- Elevating the value of careers in substance use and mental health services

**Practice-oriented tactics**

- Supporting the telehealth infrastructure and reimbursement
- Licensure, certification and scope of practice changes
- Broadening potential for reimbursement across provider and payer types
- Reducing administrative burdens and delays
- Paperwork parity with primary care and other practice specialties and settings

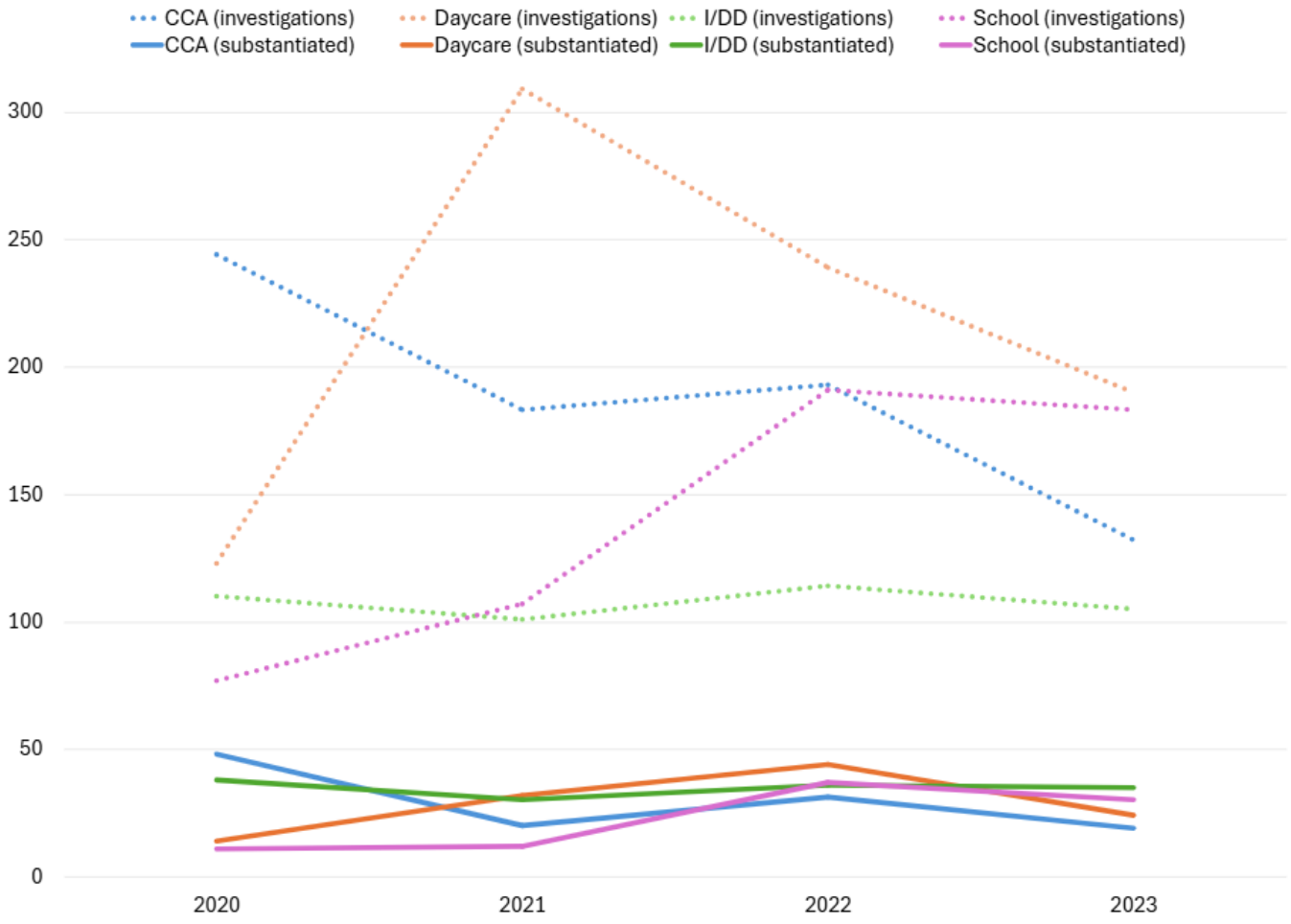
> **"From what I noticed, it seemed staff aren't able to say what's not working or to air any grievances. I noticed there's a huge amount of turnover. It seems easier just to move facilities. Nobody tried to improve or fix what's not working. They just move to another place."**
>
> *– Parent describing their experience with psychiatric residential treatment facilities*[268]

**How many providers have been charged with abuse or neglect due to an event that occurred in the workplace?**

Oregon providers may be charged with abuse or neglect due to an event occurring in the workplace, if an investigation finds it to be substantiated.

Figure 10.8 displays the number of investigations and substantiated abuse claims reported by ODHS.[367] Data is broken down by provider type. One important consideration when interpreting the chart is the passing of Senate Bill 710 in 2021, which modified the allowed and prohibited use of restraints by certain providers in certain non-familial settings.[368]

*Figure 10.8. Investigations and substantiated abuse claims reported by Oregon Department of Human Services[367], 2020 to 2024*




*CCA (child-caring agencies): private agencies/organizations licensed by ODHS to provide care and services to youth; this includes residential facilities, day treatment programs and youth shelters.*
*Daycare: licensed daycare facilities.*
*I/DD: includes 24-hour group homes and ODDS-licensed foster care homes.*

**How many coordinated care organizations and private carriers are meeting network adequacy standards for specialty behavioral health services for youth by service type? Are there any disparities regarding network adequacy standards for behavioral health services?**

Network adequacy standards aim to ensure that individuals can access the care they need within a reasonable distance of their home. "Network" refers to the group of doctors and other providers that a plan works with and "network adequacy" refers to whether that group is sufficient in numbers and locale to the plan's members.

The determination of network adequacy depends on rurality, which is broken down into urban versus rural (as of 2024, there are four rurality designations).[369] Prior to 2024, network adequacy was defined as "100 percent of members within 30 miles or 30 minutes of a provider in urban settings, and 100 percent of members within 60 miles or 60 minutes of a provider in rural settings."[370] Table 10.9 shows the percentage of CCO members with adequate access to services by geographic designation; substantial noncompliance is considered 95% and below. The DAETA team was unable to obtain this data from private commercial carriers due to report time constraints.

*Table 10.9. Percentage compliant with time and distance network adequacy standards, as of January 2023*[369]

| | **Pediatric Mental Health Provider** | | **Pediatric Substance Use Providers** | |
|---|---|---|---|---|
| | Urban | Rural | Urban | Rural |
| Coordinated Care Organization | % | % | % | % |
| Advanced Health | N/A | 100% | N/A | 92.2% |
| AllCare CCO | 100% | 100% | 0% | 0% |
| Cascade Health Alliance | N/A | 100% | N/A | 100% |
| Columbia Pacific CCO | 100% | 100% | 92.3% | 100% |
| Eastern Oregon CCO | 0% | 98.6% | 0% | 98.4% |
| Health Share | 100% | 100% | 100% | 100% |
| InterCommunity Health Network | 100% | 100% | 100% | 100% |
| Jackson Care Connect | 100% | 100% | 100% | 100% |
| PacificSource Community Solutions: Central Oregon | 100% | 100% | 100% | 100% |
| PacificSource Community Solutions: Columbia Gorge | N/A | 100% | N/A | 100% |
| PacificSource Community Solutions: Lane | 100% | 100% | 100% | 100% |
| PacificSource Community Solutions: Marion Polk | 100% | 100% | 100% | 100% |
| Trillium Community Health Plan: North | 100% | 100% | 100% | 100% |
| Trillium Community Health Plan: South | 100% | 100% | 100% | 100% |
| Umpqua Health Alliance | N/A | 100% | N/A | 99.9% |
| Yamhill Community Care Organization | 100% | 100% | 100% | 100% |

However, youth and family experiences do not always reflect what is reported by CCOs, and issues regarding access are persistent. The OHA Ombuds Program 2023 Year End Report described successes and concerns about network adequacy and OHP member access to behavioral health providers when they need them. The report praises increased financial investments and expanded home and community services (specifically Mobile Response and Stabilization Services and Intensive In-Home Behavioral Health Treatment) but points out that investments in youth mental health are far less than adult mental health investments and insufficiency in the reported network adequacy remains a problem.[371]

Some concerns raised include provider directories being out of date, resulting in "ghost networks," providers who may have accepted OHP at one time but no longer accept this insurance, and providers that may not still be open for business or taking new patients.[371]

**How do compensation packages for the mental health workforce compare to other states with similar geography and population? Are there any disparities regarding compensation packages?**

Oregon and national median wages for various behavioral health professions are presented in Table 10.10. A study by the Oregon Mental Health Regulatory Agency found that behavioral health counselors made higher wages in the more urban areas of the state, with the highest wages observed in Clackamas County and the Portland Tri-County Area. The areas with the lowest wages were in the South-Central area of the state.

*Table 10.10. Median hourly wage of the behavioral health workforce*

| Occupation | Oregon | United States |
|---|---|---|
| Behavioral health counselor | $30 | $26 |
| Behavioral health social worker | $28 | $27 |
| Clinical and counseling psychologist | $61 | $46 |
| Mental health peer | $18 | $23* |
| Psychiatrist | $138 | $124 |
| Qualified mental health associate (QMHA) | $21 | N/A |
| Qualified mental health professional (QMHP) | $30 | N/A |
| Substance use disorder counselor (including CADC) | $22 | N/A |
| Substance use disorder peer | $18 | $23* |

*Sources: 2023 U.S. Bureau of Labor Statistics[372], 2021 Mental Health & Addiction Certification Board of Oregon Workforce Survey[373], Mental Health Regulatory Agency[363]*
** The U.S. Bureau of Labor Statistics groups peers with other professions under "community health workers," which had a median hour wage of $23 in 2023[374]*

The CHSC attributes variability in wages to[366]:

- **Education:** individuals with higher education levels may earn higher wages
- **Years of experience:** more experienced staff may earn higher wages
- **Type of agency:** community-based and public workers may earn lower wages
- **Region:** Portland area counselors/therapists have slightly higher wages than the state median

Another concern that CHSE outlines is the discrepancy between Oregon employers and national companies in the private sector.[366] Over the last few years, a significant increase in telehealth services that offer remote behavioral health jobs with larger private companies are attractive to workers seeking more competitive compensation packages, increased flexibility and lower acuity caseloads. The report makes substantive recommendations for achieving a living wage for all types of mental health workers and moving toward increased wage equitability among the physical health and mental health workforces.

***Cost of Living in Oregon***

Cost of living numbers can vary depending on locale, categories of expenses and the date when numbers are calculated. Oregon is consistently ranked as having a higher cost of living than the national average. According to Ramsey Solutions, a financial consumer education group, Oregon's 2023 statewide cost of living was 16% higher than the national average, Portland was 22% higher and housing costs were 56% higher.[375]

**What student loan forgiveness options are available to the Oregon mental health workforce and what is the utilization/forgiveness rate? Are there some groups unable to access student loan forgiveness?**

A recent study found that loan repayment programs are an important and effective tool to address the behavioral health workforce shortage. A non-exhaustive list of loan forgiveness options for government workers and those working at a 501(c)(3) nonprofit organization is presented below. In addition to the national and state programs outlined, there are also many employer-specific loan forgiveness opportunities.

Oregon Behavioral Health Loan Repayment Program (OBHLRP)[376]

The OBHLRP is available to licensed behavioral health providers, certified behavioral health providers and traditional health workers in Oregon. The program awards funds to repay undergraduate and postgraduate loan debt in exchange for two years of service to underserved communities. The program was launched as part of OHA's Behavioral Health Workforce Incentives program.[377] It received over 2,000 applications and awarded available funding to 281 individuals, for a total of around 15 million dollars.[378]

Public Service Loan Forgiveness (PSLF)[379]

PSLF is available to individuals who work full-time in public service. After the individual makes 120 qualifying payments on their loan (while working for the employer), the remaining balance is forgiven. As of June 2023, 11,420 Oregonians have received loan forgiveness through this program, for a total of $732.5 million dollars forgiven.[379]

National Health Service Corps (NHSC) Loan Repayment Programs[380]

NHSC Loan Repayment programs are available to licensed health professionals who work at a qualifying site in a Health Professional Shortage Area (HPSA). There are more than 200 NHSC-approved sites in Oregon (OHA). From 2011 to 2020, the NHSC awarded more than 48,000 loan repayment awards; data is unavailable by year and state.[381]

Substance Use Disorder Treatment and Recovery Loan Repayment Program (STAR)

The STAR loan repayment program offers loan forgiveness to SUD clinicians and community health workers (including peers and recovery specialists) working at an approved facility in an HPSA county with a drug overdose mortality rate greater than the national average. It offers up to $250,000 in exchange for a six-year service commitment.

Pediatric Specialty Loan Forgiveness Program[382]

The Pediatric Specialty Loan Forgiveness Program is available to child-serving behavioral health providers, including physicians, psychologists, social workers, therapists and counselors. Up to $100,000 of loan forgiveness is provided for three years' work in a facility in a HPSA, medically underserved area or for a medically underserved population.

**What academic programs are available in Oregon for behavioral health workforce capacity building? Where are these located and what types of programs are available? Where are there gaps in the availability of these programs?**

There are many different types of academic programs that can contribute to the education and training of the behavioral health workforce. This section discusses different types of programs throughout Oregon.

Community colleges and universities are located throughout the state (Figure 10.9).[384] Most programs are in the Portland Metro Area and the western half of the state. The southeast portion of the state has very few colleges and universities.

Note: Oregon-based programs are included below. Information on certificates and degrees that can be obtained online is not presented.

**There are 17 community colleges in Oregon,** which offer certificate programs and two-year degrees preparing individuals to enter the workforce or continue their studies.[385] One innovative program at Central Oregon Community College trains students to become certified peer support specialists.[386] The program is low barrier and doesn't require a high school diploma or any academic prerequisites.

**There are 18 public and private universities**. These universities offer a number of programs that prepare individuals to join the behavioral workforce. Examples include bachelor's degrees in Addiction Counseling/Services, Behavioral Sciences, Child Development, Community Behavioral Health, Counseling, Psychology and Social Work. The Ballmer Institute at the University of Oregon is a new program with a primary objective of bolstering the behavioral health workforce.[387] The program offers a bachelor's degree in child behavioral health and focuses on preparing graduates to provide evidence-based behavioral health intervention to children and adolescents.

**Seven universities offer advanced degrees in behavioral health fields** (Table 10.11). Most programs are in the Portland Metro Area and along the I-5 corridor.

**There are four advanced medical training programs related to child behavioral health.** Oregon Health & Science University has a Psychiatric Mental Health Nurse Practitioner program (not specific to youth) and fellowship programs in Developmental Behavioral Pediatrics and Child and Adolescent Psychiatry.[388,389] Samaritan Health has a fellowship program in Child and Adolescent Psychiatry.[390]

*Table 10.11. Oregon graduate programs in the behavioral health field*

| University | Location | Programs Offered |
|---|---|---|
| George Fox University[391] | Newberg | M.A. in Clinical Mental Health Counseling<br>M.A. in Marriage, Couple and Family Counseling<br>Master of Social Work (M.S.W.)<br>Psy.D. in Clinical Psychology |
| Lewis and Clark University[392] | Portland | M.A. in Professional Mental Health Counseling (optional specializations in Addictions, Eating Disorder Treatment)<br>M.A. in Marriage, Couple & Family Therapy<br>Ed.S. in School Psychology |
| Oregon Health & Science University[393] | Portland | Dual Master of Public Health (M.P.H.) & Master of Social Work (M.S.W.)<br>Ph.D. in Clinical Psychology<br>M.D. / D.O. Residency in Psychiatry<br>M.D. / D.O. Fellowship in Child & Adolescent Psychiatry |
| Oregon State University[394] | Corvallis | Ph.D. in Psychology |
| Pacific University[395] | Forest Grove | M.A. in Applied Clinical Psychology<br>Ph.D. in Clinical Psychology<br>Psy.D. in Clinical Psychology |
| Portland State University[396] | Portland | Master of Social Work (M.S.W.)<br>Ph.D. in Applied Psychology |
| University of Oregon[397] | Eugene | M.S. in Psychology<br>M.S. in School Psychology<br>Ph.D. in Clinical Psychology<br>Ph.D. in Counseling Psychology<br>Ph.D. in School Psychology |

*Figure 10.9. Colleges in Oregon, from Oregon Goes to College*[384]


Includes public and independent, not-for-profit institutions that offer full Associate and Bachelor's degree programs; does not include branch campuses or centers.

**Community Colleges**

| | | |
|---|---|---|
| Blue Mountain Community College | *Pendleton* | 16 |
| Central Oregon Community College | *Bend* | 14 |
| Chemeketa Community College | *Salem* | 6 |
| Clackamas Community College | *Oregon City* | 4 |
| Clatsop Community College | *Astoria* | 1 |
| Columbia Gorge Community College | *The Dalles* | 15 |
| Klamath Community College | *Klamath Falls* | 13 |
| Lane Community College | *Eugene* | 9 |
| Linn-Benton Community College | *Albany* | 8 |
| Mt. Hood Community College | *Gresham* | 5 |
| Oregon Coast Community College | *Newport* | 7 |
| Portland Community College | *Portland* | 3 |
| Rogue Community College | *Grants Pass* | 12 |
| Southwestern Oregon Community College | *Coos Bay* | 10 |
| Tillamook Bay Community College | *Tillamook* | 2 |
| Treasure Valley Community College | *Ontario* | 17 |

**Public Universities**

| | | |
|---|---|---|
| Eastern Oregon University | *La Grande* | 8 |
| Oregon Institute of Technology | *Klamath Falls* | 6 |
| Oregon State University | *Corvallis* | 3 |
| Oregon State University - Cascades | *Bend* | 7 |
| Portland State University | *Portland* | 1 |
| Southern Oregon University | *Ashland* | 5 |
| University of Oregon | *Eugene* | 4 |
| Western Oregon University | *Monmouth* | 2 |

**Alliance Independent Colleges**

| | | |
|---|---|---|
| Bushnell University † | *Eugene* | 11 |
| Corban University † | *Salem* | 10 |
| George Fox University † | *Newberg* | 7 |
| Lewis & Clark College | *Portland* | 4 |
| Linfield University | *McMinnville* | 8 |
| Pacific Northwest College of Art | *Portland* | 5 |
| Pacific University | *Forest Grove* | 6 |
| Reed College | *Portland* | 3 |
| University of Portland † | *Portland* | 1 |
| Warner Pacific College † | *Portland* | 2 |
| Willamette University | *Salem* | 9 |

† *religiously-affiliated*



oregongoestocollege.org

**At public institutions, what percentage of students are in-state versus out of state? What percentage of students stay in Oregon and join the workforce?**

The percentage of in-state residents attending Oregon's public community colleges and universities has remained relatively consistent over time (Table 10.12).[398]

The Post-Secondary Employment Outcomes Explorer created by the United States Census Bureau provides insight to where Oregon graduates are working five years after obtaining their degrees.[399] An estimated 69% of Oregon graduates in system-related fields, including social sciences, psychology, health professions and related programs, education, public administration and social service professions are working in Oregon five years after graduation (Figure 10.10).[399] Estimates for master's-level professionals who stay in Oregon are higher at 75% but more driven by the large number of education graduates (Figure 10.11).[399] Doctorate-level estimates only include health professions and related programs, with 71% of graduates working in Oregon five years after graduation (Figure 10.12).[399] Notably, a large number of doctorate-level individuals remaining in Oregon are not working in the health field and are instead working in retail trade (42%).[399]

*Table 10.12. Percentage of students who are in-state Oregon residents*[398]

| | 2020-2021 | 2021-2022 | 2022-2023 | 2023-2024 |
|---|---|---|---|---|
| Community colleges | 92.9% | 93.3% | 93.6% | 94.2% |
| Public universities | 64.6% | 64.8% | 64.3% | 64.8% |

*Figure 10.10. Flow of Oregon bachelor's-level graduates, by program and industry/geography five years after graduation, from the Post-Secondary Employment Outcomes Explorer*[399]

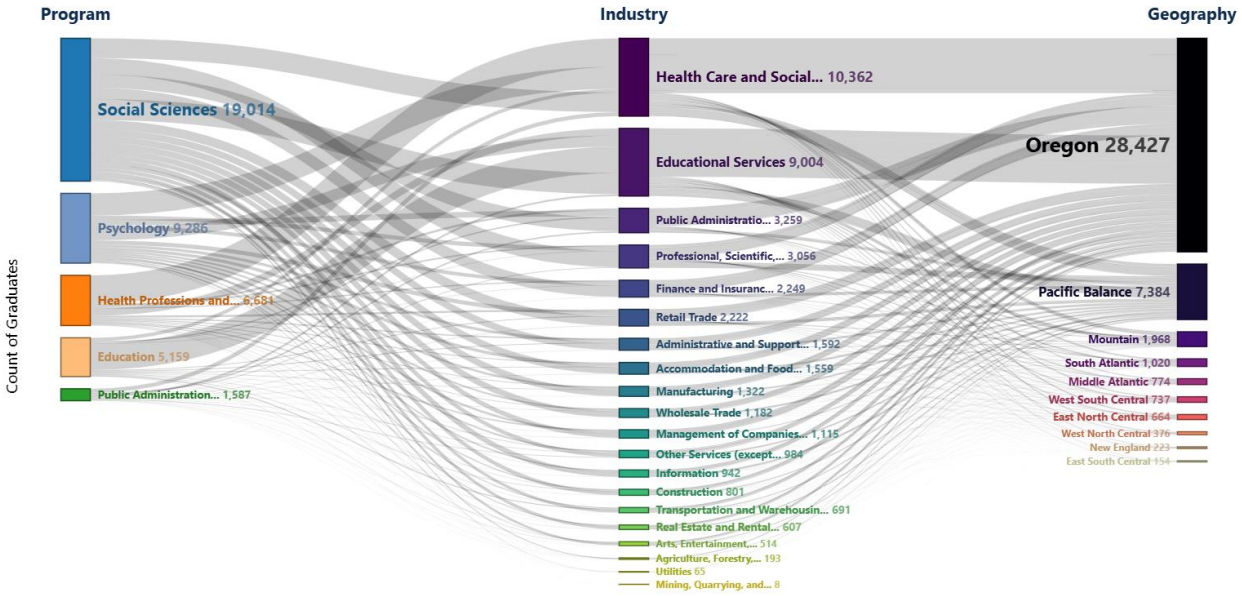


*Figure 10.11. Flow of Oregon master's-level graduates, by program and industry/geography five years after graduation, from the Post-Secondary Employment Outcomes Explorer*[399]

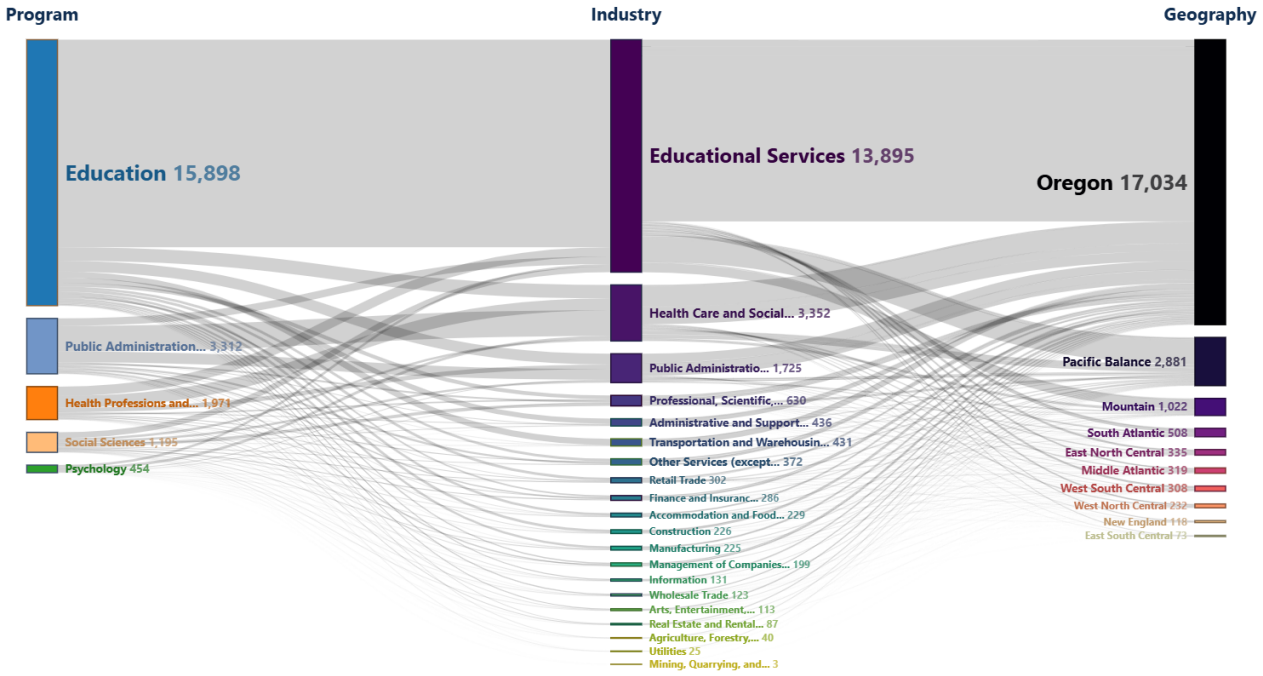
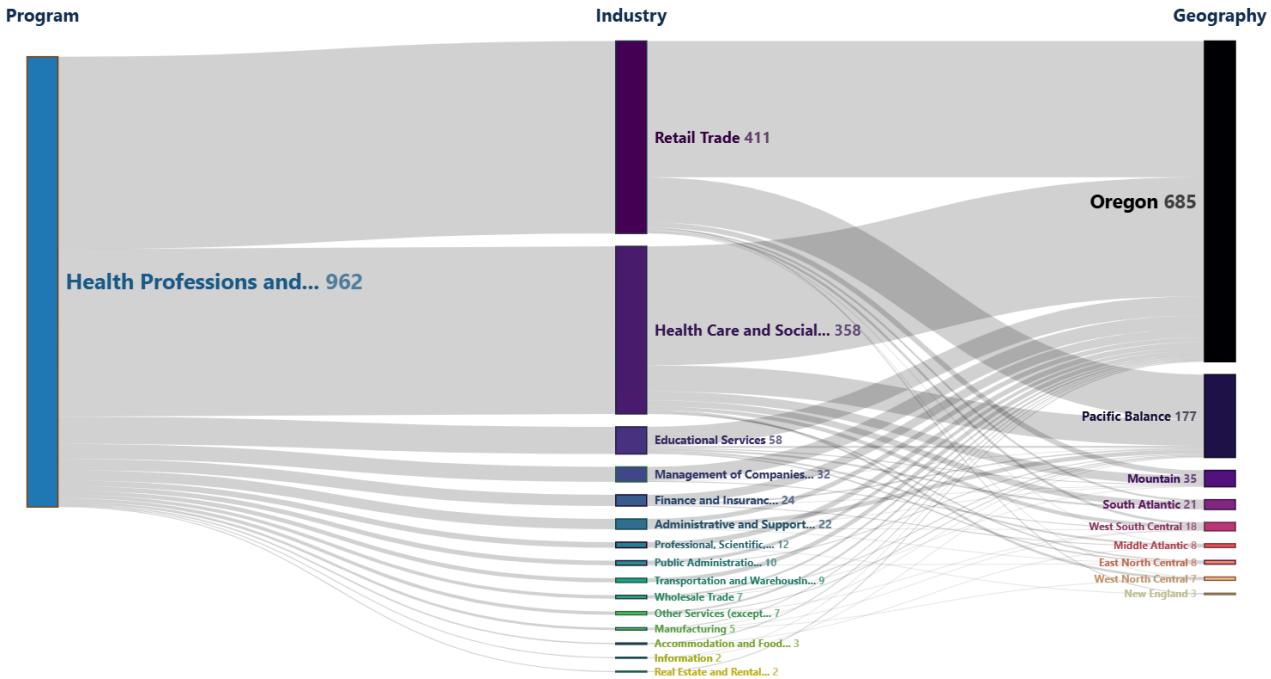



*Figure 10.12. Flow of Oregon doctorate-level graduates, by program and industry/geography five years after graduation, from the Post-Secondary Employment Outcomes Explorer*[399]



## CHAPTER INTRODUCTION

This chapter provides information on public, state-level funding in Oregon. Initiatives funded by specific counties/regions, commercial payers, private foundations or institutions are not included in this assessment.

The funding mechanisms in the system of care are complex. A fiscal assessment completed by SOCAC in 2023 outlined some of the challenges faced when trying to evaluate how funding flows across the SOC.[400] The report discussed the absence of standardized fiscal data across agencies and siloed funding models as major challenges to effectively evaluating the data. SOCAC recommends, and OHSU agrees, that a more in-depth audit is required to fully understand this information. **For these reasons, it is recommended that readers interpret this chapter with caution.**

For the purposes of this report, a high-level, simplified overview of funding sources, allocations and gaps is provided. This chapter uses Legislatively Adopted Budgets (LAB) to understand the investment, funding sources and resource allocations of each state agency. LABs cover two years — a biennium — and are developed through the process outlined in Figure 11.1.

*Figure 11.1. State funding budget process overview*[401]


## KEY TAKEAWAYS

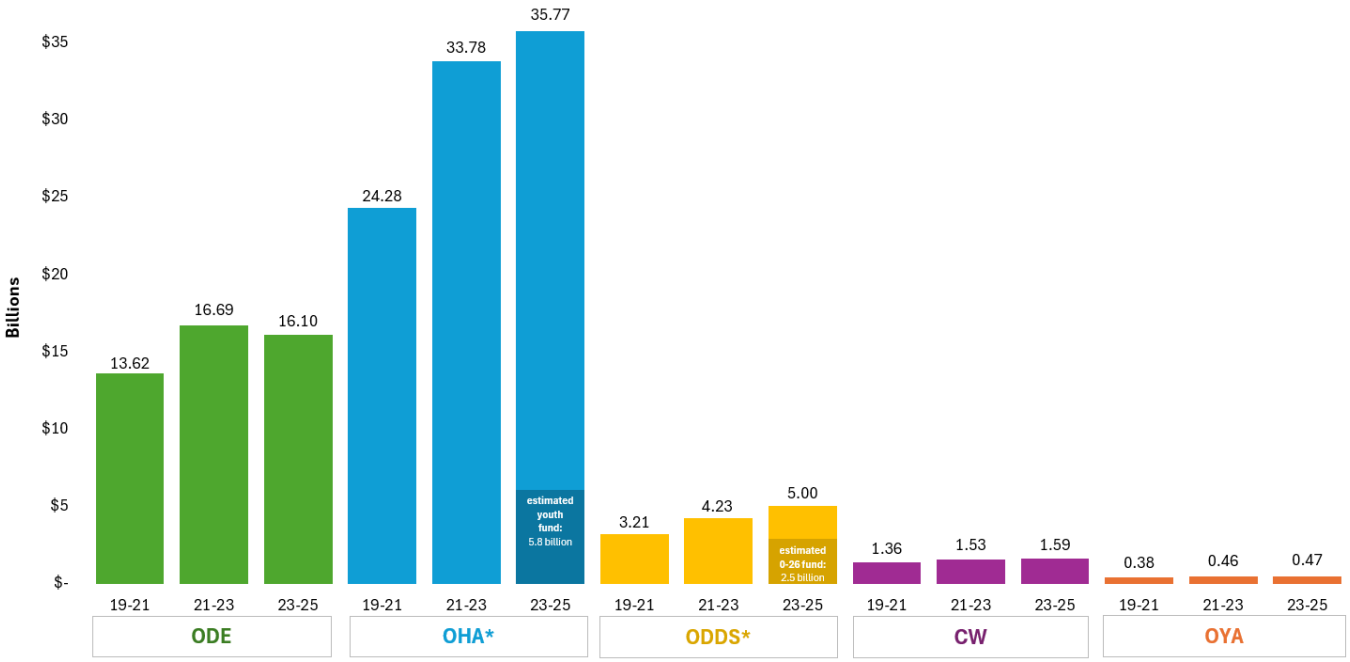
Almost $25 billion is being invested in the youth and young adult system of care for the 2023-2025 biennium.

Of the child-serving systems, Oregon Department of Education receives the most funding, followed by Oregon Health Authority (child-serving programs), Oregon Developmental Disability Services, Child Welfare and Oregon Youth Authority.

## How much money is being invested in the system of care?

An estimated 24.6 billion is being invested into the SOC for the 2023-2025 biennium. Investments by agency for the three most recent biennia are presented in Figure 11.2.[402-405] Oregon Health Authority (OHA) and the Office of Developmental Disability Services (ODDS) treat the lifespan, and Legislatively Adoptive Budgets (LABs) represent their entire budget; estimates for the child-specific budgets for the 2023-2025 biennium were directly provided by each agency.

*Figure 11.2. Total investment in the youth system of care over time*[402-407]




**ODDS and OHA serve the lifespan; estimates for the child-specific budgets for the 2023-2025 biennium were directly provided by each agency. Sources: 2023-25 Legislatively Adopted Budget Detailed Analysis[406], State of Oregon Legislative Fiscal Office[407], agency Legislatively Adopted Budgets[402-405] and agency fiscal analysts.*

## What are the funding sources in the system of care?

Public agency funding sources are organized into three categories:

- The **General Fund of Oregon** is the governor and legislature's main source of funds, which primarily comes from income taxes paid by Oregon individuals and businesses. The General Fund is required in order to receive federal matching dollars.[408]
- **Federal funds** come from Medicaid (including health-related services funds or "flex funds"), federal programs, federal block grants and any other federal source.[409]

- **Other funds** include unique or agency-specific revenue streams like lottery funds, licenses and fees, rents and royalties, bond proceeds, and donations and contributions.[402-407]

*Table 11.1. Distribution of funding sources by agency*

| | | General Fund | | Federal Funds | | Other Funds | |
|---|---|---|---|---|---|---|---|
| Agency | Biennium | Amount | % | Amount | % | Amount | % |
| Oregon Department of Education | 2019-2021 | 8.7 billion | 64% | 1.5 billion | 11% | 3.5 billion | 25% |
| | 2021-2023 | 9.2 billion | 55% | 3.4 billion | 20% | 4.1 billion | 25% |
| | 2023-2025 | 9.6 billion | 59% | 2.1 billion | 13% | 4.5 billion | 28% |
| Oregon Health Authority | 2019-2021 | 2.4 billion | 10% | 13.7 billion | 56% | 8.2 billion | 34% |
| | 2021-2023 | 3.5 billion | 10% | 19.1 billion | 57% | 11.2 billion | 33% |
| | 2023-2025 | 5.5 billion | 15% | 20.0 billion | 56% | 10.2 billion | 29% |
| Office of Developmental Disabilities | 2019-2021 | 939.3 million | 29% | 2.2 billion | 69% | 52.7 million | 2% |
| | 2021-2023 | 1.3 billion | 30% | 2.9 billion | 69% | 29.5 million | 1% |
| | 2023-2025 | 1.8 billion | 36% | 3.2 billion | 63% | 26.5 million | 1% |
| Child Welfare | 2019-2021 | 761.3 million | 56% | 551.5 million | 41% | 45.3 million | 3% |
| | 2021-2023 | 919.8 million | 60% | 576.6 million | 38% | 35.0 million | 2% |
| | 2023-2025 | 970.3 million | 61% | 579.9 million | 36% | 40.4 million | 3% |
| Oregon Youth Authority | 2019-2021 | 329.7 million | 86% | 36.7 million | 10% | 18.1 million | 5% |
| | 2021-2023 | 272.7 million | 59% | 37.0 million | 8% | 154.8 million | 33% |
| | 2023-2025 | 399.6 million | 84% | 46.3 million | 10% | 28.9 million | 6% |

**ODDS and OHA serve the lifespan; estimates for the child-specific budgets for the 2023-2025 biennium were directly provided by each agency. Sources: 2023-25 Legislatively Adopted Budget Detailed Analysis[406], State of Oregon Legislative Fiscal Office[407], agency Legislatively Adopted Budgets[402-405] and agency fiscal analysts.*

**How is funding being allocated and how does this relate to program availability, utilization and outcomes?**

The tables on the following pages detail how each agency distributed their funds for the 2023-2025 biennium. More in-depth descriptions of each category (and the specific programs and services within them) can be found in the corresponding agency's LAB.

Comprehensive financial analysis by program would be required to fully understand how investment relates to program availability, utilization and outcomes. Additionally for OHA, an analysis of CCO-level actuarial data is recommended to track the flow of funds going to CCOs and how it relates to spending on behavioral health for their youth members. These complex financial audits are outside the scope of this report; however, the Oregon Secretary of State conducts financial and performance audits of programs in the system of care. Reports can be

searched by agency on the Secretary of State website.[410] Select audits that assess the broader functioning of specific agencies are as followed:

- **Oregon Department of Education:** ODE and PPS Must Do More to Monitor Spending and Address Systemic Obstacles to Student Performance, Particularly at Struggling Schools (January 2019)[411]
- **Oregon Health Authority:** Chronic and Systemic Issues in Oregon's Mental Health Treatment System Leave Children and Their Families in Crisis (September 2020)[412]
- **Office of Developmental Disabilities:** Developmental Disabilities Leadership is Proactively Addressing Program Challenges to Ensure Optimal Service Delivery (August 2021)[413]
- **Child Welfare:** Foster Care in Oregon: Chronic management failures and high caseloads jeopardize the safety of some of the state's most vulnerable children (May 2018)[414]
- **Oregon Youth Authority:** The last overarching system audit on file was completed in 1999. More recent program-and account-specific audits are available.[415]

*Table 11.2. Oregon Department of Education funding allocation from the 2023-2025 biennium*[402]

| Allocation | Amount | % |
|---|---|---|
| **School Funding:** Directs funds to school districts and education services districts based on number of students and relative financial need | $10,200,000,000 | 63% |
| **Grant-in-Aid:** Student achievement grants, district capacity and technical assistance, STEM and CTE programs, nutritional programs, educator effectiveness and professional development, closing the opportunity gap program, specialized student services | $4,869,370,750 | 30% |
| **School for the Deaf:** School that provides education to students who are Deaf and Hard of Hearing | $22,736,345 | <1% |
| **Educator Advancement Council:** Partnership aimed at creating a more antiracist, diverse and empowered workforce | $71,345,644 | <1% |
| **Department Operations:** Overall leadership and activities of the State Board of Education and the Office of the Director | $309,486,701 | 2% |
| **Capital Bond Financing:** Office of School Facilities that provides technical assistance and funding to support local capital improvement projects | $361,000,000 | 2% |
| **Debt Service:** payment of principal and interest on bonds | $64,541,161 | <1% |
| **Youth Development:** Community prevention and intervention services for at-risk youth, includes services that support academic success and reduce criminal involvement | $40,660,888 | <1% |
| **Common School Fund:** Funds that are sent to school districts twice a year; allocations are based on the number of students served | $159,996,772 | 1% |
| **Total** | **$16,100,000,000** | |

*Table 11.3. Oregon Health Authority Funding Allocation from the 2023-2025 biennium*[403]

| Allocation | Amount | % |
|---|---|---|
| **Health Systems Division:** Develops and maintains statewide system of integrated physical, behavioral and oral health care; includes the Medicaid Division and Behavioral Health Division (reorganization will occur in the next biennium) | $26,882,000,000 | 78% |
| *Medicaid Children's Services (estimate): care received through Medicaid and the Children's Health Insurance Program (CHIP), which includes services through coordinated care organizations* | *$5,074,753,491* | -- |
| *Behavioral Health Children's Services (estimate): mental health promotion and prevention services, suicide prevention, community mental health crisis services, mobile crisis services, school-based mental health services, tribal-based mental health services, peer-delivered services, housing services, psychiatric residential treatment services, nonresidential community mental health treatment services* | *$266,357,787* | --- |
| **Health Policy & Analytics:** Develops and implements innovative approaches to lowering health care costs and improving health outcomes | $240,000,000 | 1% |
| **Central & Shared Services and Assessments:** Office of Information Services, includes implementation for REALD and SOGI | $740,000,000 | 2% |
| **Oregon State Hospital:** Highest psychiatric level of care for adults | $822,000,000 | 2% |
| **Public Health:** Works to improve care and lower health care costs by preventing leading causes of death, disease and injury | $1,353,000,000 | 4% |
| *Children's Services: Adolescent and School Health Program, Babies First! Program, Early Hearing Detection and Intervention, Family Connects Oregon, HIV Care and Treatment Program, HIV Prevention Program, Lead Poisoning Prevention Program, Maternal and Child Health Section, Newborn Screening Program, Nurse-Family Partnership Program, Oral Health Unit, Oregon Emergency Medical Systems for Children, Oregon Immunization Program, Oregon MothersCare Program, Injury and Violence Prevention, Oregon Reproductive Health Program, Oregon WIC Program, Program Design and Evaluation Services, Sexually Transmitted Disease Program, Tobacco Prevention and Education Program, Toxic-Free Kids Program, Tuberculosis Program* | *$447,754,646* | -- |
| **Oregon Educators Benefit Board:** Benefit plan administrator for school districts, education service districts and community colleges | $1,994,000,000 | 6% |
| **Public Employees Benefit Board:** Benefit plan administrator for public employees | $2,488,000,000 | 7% |
| **Total** | **$34,500,000,000** | |

*Table 11.4. Oregon Developmental Disabilities Services Office funding allocation from the 2023-2025 biennium*[404]

| Allocation | Amount | % |
|---|---|---|
| **Intellectual/Developmental Disabilities Program Services:** In-home supports, including professional behavior services, assistive technology, environmental modifications and access to PSWs/DSPs | $4,253,200,000 | 85% |
| **Intellectual/Developmental Disabilities Program Delivery:** Unknown | $100,000 | <1% |
| **Stabilization and Crisis Unit (SACU):** 24-hour residential treatment for people with I/DD whose behavioral and medical needs are not able to be met in other settings | $171,200,000 | 3% |
| **Children's Residential Services and Children's Intensive In-Home Services (CCIS):** Residential services for individuals that can no longer remain at home, including those provided at group homes and foster homes; CCIS provides intensive supports to children living at home who have behavioral health challenges, medical conditions or intense medical needs that would otherwise require facility-based care | $12,100,000 | <1% |
| **Community Developmental Disability Programs (CDDPs) – Brokerages – Regional Crisis**: CDDPs are responsible for eligibility determinations, investigations, foster care licensing and reviews; brokerages provide case management services | $430,800,000 | 9% |
| **DD Council:** Governor-appointed council that works toward systemic change, capacity building and advocacy activities (DD Council) | $2,100,000 | <1% |
| **Program Design Support and Operations:** Centralized administrative support that includes strategic planning, policy development, oversight and technical support | $135,300,000 | 3% |
| **Total** | **$5,004,800,000** | |

*Table 11.5. Child Welfare funding allocation from the 2023-2025 biennium*[404]

| Allocation | Amount | % |
|---|---|---|
| **Program Delivery:** Regional offices that provide clinical and case-level services/supervision, support family stability, coordinate with other child-serving systems through the SOC | $682,300,000 | 43% |
| **Program Design:** Leadership, guidance and centralized administrative support to program delivery staff, includes developing policy/rules, monitoring quality assurance, providing technical assistance, designing training and workforce resources, identifying best practices in service delivery | $196,300,000 | 12% |
| **Child Safety Program:** Protective and social services following reports of child maltreatment, includes Child Protective Services (CPS) and the Oregon Child Abuse Hotline | $102,700,000 | 7% |
| **Well-being Program:** Services for youth in out-of-home placement, including the recruitment, certification and training of foster families and other staff in out-of-home care | $368,200,000 | 23% |

| | | |
|---|---|---|
| **Permanency:** Services and supports with the goal of reunification, includes working with parents to meet goals so that children can remain at home or return home | $241,100,000 | 15% |
| **Total** | **$1,590,600,000** | |

*Table 11.6. Oregon Youth Authority funding allocation from the 2023-2025 biennium*[405]

| Allocation | Amount | % |
|---|---|---|
| **Facility Services:** Direct operating costs, services and programming for youth correctional facilities and youth transition facilities, includes health care for all youth in custody | $200,845,428 | (42%) |
| **Community Services:** Individualized treatment and support services, community-based services (like parole and probation), out-of-home placements (like residential services and OYA foster care), youth gang services and juvenile crime prevention and diversion | $166,494,246 | (35%) |
| **Program Support:** Direct operating costs, business support, research and data analysis, diversity, equity and inclusion, construction and maintenance, data processing, IT professional services, etc. | $81,727,895 | (17%) |
| **Other:** Debt service, facilities, capital improvements and construction, etc. | $25, 726, 293 | (5%) |
| **Total** | **$474,793,869** | |

## Where are there gaps in resource allocation? What programs are underfunded?

To better understand where there may be gaps in resource allocation, national comparisons on spending are presented. The Secretary of State audits referenced in the previous question provide additional information on program-specific gaps.

### *Oregon Department of Education*

The Education Data Initiative reports that Oregon ranks 15th out of 51 states in dollars spent per student in K-12 (Figure 11.3).[416] Another study compared each state on 32 key metrics (including graduation rates, dropout rates, test scores, bullying incidence rates and other quality/safety indicators) and found that Oregon ranks 45th out of 51 in outcomes.[417] The researchers determined that Oregon is a "High Spending & Weak School System" state (Figure 11.4).

*Figure 11.3. K-12 spending per student, from the Education Data Initiative*[416]

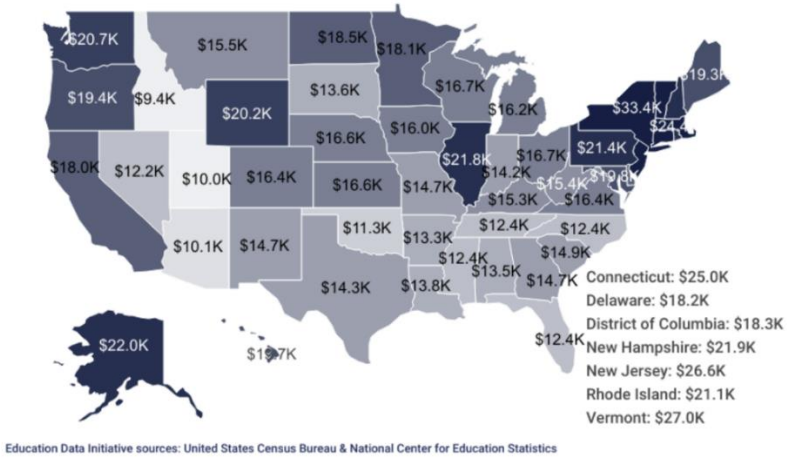
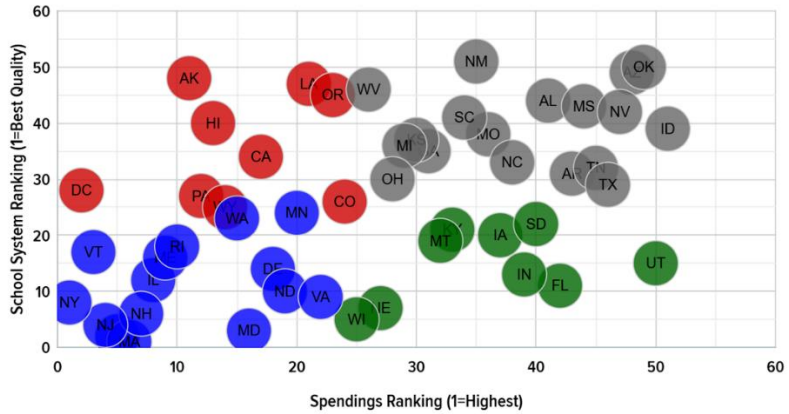



*Figure 11.4. Spending ranking by school system ranking by state, from WalletHub*[417]




High Spending & Weak School System

High Spending & Strong School System

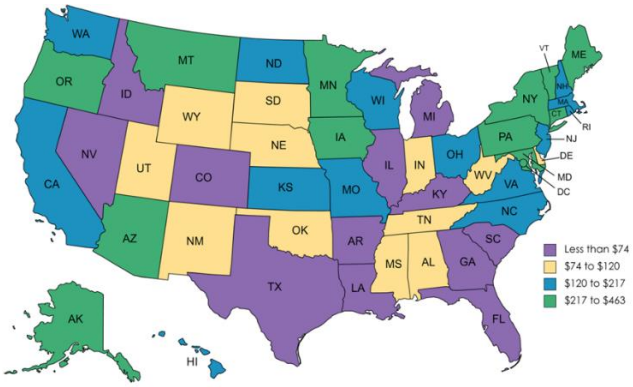
Low Spending & Weak School System

Low Spending & Strong School System

### *Oregon Health Authority*

Data on total behavioral health expenditures for youth compared to other states was not available. For all ages, the National Association of State Mental Health Program Directors Research Institute (NRI) reports that Oregon spends more per capita (lifespan) on behavioral health than most other states (Figure 11.5).[418] Please see the Behavioral Health Care System chapter for details on performance.

*Figure 11.5. State mental health funding per individual (all ages), from the National Association of State Mental Health Program Directors Research Institute*[418]



### *Office of Developmental Disability Services*

The University of Kansas leads the State of the States in Intellectual and Developmental Disabilities Project, which reports overall fiscal effort (spending) as a proxy for measuring states' commitment to people with I/DD.[419] Overall, Oregon has higher rates of fiscal effort, particularly for community-based efforts, than what is observed nationally.[419] The most recent data from 2019 shows that Oregon serves a much higher percentage of the state's population (17.6%) compared to the United States as a whole (8.5%).[419] Additionally, Medicaid dollars make up a much smaller portion of the state's overall I/DD spending (28.4%) compared to the United States (55.2%).[419]

### *Child Welfare*

Data prepared by ChildTrends indicates that Oregon invests more in child welfare and receives more in federal funding than other states with similar population sizes (Table 11.7).[420] Details about child welfare outcomes can be found in the Child Welfare System chapter of this report.

*Table 11.7. FY 2020 annual funding estimates*[420]

| State | Population in 2020 | Federal Spending | State Spending | Total |
|---|---|---|---|---|
| Alabama | 5,024,279 | $144 million | $137 million | $281 million |
| Louisiana | 4,657,757 | $166 million | $88 million | $260 million |
| Kentucky | 4,505,836 | $238 million | $360 million | $612 million |
| **Oregon** | **4,237,256** | **$247 million** | **$415 million** | **$666 million** |
| Oklahoma | 3,959,353 | $221 million | $200 million | $426 million |
| Connecticut | 3,605,944 | $388 million | $416 million | $807 million |
| Utah | 3,271,616 | $92 million | $129 million | $227 million |

**Funding estimates may not add up due to rounding error.*

### *Oregon Youth Authority*

Investments and expenditures in the juvenile justice system are less straightforward to interpret than investments in some youth-serving systems. Available data identifies that the cost to incarcerate one youth in Oregon is approximately $96,000 per year, which is less than most other states (Oregon ranks 13th out of 46 reporting states, with lower rankings equaling lower spending).[421] Oregon's incarceration costs have increased by 17% between 2014 and 2020, a lower rate of increase than many other states (Figure 11.6).

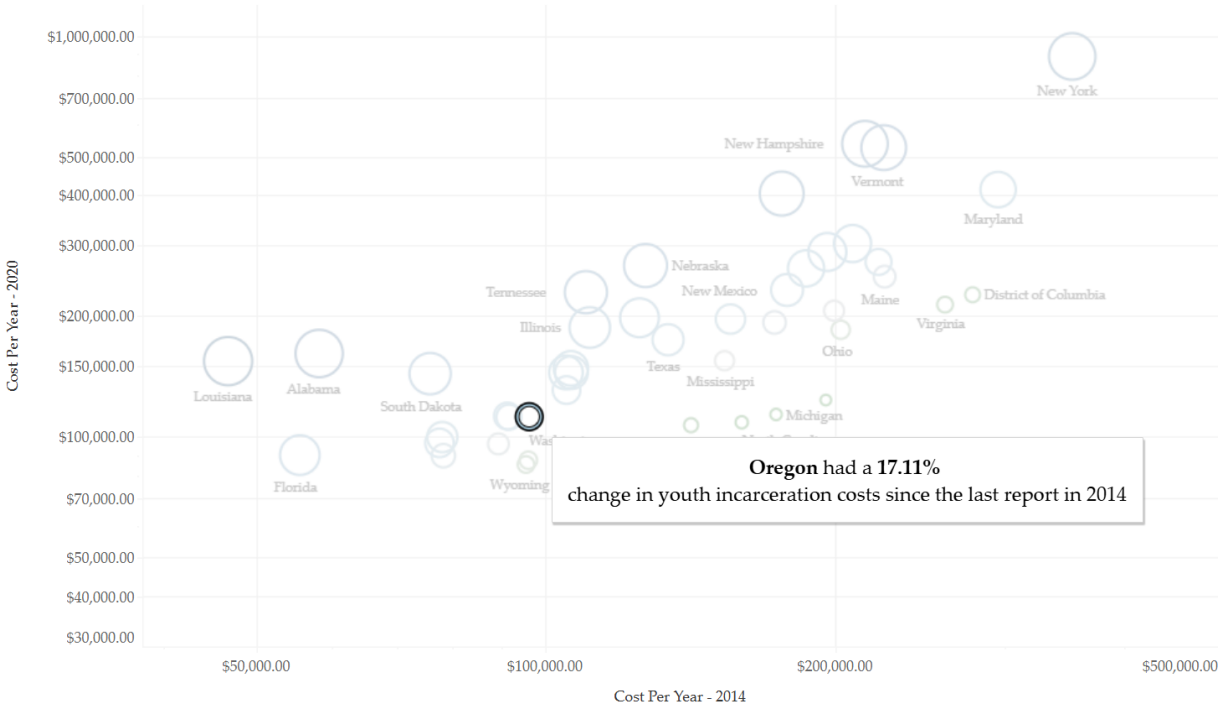
The Justice Policy Institute reports that increased costs can be attributed to both positive and negative attributes of the system[421]:

- States with fewer treatment and rehabilitation services have lower costs
- States that have private or non-unionized facilities have lower costs

- States that have few, but full, facilities (instead of states with many facilities without full occupancy) have lower costs

Please see the Juvenile Justice System chapter of this report for data on outcomes.

*Figure 11.6. Costs associated with incarceration from 2014 to 2020, from the Justice Policy Institute*[421]



## CHAPTER INTRODUCTION

Data from the National Survey of Children's Health indicates that overall, more Oregon families feel their youth receive care in a well-functioning system compared to the national average (Table 12.1). This is defined as the "family feels like a partner in their child's care, child has a medical home, child receives medical and dental prevention care, child has adequate insurance, and child has no unmet need or barriers to access services."[18] This indicator is not specific to the agencies outlined in this report and instead reflects feedback regarding families' experiences with the overall health care system. **While Oregon's rates are higher than the United States as a whole, rates are still low.**

*Table 12.1. Percentage of youth receiving care in a well-functioning system, 2022-2023*[18]

| | Oregon | United States |
|---|---|---|
| Age | % | % |
| 0 to 5 | 28.4% | 22.3% |
| 6 to 11 | 26.3% | 25.7% |
| 12 to 17 | 7.0% | 5.0% |

## KEY TAKEAWAYS

There are various mechanisms for feedback in the system of care. In particular, the education, physical health and behavioral health systems have large-scale feedback surveys with publicly available results, which promote accountability and transparency. The intellectual and developmental disabilities system, child welfare system and juvenile justice system have internal processes for collecting feedback, but data is less publicly available.

Youth and families report mixed experiences with the system of care. Common themes include barriers in navigating the complex system and obtaining needed services and supports. Youth and families also experience discrimination in the system of care to varying degrees.

Each system has laws and regulations related to providing linguistic and culturally appropriate services. These rules often require organizations to provide these services for all youth that need them, though there is very little data available on compliance.

Agencies report that trauma-informed practices are widely implemented across the organization. While there is limited quantitative data to substantiate the provision of trauma-informed care, qualitative feedback shared by families illuminates gaps.

> **Our family's experience is far from unique. Oregon's mental health care system, plagued by an alarming lack of funding and a disjointed approach, leaves children and teens slipping through the cracks, often landing in the juvenile justice system or other unsuitable placements because psychiatric resources are nonexistent. We've reached out to every possible avenue, including state senators, the governor's office and the media, but we are met with silence. Oregon's leaders appear content to let the system remain broken, all while families suffer.**
>
> *– Parent describing their experience with the system of care*[5]

**How is each system collecting youth and family experience and feedback data? How is feedback guiding service provision? Are there some groups of people who are underrepresented in feedback? What is the youth and family experience of the system? How does system experience vary by group?**

***Education System***

The Student Educational Equity Development Survey (SEED) is an annual survey that evaluates the educational experiences of grades 3-11 Oregon students. The survey assesses four domains:

- Access to learning resources
- Opportunity to learn
- Self-efficacy
- Sense of belonging

The SEED survey was optional until the 2023-2024 school year, when it became mandatory that schools make the survey available to all students. The survey is available in English, Spanish, Russian, Vietnamese, Mandarin, Cantonese and Ukrainian. Students in kindergarten, first, second and 12th grades are not eligible to complete the survey; thus, their feedback is not represented in results. ODE offers resources (including monthly drop-in sessions) to help support educators and administrators in using survey results to "make strategic modifications to curriculum, instruction, and para-academic supports that they offer students."[423] Select results from the SEED survey are presented in the Education System chapter.

ODE also collects feedback through emails and letters at the Office of the Deputy Superintendent.[424] Complaints can also be filed and submitted through ODE's website.[424]

### *Physical Health Care System*

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program evaluates the experience of individuals with Medicaid.[426] Survey data is used to track progress on several state quality measures. Their child-specific surveys ask questions related to communication, access to care, care coordination and more. The sampling methodology includes actively recruiting youth with chronic conditions in addition to the general population of Medicaid youth. The survey also oversamples certain racial and ethnic groups to ensure adequate representation. However, it is important to note that overall response rates on this survey are around 15%.

In general, individuals are satisfied with services received through the Oregon Health Plan (Table 12.2).[426] The only metric that has consistently lower rates of parents/caregivers expressing satisfaction is *access to specialized services* for youth with chronic conditions. *Coordination of care* for this group is also lower than the global rating for all youth.

*Table 12.2. Patient experience measures, table adapted from the Consumer Assessment of Healthcare Providers and Systems State Banner Books*[426]

| | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| Indicator and Percentage of Respondents Selecting "Always" or "Usually" | % | % | % | % |
| Getting needed care: Easy to get needed care and see specialists | 82.0% | 82.7% | 80.2% | 77.7% |
| Getting care quickly: Getting urgent and routine care as soon as it's needed | 88.7% | 88.5% | 86.0% | 84.2% |
| How well doctors communicate: Provider explains things, listens carefully, shows respect, spends enough time | 94.6% | 94.6% | 93.9% | 93.4% |
| Customer service: Provides needed information and treats individuals with courtesy and respect | 88.8% | 87.8% | 86.3% | 89.6% |
| Coordination of care | 82.4% | 87.0% | 82.9% | 82.5% |
| Children with Chronic Conditions | | | | |
| Access to prescription medication | 88.3% | 89.5% | 85.7% | 86.9% |
| Access to specialized services | 69.4% | 68.2% | 66.8% | 65.6% |
| Getting needed information | 91.3% | 90.9% | 89.3% | 89.3% |
| Personal doctor who knows child | 89.8% | 89.6% | 88.1% | 87.1% |
| Coordination of care | 77.9% | 75.9% | 75.1% | 74.3% |

### *Behavioral Health System*

The Mental Health Statistics Improvement Program Survey (MHSIP) collects feedback about the quality and efficiency of mental health services for individuals with Medicaid.[215] Two surveys in particular, the Youth Services Survey (YSS) and the Youth Services Survey for Families (YSSF), help to assess the experience of youth being served by the behavioral health

system. The YSS is administered to individuals ages 14 to 17, whereas the YSSF is administered to caregivers of youth ages 0 to 17[215]; data is not collected directly from youth under 14 years of age. Survey demographic data suggests that all racial/ethnic groups and genders are represented in results. In terms of geographic representation, there are very few responses from youth living in *Frontier* designation counties. Statewide and CCO-level reports are available to the public. It is important to note that overall response rates on this survey are around 16-23%. Annual MHSIP results are reported to the federal government, which is a requirement to receive special block grant funds that help pay for non-Medicaid community mental health services.

> **Families need to be able to share their experiences openly and honestly without worrying there will be repercussions if they need services again.**
>
> *– Parent describing their experience with the system of care[268]*

The MHSIP surveys assess six domains[215]:

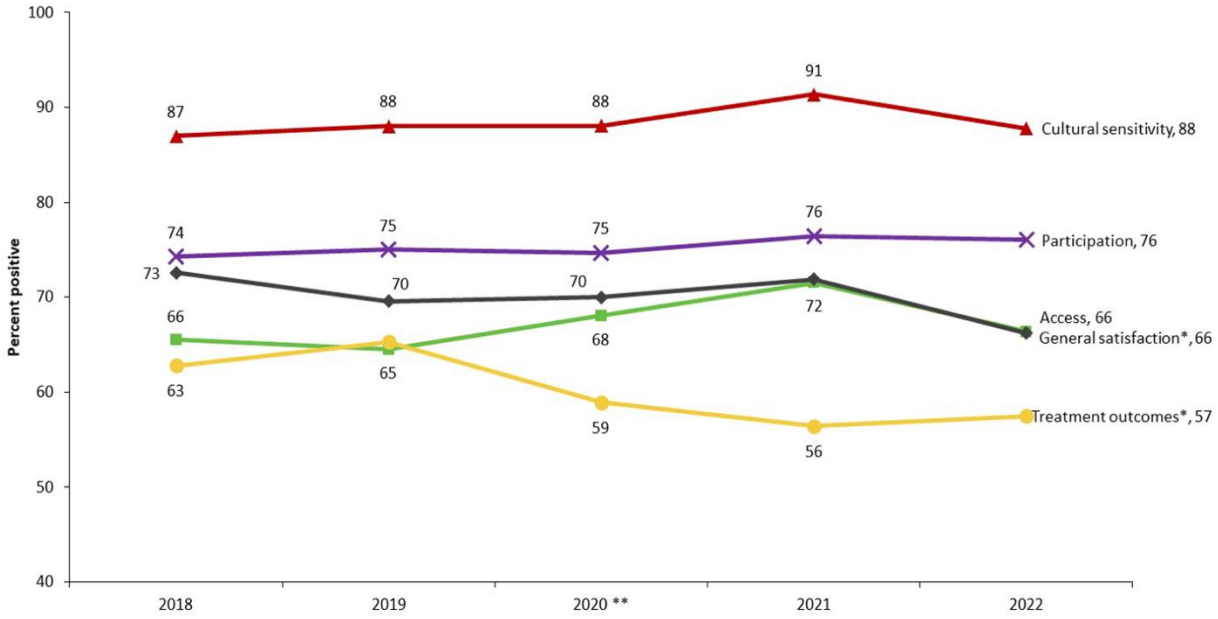
- **Access:** Obtaining services at a convenient time and location.
- **Cultural Sensitivity:** Feeling like providers respect and are sensitive to cultural and ethnic backgrounds.
- **Daily Functioning (YSSF only):** Experiencing improvement in day-to-day functioning.
- **General Satisfaction:** Receiving the help that was needed and feeling satisfied with services.
- **Participation:** Having choice in services, goals and treatment.
- **Treatment Outcomes:** Observing improvement and feeling satisfied with progress made.
- **Social Connectedness (YSFF only)**: Having a support network and social connection.

For both the YSS and YSSF, the Cultural Sensitivity and Participation domains were highly rated, and Treatment Outcomes were poorly rated (Figure 12.1).

Trends by demographic group from the 2022 YSS survey (n = 687) are presented below (no differences by race or ethnicity were observed)[215]:

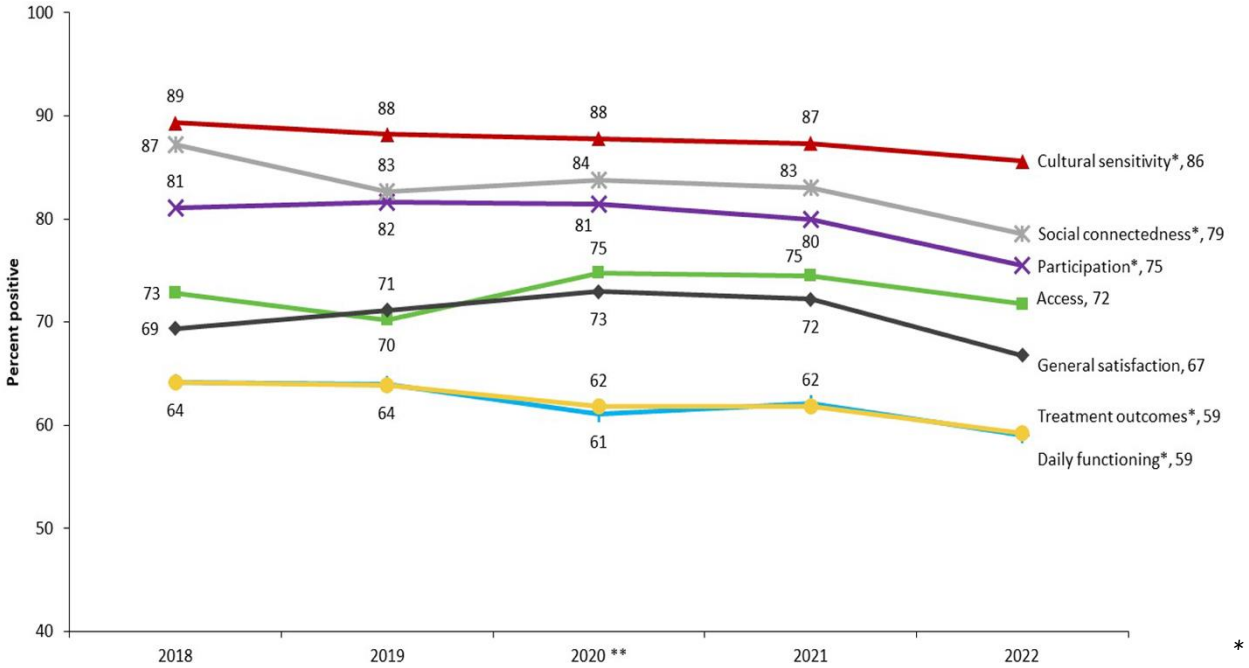
- **Access:** Youth in residential or day treatment programs were less satisfied than youth receiving outpatient services.
- **Cultural Sensitivity:** Males were less satisfied than all other genders.
- **General Satisfaction:** Youth in residential or day treatment programs were less satisfied than youth receiving outpatient services.
- **Participation:** Youth ages 14-15 were less satisfied than youth ages 16-17; male youth were less satisfied than all other genders, youth in residential or day treatment programs were less satisfied than youth receiving outpatient services.
- **Treatment Outcomes:** Females have had a downward trend in satisfaction over time while other genders remain stable; youth in urban areas have had a downward trend in satisfaction over time while youth in rural areas have not; youth in outpatient care have had a downward trend in satisfaction.

*Figure 12.1. Youth Services Survey (completed by youth ages 14 to 17) Domain Satisfaction Trends, from Comagine Health*[427]




**Indicates a statistically significant upward or downward trend (p <= 0.05) over the last five years for that domain.*
***2020 results include respondents from provider types who were not included in other survey years. Responses from these provider types were minimal (2.3%), but care should be taken when interpreting trending.*

*Figure 12.2. Youth Services Survey for Families (completed by caregivers of youth ages 0 to 17) Domain Satisfaction Trends, from Comagine Health*[427]




**Indicates a statistically significant upward or downward trend (p <= 0.05) over the last five years for that domain.*
***2020 results include respondents from provider types who were not included in other survey years. Responses from these provider types were minimal (2.3%), but care should be taken when interpreting trending.*

Trends by demographic group from the 2022 YSSF survey (n = 1,838) include[427]:

- **Access:** Hispanic caregivers and caregivers whose primary language was Spanish had higher rates of satisfaction than other groups.
- **Cultural Sensitivity:** Caregivers of youth who selected "other" for gender and youth ages 13 to 17 had lower rates of satisfaction than other groups; caregivers of Black / African American youth and White youth had a significant downward trend in satisfaction from 2018 to 2022.
- **Daily Functioning:** Caregivers in urban areas and caregivers of youth receiving outpatient services have had a significant downward trend in satisfaction.
- **General Satisfaction:** Caregivers of youth ages 13 to 17 showed a downward trend in satisfaction from 2018 to 2022 and were in general less satisfied than caregivers of youth ages 0 to 12.
- **Treatment Outcomes:** Spanish-speaking caregivers had higher satisfaction rates that English-speaking caregivers.
- **Participation:** Caregivers of male youth and youth in residential services were more satisfied than other groups; caregivers of youth ages 13 to 17 were less satisfied that caregivers of youth ages 0 to 12.
- **Social Connectedness:** Caregivers of Hispanic youth were less satisfied than other groups.

OHA also collects data through their Ombuds program, which is required in Oregon statute.[428] This program collects OHP member feedback data related to access to care and quality of care. Quarterly reports with data and recommendations are provided to the Governor, OHA Director and the Oregon Health Policy Board. From 2020 to 2023, there were 126 complaints received for individuals ages 0 to 26.[371]

### *Intellectual and Developmental Disabilities System*

ODDS collects client experience and feedback data through quality assurance audits and client interviews, National Core Indicators, advisory groups and community listening sessions, the first of which was held in Fall 2023.

The National Core Indicators – Intellectual and Developmental Disabilities (NCI-IDD) Child and Family Survey collects data on the experiences and satisfaction of families with children who have intellectual and developmental disabilities (I/DD). The survey includes data from nine states including Oregon. The survey examines the quality of services and supports that children with I/DD receive, focusing on areas like access to health care, educational opportunities and participation in community activities. It also looks at the safety and well-being of the children, as well as how effectively families are supported in their caregiving roles. The goal of the survey is to gather information that can help improve services for children with I/DD and their families, ensuring they receive the support needed to thrive.[280]

In addition to the NCI-IDD survey results presented in the Intellectual and Developmental Disabilities System chapter, the most recent survey had several positive findings related to family experience[280]:

- Oregon parents are more likely to feel like services and supports have made a positive difference in their child's life (96%) than the national average (93%).
- Oregon parents are more likely to feel that family supports have improved their ability to care for their child (92%) compared to the national average (90%).
- A large majority of Oregon parents feel like services and supports help their child live a good life (95%), which is similar to the national average (94%).

A 2021 audit completed by the Oregon Secretary of State evaluated the state's approach to managing services for individuals with I/DD. The audit focuses on the state's I/DD system, examining areas such as the delivery of services, the management of funding and the effectiveness of programs designed to support people with I/DD.[429] The audit found that while Oregon provides essential services for people with I/DD, there are areas for improvement in terms of accessibility, efficiency and oversight. The audit highlights challenges such as delays in service delivery, inadequate coordination and inconsistent quality of care. Feedback from families of individuals with I/DD reflects these concerns, with families expressing frustration over service delays, difficulties accessing appropriate care and challenges navigating the system. They also highlighted the need for better communication and coordination and more reliable information about available resources. The report offers recommendations for improving the system, including better resource allocation, enhanced service delivery and improved accountability, with the goal of addressing these concerns and ensuring better outcomes for individuals with I/DD and their families.

In 2017, ODDS created a quality improvement unit to enhance I/DD services. This unit manages quality assurance activities, such as conducting regular reviews of brokerages and Community Developmental Disabilities Programs (CDDPs), overseeing licensing and working with abuse investigators and safety offices. It also sets quality metrics for I/DD programs and gathers data to evaluate performance and guide policy decisions.[404]

***Child Welfare System***

Child Welfare collects direct feedback from individuals through a resource home exit survey and certified provider survey. Their vision for transformation also discusses inclusion of community and lived experiences. Many of Child Welfare's advisory groups (such as the Continuous Quality Improvement Advisory Group) includes community members and individuals with lived experience. Their goal is to center equity in the use of data and action plans.

Child Welfare also tracks several federal metrics related to youth experience in foster care, including maltreatment and placement stability. These are presented in the Child Welfare chapter.

### *Juvenile Justice*

The juvenile justice system gathers client feedback information through the Performance-based Standards (PbS) for Juvenile Systems.[430] Youth, staff and families are surveyed biannually, with the responses being compiled and analyzed along with administrative information such as unusual incidents and services offered by the facility. Data from PbS was not able to be obtained within the time frame of this assessment.

### *System of Care*

In addition to system-specific efforts, the System of Care Advisory Council (SOCAC) collects feedback through several mechanisms.

#### Oregon SOC Barrier Reports

The Oregon SOC Barrier Reports describe all the barriers that youth and families have brought forward to their regional SOC. An analysis of these reports found that "families have mental/behavioral needs that may go unaddressed due to the lack of services or services providers, or due to obstacles in accessing the services."[431] Barriers include Oregon not having enough behavioral health providers, issues with referral and approval processes, limited intensity and frequency of services, and transportation challenges.

Additionally, systemwide administrative issues were identified as having "either facilitated or hindered processes including system navigation, timing needed for approval of services and care plans, and administrative paperwork."[431] At times, "these processes and systems presented as barriers to successful services access."[431] Barriers impact the system's ability to effectively communicate, coordinate and collaborate, which in turn impacts the family experience.[431]

> **Everything seems siloed. There needs to be some attempt from people within the system to show they are working with us. We're not on opposing teams, and that's what I felt a lot. We were competing teams as opposed to working together to try to achieve something.**
>
> *– Parent describing their experience with the system of care*[5]

#### Youth and Family Engagement Focus Groups

SOCAC also actively engages with specific cultural groups to gather feedback and user experience information. A series of mini-grant engagement efforts found that many people are unaware of the SOC's role in addressing the needs of families.[432-437] Focus groups led by Jackson Street Youth Services found that youth who are homeless or at risk of homelessness "were surprised to find out that there was a system in place to support them [the Oregon System of Care]… even though they reported being served by multiple agencies that are a part of the System

of Care."[433] Youth reported that transportation issues, lack of services in rural areas, lack of communication with families and lack of communication across agencies were barriers in accessing care.

### *SOCAC Youth Survey*

As part of this report's data gathering process, SOCAC partnered with the Oregon School-Based Health Alliance (OSBHA) to gather feedback from youth involved with the SOC. The survey was available in English, Spanish, Vietnamese and Simplified Chinese. The ages of participating youth were 59% under 18 years old and 41% over 18 years old.[438] The most popular county of residence was Lane County (42%)[438], but only four counties had more than five respondents. Half of the respondents identified as a girl or woman, and 21 identified as a boy or man (other participants identified as either nonbinary, Genderfluid, chose not to answer, transgender male, questioning/exploring, Genderqueer, Demigirl or did not know).[438] Youth reported their sexual orientation as straight or heterosexual (44%), bisexual (23%) or pansexual (14%). Of the 70 youth who answered, 47% reported having a disability or a physical, mental, emotional, cognitive or intellectual condition.[438] Race and ethnicity data are not reported due to small number counts, but 14 distinct racial/ethnic identities were selected.

Youth commonly reported the following reasons for SOC involvement[438]:

- Mental health (78%)
- Trauma (45%)
- Difficulties in school (40%)
- I/DD (37%)
- Suicidal ideation (35%)

Around one-third (32%) of youth reported feeling discouraged, discriminated against or experienced added barriers to getting what they need. There were 25 open-ended responses indicating services received and challenges faced. The following themes emerged[438]:

- Unhelpful services (36%)
- Wait times (20%)
- Obtaining diagnosis (12%)
- Complex needs (12%)
- Symptoms (12%)
- Costs (12%)
- Not taken seriously (12%)
- Physical access (4%)
- Parent/guardian support (4%)
- Discrimination (4%)

Outside of formal support, over 50% of youth described seeking informal emotional and peer support. Support was most commonly obtained from friends (85%), family (72%) or a partner (45%). Most youth (93%) rated their natural supports as "very" or "somewhat" helpful.[438]

OHSU Parent/Caregiver Survey

OHSU surveyed parents and caregivers about their experience in the SOC (see Methods chapter for more information). Data for the education, behavioral health, I/DD and physical health care systems is presented. Inadequate representation from the juvenile justice system was obtained, and data is not provided to protect privacy. Parents reported varying experiences with each system (Figure 12.3, Figure 12.4)[5]:

- **Education System:** Less than half (40%) have had an overall positive experience and one-third (34%) reported their youth received the help they needed from the system.
- **Physical Health Care System:** Most (78%) have had an overall positive experience and almost two-thirds (62%) reported their youth received the help they needed from the system.
- **Behavioral Health Care System:** Overall ratings of the system were almost equally split between positive, neutral and negative and slightly more than one-third (38%) reported their youth received the help they needed from the system.
- **I/DD System:** A majority (70%) of families had a positive experience with the system and around a third (36%) reported their youth received the help they needed from the system.
- **Child Welfare System:** A majority (64%) of families had a positive experience and a majority (64%) reported their youth received the help they needed from the system.

*Figure 12.3. Overall experience of the system of care, as reported by parents/caregivers on the OHSU Parent/Caregiver Survey[5]*

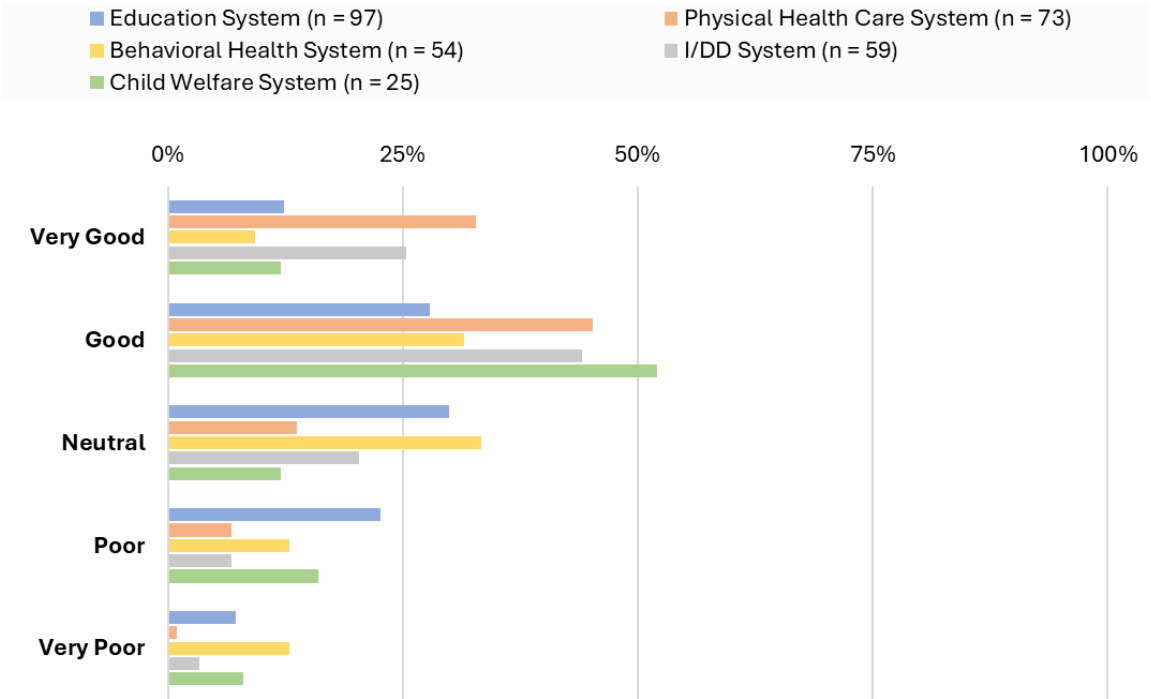
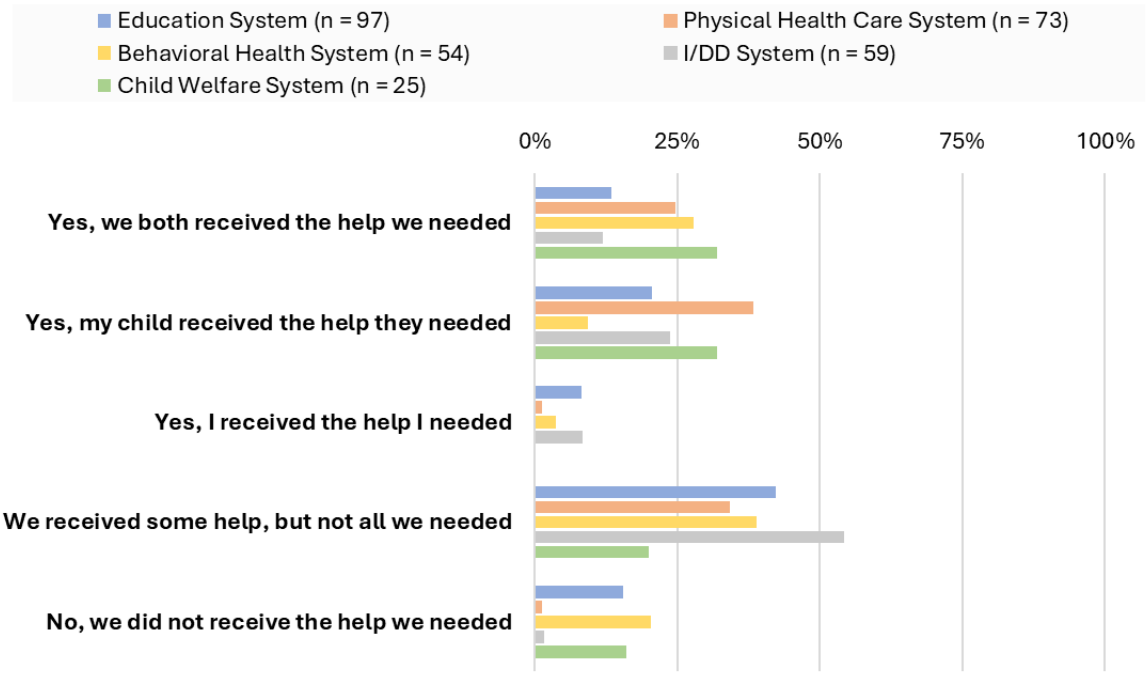


*Figure 12.4. Help received by the system of care, as reported by parents/caregivers on the OHSU Parent/Caregiver Survey*[5]




When asked to share more about their experiences, parents often described the following as contributing to their experiences[5]:

- **Education System:** Barriers to receiving special education services and a need for the parent to strongly advocate for their child to receive the accommodations and services they need.
- **Physical Health Care System:** High-quality primary care providers filling in the gaps for specialty or behavioral health care.
- **Behavioral Health System:** Shortage of qualified providers who have the experience and availability to treat complex youth and the overall limited access to mental health services across the continuum.
- **I/DD System:** Barriers to getting into the system (although once in, services are helpful) and high rates of turnover/lack of experience among I/DD case managers.
- **Child Welfare System:** Traumatic experiences related to working with Child Welfare and a lack of resources to address youth mental health challenges.

In addition to the online survey, 24 parents participated in interviews to discuss their experience with the system of care. Due to the recruitment methodology and small sample size, these results may not be generalizable to all families in the SOC (see Methods chapter for more information).

When asked about what is working well in the system, responses varied greatly and were specific to each individual experience; no common themes emerged. A positive experience appeared dependent on the individual providers that the family worked with. However, when asked what parents say needs to be improved in the system, one clear theme emerged: **accessing services, supports and care is a difficult, convoluted process across all systems**.[5] Common issues included[5]:

- A lack of transparency around program/service eligibility
- Unclear pathways into care
- Inadequate coverage for certain services, specifically for complex or high-needs youth
- Poor communication within and across systems
- A concern that parents must be knowledgeable and savvy to successfully navigate the system

> **No child should have their education disrupted this way, and no family should feel this level of helplessness in accessing basic mental health or educational support.**
>
> *– Parent describing their experience with the education system*[5]
>
> **Our children have, at times, received more support for their behavioral health needs from their primary care physician than from the mental health and behavioral health services specifically designated to address those needs. This gap highlights a critical flaw in the system, where those intended to provide specialized care often fall short, leaving primary care physicians to fill in the gaps.**
>
> *– Parent describing their experience with the physical health care system*[5]
>
> **In our area, we have had a difficult time with pediatricians who do not understand complex disabilities or complex medical needs, especially when it comes to support and equipment.**
>
> *– Parent describing their experience with the physical health care system*[5]
>
> **My child has received stellar care in all medical settings, including the hospital.**
>
> *– Parent describing their experience with the physical health care system*[5]

**Across systems I feel like there is an overall gap in the understanding of trauma and the effect it has on youth and families. In the rural and frontier communities, there is a culture that is not conducive to healing. I also noticed a lack of providers who were qualified to meet the needs of youth. It has taken some time to find qualified providers and the path to do so has inflicted trauma and compounded existing trauma.**

*– Parent describing their experience with the behavioral health care system*[5]

**Having ODDS has been a huge help to my child and me. Being able to have someone who my child knows take care of him so I can provide for my family takes a huge weight off of me.**

*– Parent describing their experience with the I/DD system*[5]

**We had to jump through a lot of hoops to get what we needed at first, but after we got established, it began to get easier to get the things we needed.**

*– Parent describing their experience with the I/DD system*[5]

**In our experience, DHS child welfare is stretched thin and, as a result, too often focuses on protecting itself rather than safeguarding the rights and well-being of children and families within Oregon's broken system. Families like ours, who are already navigating immense challenges, should not be forced to contend with an agency that often adds to the burden rather than alleviating it.**

*– Parent describing their experience with the child welfare system*[5]

**How many youth experience racism or other forms of discrimination within each system? Are there groups more likely to experience racism or other forms of discrimination?**

> **The focus of this work is always on the mainstream… standards focus on the [dominant population]; anyone who falls out of this — Africans, African Americans, Asians — is seen as an outlier and we are trying to bring them to [so-called] normalized behavior […] That causes a lot of people to step back and not even want help from systems […] They have found ways to thrive and survive in their own communities.**
>
> *– Parent describing their experience in the SOC*
> *SOC Strategic Plan 2022-2025*

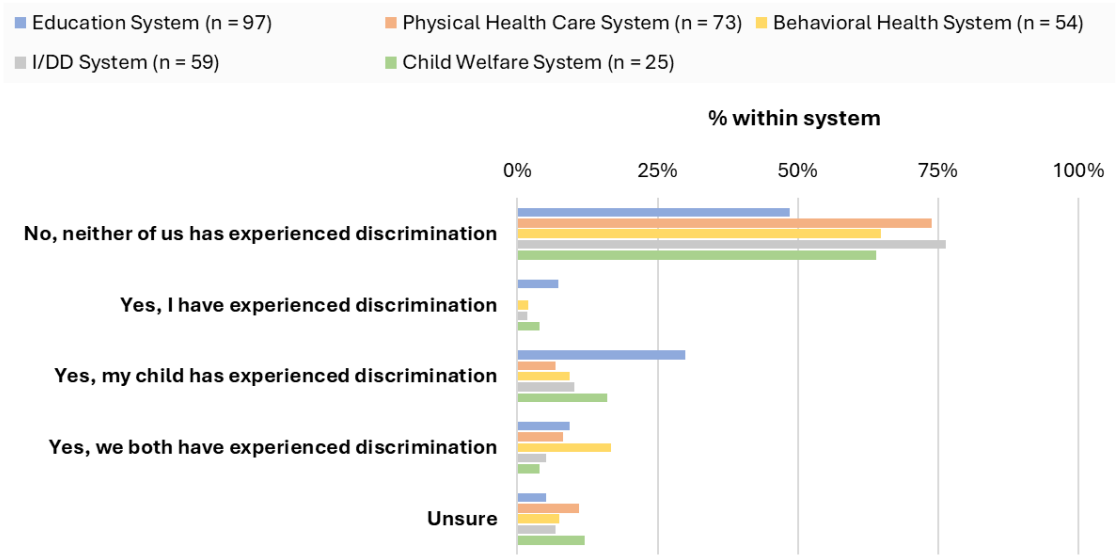
***OHSU Parent/Caregiver Survey***

OHSU collected parent/caregiver reports of discrimination within the SOC. Discrimination was defined as "being treated differently because of your race/ethnicity, economic status, sexual orientation, gender identity, disability, diagnosis, religion, primary language or other personal characteristics."[5]

Parents reported varying experiences with each system (Figure 12.5)[5]:

- **Education System:** Almost half (46%) reported experiencing some form of discrimination.
- **Physical Health Care System:** Most (75%) have not experienced discrimination.
- **Behavioral Health System:** Around a quarter (28%) of families reported experiencing some form of discrimination.
- **I/DD System:** Some (17%) of families have experienced some form of discrimination.
- **Child Welfare System:** Around a quarter (24%) of families have experienced some form of discrimination.

*Figure 12.5. Experience with discrimination in the system of care, as reported by parents/caregivers on the OHSU Parent/Caregiver Survey[5]*




### *Student Health Survey*

The SHS asked students about discriminatory experiences in school. Over 75% of students in grades 6, 8 and 11 reported that adults in their school respect people of different races, ethnicities, religions, genders and sexual orientation.[22] However, when asked if there is conflict or tension at their school based on racial, cultural, gender, religious and other identities, 31% of 11th graders, 32% of eighth graders and 22% of sixth graders agreed or strongly agreed.[22] Students were also asked about bullying based on identity (Table 12.3).

*Table 12.3. Bullying in schools based on personal identity, adapted from the 2022 Student Health Survey[22]*

| | Grade 6* | Grade 8 | Grade 11 |
|---|---|---|---|
| Reason for Bullying | % | % | % |
| Were not bullied | N/A | 64.7% | 75.3% |
| Bullied about race/ethnicity | N/A | 3.5% | 2.5% |
| Unwanted sexual comments or attention | N/A | 4.6% | 4.7% |
| Bullied about sexual orientation | N/A | 4.5% | 2.8% |
| Bullied about gender or gender identity | N/A | 3.3% | 1.9% |
| Bullied about a physical, mental or emotional disability | N/A | 3.6% | 2.2% |

**This question was not asked of 6th graders.*

**What types of cultural and linguistic services are in place in each system? Are there any cultures or languages that are not represented or lack resources?**

Cultural and linguistic services are crucial in the SOC. They strengthen effective communication and understanding between youth and families from diverse backgrounds and those providing services. This both improves the quality of services and supports the experience of youth and families.

***Education System***

Oregon Department of Education offers many cultural and linguistic services to youth.

Culturally Specific After School Learning Program (CSASL)[439]

The CSASL program provides culturally affirming after-school learning for students. It focuses on four pillars: addressing learning gaps with academic and mental health support, promoting cultural identity development, fostering leadership and self-advocacy skills, and strengthening community involvement through family-school partnerships.

Multilingual and Migrant Education (MME) Team[440]

The MME team supports multilingual and migrant students, including English learners in Title III programs, migrant students in Title I-C programs, refugee and newcomer immigrants, and students in dual language programs. The English Learner Initiative (Title III) helps non-native-speaking youth and youth lacking English proficiency achieve proficiency in English for academic success. In the 2023-2024 school year, there were an estimated 65,965 youth (12.2% of all students) in the English learner program.[152] The Migrant Education (Title I-C) program offers educational programs for migrant youth to mitigate disruptions and challenges; this involves ensuring equal educational opportunities and providing support. In 2019-2020, a total of 18,839 youth were eligible for services in Oregon, with 59% of them receiving services.[441]

Cultural Toolkits[442]

Workgroups composed of target communities create toolkits based on community needs; they include resources to celebrate cultures, traditions and foods. Toolkits are available for African heritage, Indigenous, Latinx and Pasifika populations.

Student Success Advisory Groups[443]

The Student Success Act established Student Success Advisory Groups (SSAGs) to improve education outcomes among marginalized student groups. Composed of impacted community members, SSAGs address systemic education inequities through strategic plans and investments. ODE currently convenes 6 SSAGS: American Indian / Alaskan Native Education Advisory Committee, African American / Black SSAG, Immigrant / Refugee SSAG, Latino/a/x and Indigenous SSAG, LGBTQ2SIA+ SSAG, and Native Hawaiian / Pacific Islander SSAG.

### *Behavioral Health*

National Culturally and Linguistically Appropriate Services (CLAS) standards "are intended to advance health equity, improve quality and help eliminate health care disparities by establishing a blueprint for health and health care organizations."[444] The standards are centered on equitable considerations through the entire health care structure, including leadership, the workforce and service delivery.[444] The full standards can be found on the Think Cultural Health[445] federal website.

In Oregon, Culturally and Linguistically Specific Services (CLSS) are providers, programs and organizations that provide care to minority populations and often include providers with lived experience in the communities they serve.[446] Interpretive services and/or direct care in non-English languages are available through this service. Per OHA, Medicaid-based data on CLSS is very poor quality and incomplete. CCOs often pay CLSS providers directly without routing information through OHA, so the state does not have an adequate monitoring mechanism for this service.

The 2023 CCO Metric Annual Report includes a *Meaningful Language Access* measure, which "assesses the percentage of visits for which a qualified and certified interpreter was provided to a sample of members who needed interpreter services."[183] Data for this measure includes all types of health care visits, not just behavioral health. In 2023, CCOs remained significantly below the goal benchmark of 75%, with only 10.7% of statewide visits receiving adequate interpretation services (Table 12.4).[183]

*Table 12.4. Percentage of audited cases meeting meaningful language access requirements, 2023*[183]

| Coordinated Care Organization | % of Audited Cases Meeting Language Access Requirement |
|---|---|
| Advanced Health | 6.1% |
| AllCare CCO | 0.0% |
| Cascade Health Alliance | 1.0% |
| Columbia Pacific CCO | 1.5% |
| Eastern Oregon CCO | 10.7% |
| Health Share of Oregon | 7.0% |
| InterCommunity Health Network | 2.0% |
| Jackson Care Connect | 4.1% |
| PacificSource: Central | 10.8% |
| PacificSource: Gorge | 21.3% |
| PacificSource: Lane | 20.7% |
| PacificSource: Marion/Polk | 15.6% |
| Trillium: North | 13.4% |
| Trillium: South | 6.6% |
| Umpqua Health Alliance | 4.1% |
| Yamhill Community Care | 9.9% |
| **Statewide** | **10.7%** |

An analysis of Oregon's SOC Barrier Reports found that "there are obstacles to services that are particular to those from vulnerable, high risk or marginalized populations."[431] In particular, migrant communities, rural communities, tribal communities, LGBTQ+ youth, youth with SUD and youth with sexualized behaviors have difficulties accessing culturally responsive services.

Please see the MHSIP results previously presented in this chapter for additional information about cultural responsiveness.

### *I/DD System*

All services provided by ODDS are designed to be responsive to cultural and linguistic needs. This ensures that, regardless of language, communication style, race, ethnicity, cultural background or citizenship status, individuals who qualify for ODDS services have the right to access them. The goal is to offer services that are person-centered, equitable, flexible and inclusive of the community, while honoring each person's unique vision for their life.[286] ODDS was unable to provide data on the agency's linguistic and cultural responsiveness.

### *Child Welfare System*

Child Welfare aims to be culturally responsive "by embracing the communities' lived experiences and the cultures of children and young adults in decision-making that affects their safety, health and well-being; as a result, delivering services aligned with the cultural context of children, young adults, family and community so they can live their lives with dignity, autonomy and equality."[53] The full list of initiatives related to culturally responsive care can be found in the Vision for Transformation.

Prospective resource parents, relative resource parents, pre-adoptive parents and guardians are required to complete training related to cultural responsiveness. Topics include educating the foster parents on the Indian Child Welfare Act (ICWA), parenting in racially and culturally diverse families and cultural humility.[447]

Child Welfare collects data on the number of children who are placed in resource homes with foster parents who are the same race/ethnicity as them. On average, around 68-70% of youth are placed with caretakers who are the same race/ethnicity.[45] Additionally, the agency collects data on language needs of youth in foster care, but this data was unable to be prepared and shared externally within the time frame of the report.

### *Juvenile Justice System*

The Oregon Judicial Branch is required to provide court-certified interpretive services to individuals who need them.[448]

The Oregon Juvenile Detention Facility Guidelines outline several rules related to providing handbooks, forms and other materials translated into languages spoken by youth in their facilities.[449] The guideline also state that facilities will have a "language plan to address how to allocate resources necessary to address the language needs of limited English-proficient youth and parents or caregivers."[449] The Juvenile Detention Education Program also offers educational services and appropriate curriculum to youth who have English learning needs. As part of their service array, the juvenile justice system also offers a cultural enrichment program that provides "services designed to enhance one's awareness of different cultural practices."[450] While data on this program is publicly available[324], juvenile justice leadership has advised the OHSU team to not include the data due to reporting inaccuracies.

OYA offers both multicultural and language services to youth and families through the Office of Inclusion and Intercultural Relations.[451]

Services offered include:

- OYA Translation and Interpretation Services
- Asian American and Pacific Islander Services
- African American Services
- Hispanic and Latinx Services
- LGBTQ+ Services
- Native American Services
- Tattoo Removal Services

**What trauma-informed practices are in place within each system? Are some groups receiving trauma-informed care over others?**

A trauma-informed approach incorporates an understanding of the widespread prevalence of trauma in individuals' lives. It helps those working within systems to better understand and respond to the needs of those who have experienced traumatic events, preventing further traumatization and improving their overall health and well-being. In 2017, the Oregon Legislature adopted House Concurrent Resolution 33, which called for implementation of trauma-informed practices among "employees of the State of Oregon and other individuals who interface directly with children and adults."[452] The resolution specifically called upon the State Board of Education, ODHS, OHA, OYA, the Office of Community Colleges and Workforce Development, the Department of Justice and the Department of Corrections to become trauma-informed. At an enterprise level, it is unclear how recommendations of this resolution have been implemented or evaluated, but agencies report global implementation of trauma-informed policy and procedure. Despite these commitments, youth and families report varying experiences. A brief overview of each agency's general approach to providing trauma-informed care and select youth and family quotes are presented.

> **"All I can say is professionals in Oregon need continuous learning about what disability truly entails and must listen to those who live these experiences daily. For us, this is one of the most dehumanizing and traumatizing aspects of the system. How many assessments must my child endure to be deemed worthy of support? Each one is othering, emotionally taxing and drains our energy. This process is deeply traumatizing for both children and their caregivers."**
>
> *– Parent describing their experience with the system of care*[5]

### *Education System*

ODE has adopted trauma-informed practices to create safe environments for all staff and students by recognizing the impact of trauma and the role schools play in fostering resilience. This includes identifying signs of trauma, incorporating trauma-informed strategies into policies and preventing re-traumatization while promoting resilience in both students and staff.[453]

In 2019, ODE concluded a pilot study that involved using trauma-informed school coordinators to share information and guide different school staff members.[454] Some strategies included hosting a full-day training related to trauma concepts and practices, trauma-informed changes to "curricula, attendance team activities, employee resources, improvement plans, and hiring policies."[454] One result from these efforts was increased partnership with youth and families. House Bill 2368 directs ODE to partner with OHA to continue their efforts related to trauma-informed practices in the public education system.[455]

### *Behavioral Health System*

OHA outlines several trauma-informed approaches on its website.[456] The agency advocates that all health care providers provide care that is consistent with trauma-informed principles and requires that all behavioral health contractors be trauma-informed in their service delivery. OHA also funds Trauma Informed Oregon, which trains and provides resources to providers across the state.[457]

> **When you walked in [to treatment facility], it felt very prison-like. Not a healing environment.**
>
> *– Parent describing their experience with psychiatric inpatient treatment*[26]

### *I/DD System and Child Welfare System*

ODDS and Child Welfare are housed within the broader Oregon Department of Human Services (ODHS). ODHS has a trauma-informed organizational policy that applies to both agencies. The policy states that ODHS adopts "an approach of presumed trauma," which means that they "engage all staff and service recipients on the presumption that they have experienced trauma."[458]

Additionally, Child Welfare outlines several approaches to achieving initiatives related to improving care for youth and families in their Vision for Transformation. The agency aims to "recognize the impact of trauma, including historical trauma, and promote a culture of safety, empowerment and healing."[53] The full list of initiatives can be found in the Vision for Transformation. The implementation of trauma-informed practices in child welfare is especially important considering the high rates of trauma among the population served (see Population Description and Child Welfare System chapters).

Prospective resource parents, relative resource parents, pre-adoptive parents and guardians are required to complete training related to trauma-informed care. Topics include educating the foster parents on trauma-related behaviors, trauma-informed parenting, separation, grief and loss.[447]

> **I wish there were more services set up for children in foster care like counseling for trauma.**
>
> *– Parent describing their experience with Child Welfare*[268]

***Juvenile Justice System***

While a trauma-informed approach is an expectation of all providers in the system of care, it is especially important considering the high rates of trauma in the juvenile justice population.[32] House Bill 2575 (enacted in 2021) directs the Department of Justice (DOJ) to fund training programs related to trauma-informed practices for law enforcement agencies and local governments.[459] DOJ has partnered with Trauma Informed Oregon to implement training programs across the state.[460]

OYA uses the Positive Human Development (PHD) and Developmental Approach to Parole and Probation (DAPP) to guide their work with youth in their custody.[461] Their practice guide outlines several trauma-informed best practices specific to working with juvenile offenders, including advocating for youth to be in the least restrictive setting whenever possible.[461]

## CHAPTER INTRODUCTION

Transforming the system of care (SOC) requires committed partnership, sustainable and adequate resources and an effective infrastructure. This chapter presents the results of a self-assessment about Oregon's SOC and its readiness for change. Some of the items assessed include structures and processes for system management, data management, quality improvement, interagency partnerships, youth and family partnerships, financing and workforce development.[1]

*Figure 13.1. Infrastructure elements assessed by the system of care, from the Institute for Innovation & Implementation*[1]

| Infrastructure Elements | |
|---|---|
| Point of accountability structures for SOC policy and for system management and oversight | Structure and/or process for outreach, information, and referral |
| Financing for SOC infrastructure, services, and supports | Extensive provider network for comprehensive service array |
| Structure and/or process to manage care and costs for high-need populations (e.g., care management entity, health home) | Structure and/or process for training, technical assistance, coaching, and workforce development |
| Structure and/or process for interagency partnerships/agreements | Structure and/or process for implementing and monitoring evidence-informed and promising interventions |
| Structure and/or process for integrating primary health and mental health care | Structure and/or process for achieving mental health equity and eliminating disparities in access, quality of services, and outcomes for diverse populations |
| Structure and/or process for partnerships with family organizations and/or family leaders | Structure and/or process for accountability and quality improvement, including measuring and monitoring service utilization, quality, outcomes, equity, and cost, including utilization of psychotropic medications |
| Structure and/or process for partnerships with youth organizations and/or youth leaders | Structure and/or process for strategic communications |
| Defined access/entry points to care | Structure and/or process for strategic planning and identifying and resolving barriers |

## KEY TAKEAWAYS

The System of Care Advisory Council's overall indicator score on the System Reform Support Instrument (SRSI) was 19% compared to the averaged regional systems of cares' score of 15%. Overall, the SRSI found that Oregon is not yet ready for system transformation and needs to continue building foundational elements for change.

The system of care struggles with clarity of messaging, communication gaps, meaningful youth and family engagement, and structural and system challenges.

## What is the system of care's readiness for change?

### *System of Care Self-Evaluation on Readiness to Change*

In 2023, Oregon's System of Care (SOC) completed a self-evaluation of the system's infrastructure using the System Reform Support Instrument (SRSI) developed by the University of Connecticut's Innovations Institute.[462] The SRSI assesses readiness for a modernized system by prioritizing indicators within four levels (policy, management, practice and community) and seven cross-cutting areas (leadership, financing, access and appropriate population, accountability, services and supports, workforce, collaboration and communication).

SRSI Levels

- **Policy** reforms establish the legal and regulatory framework that guides system operations.
- **Management** reforms ensure policies are translated into actionable plans, staff are trained and supported, and resources are managed efficiently.
- **Practice** reforms focus on interactions between service providers and youth and families served.
- **Community** changes foster collaboration and partnership among families, community organizations, service providers and systems.

The SRSI is intended to be used at three phases of system transformation: Pre-Implementation, Implementation and Sustainability. As this was Oregon's first use of the tool, the Pre-Implementation indicators were used. The Pre-Implementation phase focuses on foundational elements needed before system transformation can begin. Indicators were ranked as not implemented (0%), partially implemented (50%) or fully implemented (100%). Indicators were assessed through dialogue with system partners and documented processes and content.

In addition to the SOCAC, eight out of 15 regional SOCs participated in the SRSI process (Curry County, Coos County, Lane County, Columbia Gorge, Josephine County, Tri-County, Douglas County and Jackson County SOCs).[462] SOCAC's overall SRSI indicator score was 19% compared to the averaged regional SOC's score of 15%.[462] Overall, the SRSI found Oregon is not yet ready for system transformation and needs to continue building foundational elements for system transformation.[462]

Scores vary across the individual domains within the assessment. The following areas are most ready for system change (Table 13.1)[462]:

- **Policy: Leadership (Regional SOCs and SOCAC)**
  Clear vision, goals, leadership, partnerships and plans for system reform.
- **Management: Financing (SOCAC)**
  Financing structures that support ideal care pathways and nontraditional services and supports.
- **Community: Collaboration and Communication (Regional SOCs and SOCAC)**
  Input from stakeholders, plan for engagement and information sharing with the community.

The following areas are least ready for system change (Table 13.1)[462]:

- **Policy: Access and Appropriate Population (Regional SOCs and SOCAC)**
  Prioritization of getting families the right services and supports at the right time with the right intensity.
- **Management: Accountability (Regional SOCs and SOCAC)**
  Processes that track child-level outcomes and inform quality improvement and protect against conflicts of interest.
- **Practice: Services and Supports (Regional SOCs and SOCAC)**
  Training, certification and supervision for providers to implement evidence-based and promising practices (EBPPs).

*Table 13.1. Oregon's pre-implementation results on the System Reform Support Instrument*[462]

| | **Regional Systems of Care** | **System of Care Advisory Council** |
|---|---|---|
| SRSI Domain | % | % |
| Policy | 19% | 19% |
| Leadership | 25% | 25% |
| Financing | 13% | 13% |
| Access and Appropriate Population | 6% | 0% |
| Accountability | 15% | 17% |
| Management | 12% | 21% |
| Leadership | 8% | 25% |
| Financing | 16% | 50% |
| Access and Appropriate Population | 19% | 13% |
| Accountability | 0% | 0% |
| Practice | 4% | 7% |
| Services and Supports | 0% | 0% |
| Workforce | 6% | 25% |
| Accountability | 5% | 0% |
| Community | 29% | 33% |
| Collaboration and Communication | 29% | 33% |

***Scoring Key:*** *0% = not implemented, 50% = partially implemented, 100% = fully implemented.*

The School of Business Administration at Portland State University found similar themes in a recent evaluation of SOCAC's effectiveness in communication, engagement and outreach.[463] Through a series of 15 qualitative interviews with key stakeholders and analysis of current practices, they reported four key findings[463]:

- **Clarity of Messaging:** SOCAC's mission is widely respected, but internal and external collaborators noted confusion regarding how SOCAC's advisory capacity translates into tangible actions.
- **Engagement and Representation:** Youth and family voices are central to SOCAC's mission, yet these perspectives are inconsistently integrated into decision-making processes.
- **Structural and Systemic Challenges:** Fragmented state systems, limited regulatory authority and the need for stronger follow-through mechanisms constrain SOCAC's capacity to enact large-scale improvements.
- **Communication Gaps:** While SOCAC is recognized in professional circles, website accessibility and community-level engagement remain areas needing significant refinement.

# CONCLUSIONS

This report answers important questions about the Oregon System of Care (SOC). It does not answer all the questions that were asked or that need to be answered; however, certain conclusions may be drawn.

First, Oregon has made significant investments in the SOC. These include financial as well as human investments made by countless Oregonians committed to improving the lives of youth and families in our state. Working to improve the SOC honors the contributions of those Oregonians. Like individual resilience, system resilience is reflected by the capacity to experience challenges, learn from them and continue to move forward.

Despite Oregon's recent investments, many of the state's youth-serving systems are performing below their counterparts in other states. Understanding the reasons for this is beyond the scope of this report. However, it should be recognized that Oregon's youth have complex needs compared to other states; that many recent investments, such as in the behavioral health system, are in early stages of development; and that systems improvement takes time. Long-term improvements in outcomes will only be achieved by supporting current and future investments, while also furthering efforts to improve SOC efficiency and effectiveness.

Throughout this assessment, concerns were repeatedly expressed by youth and families, providers, system partners and consultants regarding the difficulty of navigating the Oregon SOC. Different parts of the system operate in silos, without clear pathways and coordination among the parts; this leads to repeated barriers in accessing services and supports.

Similarly, throughout the SOC, data systems operate in disconnected silos, as discussed in the Limitations section of this report. This leads to a lack of transparency and multiple barriers to tracking and improving SOC performance. Taken together, the disconnectedness of systems and data systems contributes to increased caregiver and workforce burnout; poorer tracking of services, supports, processes and outcomes; less-effective services and supports — and, ultimately, poorer outcomes for youth.

### *Recommendations*

This report was not intended to provide comprehensive recommendations about the Oregon SOC, nor was it intended to evaluate and provide recommendations about data systems within the Oregon SOC. Therefore, the recommendations presented below are limited and should be followed up with a more comprehensive analysis and recommendations for SOC reform, as well as data systems reform.

1. As part of SOCAC's strategic planning for 2026-2029, the OHSU DAETA team recommends engaging in a process to examine statewide data systems and ongoing data processes, to characterize areas of need and redundancy and identify a more effective statewide data strategy. Key elements to consider:
   - What are the different data systems throughout the SOC? Where are there redundancies of data collection and evaluation efforts? Where are there gaps?
   - What are regulatory or other barriers to data transparency and sharing?
   - Are there centralized data systems or data tools that could connect different systems to more effectively use data for system improvement?
   - How can the processes of determining and coordinating data points and processes and evaluating/reporting on data be improved across systems?
   - How can all SOC agencies build in ongoing mechanisms for qualitative feedback from youth and families, caregivers, agency staff and providers to have cross-system perspectives of areas for ongoing improvement?

2. The state is making significant investments in the SOC for youth, particularly in behavioral health. As these investments are developed, it will be imperative that clear indicators be developed and monitored to measure the impact and value of these investments, particularly across different systems. For example, are youth with I/DD benefiting from new behavioral health services and supports? Are youth within the child welfare system accessing behavioral health beds and are they able to access step-down programs in the community after inpatient psychiatric treatment?

3. A highly valuable outcome from the upcoming 2026-2029 strategic plan would be the determination of which agency or state entity should guide statewide SOC data efforts. This would include selection of cross-system data points, coordination of data among different parts of the system and monitoring/oversight of key indicators of whether the system is functioning effectively for the youth and families it serves.

The state of Oregon has a history of being bold and innovative in health care and other areas related to its population's wellbeing. This report identifies areas of strength within the SOC as well as many areas that need improvement. There is ample evidence, and hope, that Oregon can use its many resources and strengths to identify areas of greatest need and move forward as a state to address these critical areas for its youth and families.

# APPENDIX A. COUNTY CROSSTABS

SOC | CCO | ATAB | ESD | ODHS

| County | Local System of Care | Coordinated Care Organization (CCO) | Area Trauma Advisory Board Region | Education Service District | Child Welfare District |
|---|---|---|---|---|---|
| **Baker** | Eastern Oregon | Eastern Oregon CCO | 9 | 7 | 13 |
| **Benton** | Linn, Benton, & Lincoln Counties | InterCommunity Health Network CCO | 2 | 11 | 4 |
| **Clackamas** | Tri-County | Health Share / Trillium Community Health Plan | 1 | 1 | 15 |
| **Clatsop** | North Coast | Columbia Pacific CCO | 1 | 15 | 1 |
| **Columbia** | North Coast | Columbia Pacific CCO | 1 | 15 | 1 |
| **Coos** | Coos County | Advanced Health | 3 | 17 | 7 |
| **Crook** | Central Oregon | PacificSource Community Solutions: Central Oregon | 7 | 6 | 10 |
| **Curry** | Curry County | AllCare CCO / Advanced Health | 5 | 17 | 7 |
| **Deschutes** | Central Oregon | PacificSource Community Solutions: Central Oregon | 7 | 6 | 10 |
| **Douglas** | Douglas County | Umpqua Health Alliance | 3 | 3 | 6 |
| **Gilliam** | Eastern Oregon | Eastern Oregon CCO | 6 | 14 | 9 |
| **Grant** | Eastern Oregon | Eastern Oregon CCO | 7 | 4 | 14 |
| **Harney** | Eastern Oregon | Eastern Oregon CCO | 7 | 5 | 14 |
| **Hood River** | Columbia Gorge | PacificSource Community Solutions: Columbia Gorge | 6 | 2 | 9 |
| **Jackson** | Jackson County | AllCare CCO/Jackson Care Connect | 5 | 18 | 8 |
| **Jefferson** | Central Oregon | PacificSource Community Solutions: Central Oregon | 7 | 8 | 10 |
| **Josephine** | Josephine County | AllCare CCO | 5 | 18 | 8 |
| **Klamath** | Klamath County | Cascade Health Alliance | 7 | 18 | 11 |

| County | Local System of Care | Coordinated Care Organization (CCO) | Area Trauma Advisory Board Region | Education Service District | Child Welfare District |
|---|---|---|---|---|---|
| **Lake** | Eastern Oregon | Eastern Oregon CCO | 7 | 9 | 11 |
| **Lane** | Lane County | Trillium Community Health Plan/PacificSource Community Solutions: Lane | 3 | 10 | 5 |
| **Lincoln** | Linn, Benton, & Lincoln Counties | InterCommunity Health Network CCO | 2 | 11 | 4 |
| **Linn** | Linn, Benton, & Lincoln Counties | InterCommunity Health Network CCO | 2 | 11 | 4 |
| **Malheur** | Eastern Oregon | Eastern Oregon CCO | 9 | 12 | 14 |
| **Marion** | Marion and Polk Counties | PacificSource Community Solutions: Marion/Polk | 2 | 19 | 3 |
| **Morrow** | Eastern Oregon | Eastern Oregon CCO | 9 | 7 | 12 |
| **Multnomah** | Tri-County | Health Share/Trillium Community Health Plan | 1 | 13 | 2 |
| **Polk** | Marion and Polk Counties | PacificSource Community Solutions: Marion/Polk | 2 | 19 | 3 |
| **Sherman** | Eastern Oregon | Eastern Oregon CCO | 6 | 14 | 9 |
| **Tillamook** | North Coast | Columbia Pacific CCO | 1 | 15 | 1 |
| **Umatilla** | Eastern Oregon | Eastern Oregon CCO | 9 | 7 | 12 |
| **Union** | Eastern Oregon | Eastern Oregon CCO | 9 | 7 | 13 |
| **Wallowa** | Eastern Oregon | Eastern Oregon CCO | 9 | 16 | 13 |
| **Wasco** | Columbia Gorge | PacificSource Community Solutions: Columbia Gorge | 6 | 2 | 9 |
| **Washington** | Tri- County | Health Share/Trillium Community Health Plan | 1 | 15 | 16 |
| **Wheeler** | Eastern Oregon | Eastern Oregon CCO | 7 | 14 | 9 |
| **Yamhill** | Yamhill County | Yamhill Community Care | 2 | 19 | 3 |

# APPENDIX B. RESEARCH QUESTIONS

| Question | Missing |
|---|---|
| **Population Description** | |
| 1. How many youth are being served by each system? How many youth are being served by more than one system? | - Cross-system involvement for youth in the education system |
| 2. What are the demographics of the youth being served by each system (age, gender, sexual orientation, primary language, race/ethnicity, location/region, insurance status/coverage)? Are there groups that are disproportionately represented in any system? | - Primary language and insurance data<br>- Exact age data is not published by ODE |
| 3. What are the clinical characteristics of the youth being served by each system (mental health diagnoses, substance use disorders, intellectual and developmental disabilities, trauma, pediatric chronic conditions / medical complexity, suicidality, overdose)? How does this compare to the national population? Are there groups that are disproportionately represented in any system? | - Substance use data for youth in I/DD and Child Welfare systems<br>- Trauma history data for youth in the I/DD system<br>- System-wide trauma data is not collected for the BH system<br>- Data on co-occurring mental health diagnoses are not collected for youth with I/DD<br>- Suicidality data for youth in the I/DD system, JJ (as a whole), BH (system-wide)<br>- Medical complexity data for all systems<br>- Clinical data for youth in the JJ system, as a whole, is unavailable |
| 4. Where do youth in each system live and who do they live with? How do living arrangements vary across different demographic groups? | - National and Oregon comparison data<br>- While ODDS does not collect this data, some data was available from the SOC dashboard<br>- Data for youth in the JJ system as a whole |
| 5. How many families experience housing instability or homelessness in each system? How does this compare to Oregon / nationally? Are there groups that are disproportionately affected? | - I/DD system and juvenile justice system data<br>- Due to the unreliable nature of this data in MMIS and MOTS, OHA was unable to provide this |
| 6. How many families meet the federal poverty level in each system? How many families experience | - I/DD system, Child Welfare system, and juvenile justice system data |

| | |
|---|---|
| food insecurity in each system? How does this compare to the Oregon / national population? | - Due to the unreliable nature of this data in MMIS and MOTS, OHA was unable to provide this |
| **Neighborhood & Community** | |
| 7. What access to nature, parks, and outdoor recreational activities is available in different regions of Oregon? Are there disparities in access? | |
| 8. What type of internet options are available in different regions of Oregon? Are these options reliable, affordable, and fast? Are there regional or other disparities in access? | |
| 9. What public transportation services are available in the different regions of Oregon? Are there regional or other disparities in access? | |
| 10. What Non-emergent Medical Transport (NEMT) services are available in different regions of Oregon? Are there some groups that do not have access to NEMT? | - Data on commercial carrier coverage<br>- CCOs submit quarterly reports to the Oregon Health Authority (OHA) that includes ride information, call center metrics, and reimbursement data; this data was requested but unable to be obtained |
| 11. How many families in Oregon have access to childcare? How many childcare providers does Oregon have and where are they working? Where are there gaps in the availability of childcare providers serving youth and families? | - Demographic data specific to early learning care in Oregon |
| 12. Are there supervised and age-appropriate youth drop-in centers available in each community? Who do they serve and what services do they provide? Are there regional or other disparities in access? | |
| 13. How many caregivers experience burnout and what are some resources available to help? Are there regional or other disparities in access to caregiver resources? | |
| 14. What type of educational and support services are available to parents? Are there regional or other disparities in access to educational and support services? | |
| 15. What formal respite options are available across the state? Who has access to respite? | |
| **Education System** | |
| 16. How many families in Oregon have access to after-school care and early learning? How many families are waitlisted for these services? Are there regional or other disparities in access? | - Demographic data on who is accessing early learning care in Oregon |
| 17. How many youth ages 0 to 5 have been referred to / are receiving / were denied Early Intervention / | - Referral and denial data |

| | |
|---|---|
| Early Childhood Special Education (EI/ESCE) services? What barriers exist in access and availability across districts. Are there groups that are disproportionately receiving or denied access to these services? | |
| 18. How many youth ages 5 to 21 have been referred to, are receiving, or were denied special education services (including 504 plan, Individual Education Plan (IEP), Extended School Year (ESY)? What barriers exist in access and availability across districts? Are there groups that are disproportionately receiving or denied access to these services? | - Data specific to each type of accommodation |
| 19. What are Oregon's rates for chronic absence, suspension, expulsion, dropout / pushout, and graduation, and how do these rates compare to other states? Are there groups that are disproportionately represented in any of these categories? | |
| 20. What school-based mental health services (including screening and outreach) are available in each region and what is the utilization rate? Are there regional or other disparities in access? | |
| 21. What substance use education is occurring in schools, at what grade levels, and what are the outcomes? Are there regional or other disparities in access to substance use education in schools? | - Regional disparities in substance use education |
| 22. Do students feel safe and included at school? Are certain groups of students more likely to feel unsafe or not included? | - Stratification by demographic groups is available through the SHS crosstabs function. However, this data was not able to be included in the timeline of this report due to the complexity of this data and the limited timeframe of this report.<br>- The SEED survey general demographics of participating youth, but the team was unable to locate data specific to the variables associated with the sense of belonging in the timeframe of this report |
| 23. What is the role of education stress and how does it contribute to chronic stress / risk for mental health challenges? Are there groups that are disproportionately at risk of education stress? | - Education stress data by demographic group |

| | |
|---|---|
| **Physical Health Care System** | |
| 24. How many mothers are accessing prenatal and postpartum care? Are there groups that are disproportionately not accessing or receiving care? | |
| 25. What screening is occurring for and what is the prevalence of postpartum Depression and Anxiety? Are there groups that are disproportionately not getting screened? | - Youth-specific data for depression and substance use screening. These metrics include ages 12 and older |
| 26. How many youth have primary care physicians and are attending well-child visits? Are there groups of youth that do not have a primary care physician? | - Non-CCO member data |
| 27. What Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services are youth requesting and receiving? How many denials are occurring and for what services and why? How have services requested, received and denied changed over time? | - OHA was unable to provide data on the number of youth requesting and receiving services, the types of services associated with denials, and service data over time. |
| 28. What type of behavioral health screening and treatment is occurring in primary care settings, including screening for social determinants of health and early social-emotional health screening? Are there groups that are disproportionately now getting behavioral health screening or receiving treatment? | - Demographic data to understand disparities in access |
| 29. What support do primary care providers have in working with system-involved youth? | |
| 30. How many primary care visits occur via telehealth? Are there some groups of people who do not have access to primary care visits via telehealth? | - Additional research is needed to comprehensively answer how many telehealth visits are occurring in the primary care setting for different groups of youth. While individual-level utilization data couldn't be obtained given the timeframe of the report, data on overall use of telehealth by individuals with OHP (for all ages) and use for behavioral health services within primary care (ages 0 to 26) is presented. |
| **Behavioral Health Care System** | |
| 31. How does access to youth behavioral health services in Oregon compare nationally? Are there gaps in access to youth behavioral health services for various groups or regions? | |
| 32. What early intervention services and supports are available in Oregon? What is the utilization rate for the different services? | |

| | |
|---|---|
| 33. What types of early intervention services and supports are not available in Oregon that youth, families, or providers have expressed a need for? | |
| 34. What types of crisis services and for each, what is the eligibility, regional availability, capacity / waitlist, population served, cross-system involvement, services provided, utilization rate, and outcomes? | |
| 35. What community-based behavioral health programs and treatments are available and for each, what is the eligibility, regional availability, capacity / waitlist, population served, cross-system involvement, services provided, utilization rate, and program outcomes? | |
| 36. What types of community-based behavioral health programs and treatments are not available in Oregon that youth, families, or providers have expressed a need for? | |
| 37. How many youth are accessing emergency departments with behavioral health presentations and what systems are these youth involved with? What is the prevalence / length of stay of emergency department boarding and how does that differ across demographics, regions, and hospitals? | |
| 38. How many psychiatric residential, subacute, and acute inpatient beds are in Oregon? How does this compare to other states with similar population levels and geography? How does bed availability fluctuate over time? For the different programs, what is the regional availability, admission criteria (including diagnosis, insurance, etc.), referral process (from where the program is accessed), capacity, waitlist, utilization rate, and program outcomes (Clinical and family-reported)? | - Data on individual program waitlists, utilization rates, and outcomes is unable to be included in this report, as it was not tracked in a systematic way during the report timeframe. |
| 39. How many Substance Use Disorder residential beds are available in Oregon? What are programs' regional availability, admission criteria (including diagnosis, insurance, etc.), referral processes (from where the program is accessed), capacity, waitlist, utilization rate, and program outcomes (clinical and family-reported? | |
| 40. How many Behavior Residential Services (BRS) are in Oregon? How does this compare to other states with similar population levels and geography? How does bed availability fluctuate over time? What is the regional availability, admission criteria (including diagnosis, insurance, etc.), referral processes (from where the program is accessed), capacity, waitlist, | - Data on BRS waitlists or program outcomes |

| | |
|---|---|
| utilization rate, and program outcomes (clinical and family-reported? | |
| 41. What barriers do families face when moving through the levels of care? | - This question will be addressed in the Care Pathways Analysis, which is scheduled to be completed in 2025.This analysis could not be completed in the time frame of this report due to the issues outlined in the *Limitations* section. |
| 42. What are some barriers to treatment for youth with medical comorbidities? | - OHA has been gathering community feedback on this topic and plans to release a report in Q2 2025. |
| **Intellectual and Developmental Disabilities System** | |
| 43. How many youth are eligible for Intellectual and Developmental Disability services are how many are receiving services? Are there groups disproportionately represented in either category? | |
| 44. What is the distribution of needs assessment levels and how does this relate to services received? Are there groups that are disproportionately represented in any needs assessment level? Is there equity between needs assessment level and services received? | |
| 45. How many youth are accessing the full hours of support services per their Individualized Support Plan? | - Aggregate numbers were provided which do not allow for an assessment of disparities. |
| 46. How many youth and families have Personal Support Workers and / or Direct Support Professionals? How many families lack access to these professionals in their communities? | |
| 47. What behavioral health services are provided to youth with Intellectual and Developmental Disabilities? Are there groups that have more or less access to these supports? | - ODDS does not collect data on gaps in BH services provided. OHA collects this data but it was unable to be included in the timeframe of this report. |
| 48. Are behavioral health services for youth with Intellectual and Developmental Disabilities restricted or limited due to office policy, insurance, lack of provider ability or willingness to accept and treat youth with Intellectual and Developmental Disabilities? Are there any disparities in who experiences this? | - ODDS does not collect information on restrictions and limitations in accessing MH services |
| **Child Welfare System** | |
| 49. What are the different levels of involvement and their prevalence, including abuse calls, Child Protective Services contacts / screens / removals from home), In-Home Family Services, Foster Care, | |

| | |
|---|---|
| and the Adoption and Guardianship Program? Are there groups that are disproportionately represented in the different levels of involvement? How does this compare to other states? | |
| 50. What factors are associated with Child Welfare involvement? Are there groups disproportionately at risk of becoming involved with Child Welfare? | |
| 51. How many parents have had to relinquish rights in order for their youth to receive services? How many parents have had their rights re-instated once services transitioned? What is the process to re-instate parental rights once services transition? Are parents engaged in the process of their youth receiving services even if they were required to relinquish their rights? | |
| **Juvenile Justice System** | |
| 52. How many youth are involved with the juvenile justice system who are not committed to the Oregon Youth Authority? Are there groups disproportionately represented? | |
| 53. How many youth are committed and under the guardianship of the Oregon Youth Authority? How does this compare to other states? Are there groups that are disproportionately represented? | |
| 54. What risk factors are associated with delinquent behavior, charges, etc.? Are there groups disproportionately at risk? | |
| 55. How many youth are receiving restorative services and what is the average length of time and outcome of these services (fitness to proceed)? Are there inequities in who is determined to be “fit to proceed”? How many youth are under the jurisdiction of the Psychiatric Services Review Board? Are there groups that are disproportionately represented? | - Demographic information for youth receiving restorative services |
| 56. How many youth are accessing behavioral health services through the juvenile justice department and what services are they accessing? Are there inequities in access to care? | |
| **System Workforce** | |
| 57. How many mental health professionals does Oregon currently have who serve youth and families? What is the distribution of providers and where are they working? Are there any disparities in where providers are available? | |
| 58. How many traditional health workers does Oregon currently have who serve youth and families? What | - Current data is unavailable that reflects, that many peers are being |

| | |
|---|---|
| is the distribution of workers and where are they working? Where are the gaps in the availability of traditional health workers? | hired directly through community MH programs rather than subcontracting with non-profits. |
| 59. How many primary care providers does Oregon have and where do they work? What behavioral health training and continuing education is required? What knowledge do they have of behavioral health resources? | |
| 60. How many specialized Intellectual and Developmental Disability workers are serving youth and families and where are they working? Where are there gaps in availability? | - Data on I/DD specialization within the broader medical professions (medical doctors, nurses, and allied health professionals) |
| 61. What does cultural diversity look like in the system of care workforce? Is there an accurate representation of people of color and other minorities? Are there any underrepresented groups? | |
| 62. What are some regulations in place regarding workplace safety? What are some resources available for burnout and stress? Are some groups unable to access resources? Are some workplaces without safety regulations? | |
| 63. How many providers have been charged with abuse or neglect due to an event that occurred in the workplace? | |
| 64. How many Coordinated Care Organizations and private carriers are meeting network adequacy standards for specialty behavioral health services for youth by service type? Are there any disparities regarding network adequacy standards for behavioral health services? | - Data from private carriers was unable to be obtained |
| 65. How do compensation packages for the mental health workforce compare to other states with similar geography and population? Are there any disparities regarding compensation packages? | |
| 66. What student loan forgiveness options are available to the Oregon mental health workforce and what is the utilization and forgiveness rate? Are there some groups unable to access student loan forgiveness? | |
| 67. What academic programs are available in Oregon for behavioral health workforce capacity building? Where are these located and what types of programs are available? Where are there gaps in the availability of programs? | |
| 68. At public institutions, what percent of students are in-state versus out-of-state? What percent of students stay in Oregon and join the workforce? | |

| | |
|---|---|
| **System Funding** | |
| 69. How much money is being invested in the system of care? | |
| 70. What are the funding sources in the system of care? | |
| 71. How is funding being allocated and how does this relate to program availability, utilization, and outcomes? | |
| 72. Where are there gaps in resource allocation? What programs are under-funded? | |
| **Youth and Family Experience of the System** | |
| 73. How is each system collecting youth and family experience and feedback data? How is feedback guiding service provision? Are there some groups of people who are underrepresented in feedback? | - In the BH system, data is not collected directly from youth under 14 years of age<br>- Juvenile Justice system data from Performance-Based Standards (PBs) |
| 74. What is the youth and family experience of the system? How does experience vary by group? | |
| 75. How many youth experience racism or other forms of discrimination within each system? Are there groups more likely to experience racism or other forms of discrimination? | |
| 76. What type of cultural and linguistic services are in place in each system? Are there any cultures or languages that are not represented or lack resources? | - Child Welfare collects language need data but were unable to share this data in the timeframe of this report |
| 77. What trauma-informed practices are in place within each system? Are some groups receiving trauma-informed care over others? | |
| 78. What is Oregon's system of care's readiness for change? | |
| **System Readiness for Change** | |
| 79. What is the system of care's readiness for change? | |

# ANNOTATED BIBLIOGRAPHY

## Introduction


1. Stroup BA, Blau GM, Larson J. *The Evolution of the System of Care Approach*. The Institute for Innovation and Implementation, University of Maryland. https://nttacmentalhealth.org/wp-content/uploads/2023/04/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf. Published 2021. Accessed February 14, 2025.

   This document provides an overview of the System of Care (SOC) approach, exploring its evolution and key principles in supporting children and families. It highlights how SOC frameworks have developed to promote community-based mental health services that are comprehensive, accessible, and individualized.

2. Oregon Legislative Assembly. *Senate Bill 1*. Oregon Legislative Assembly. https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/SB1/Enrolled. Published June 29, 2019. Accessed February 14, 2025.

   Senate Bill 1 (SB 1), enacted in 2019 in Oregon, establishes the System of Care Advisory Council to develop a coordinated, statewide system of care for youth engaged with multiple service systems, such as child welfare and juvenile justice. The bill emphasizes cultural competence and cultural responsiveness in service delivery, ensuring that systems address the needs of diverse youth and families. Key provisions include developing a comprehensive care plan, establishing interdisciplinary assessment teams, and creating the Children's System Data Dashboard to track youth outcomes. SB 1 aims to improve access to services, reduce barriers, and ensure equitable, culturally competent care for all youth.

3. Oregon Legislative Assembly. Senate Bill 4 (SB 4). https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureDocument/SB4. Published March 29, 2023. Accessed February 14, 2025.

   Senate Bill 4 (SB 4) focuses on economic development, particularly supporting Oregon's semiconductor and advanced manufacturing sectors. The bill establishes a program through the Oregon Business Development Department to award grants and loans to businesses applying for federal semiconductor financial assistance. The program is designed to stimulate site development, workforce training, and research, including collaborations with educational institutions.

4. Oregon Health Authority. Tri-County System of Care Information. https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/Tri-County-SOC-Information.pdf. Accessed February 4, 2025.

   The Tri-County System of Care (SOC) document outlines the collaborative efforts among Clackamas, Multnomah, and Washington counties in Oregon to improve services for children, youth, and families facing behavioral health challenges. It emphasizes a family-driven, youth-guided, and community-based approach, integrating over 40 local organizations to address system barriers.

5. Data, Evaluation, and Technical Assistance Team. Oregon Health & Science University. Parent / caregiver survey and interview. Conducted 2024.

   As part of the data gathering for the SOC report, the OHSU DAETA team surveyed parents and caregivers of youth involved in the system of care. A full description of the methodology used can be found in the methods section; results from the survey are presented throughout the report.

## Population Description


6. Office of Reporting, Research and Analytics, Oregon Department of Human Services. Children's System of Care Data Dashboard. https://www.oregon.gov/odhs/data/pages/cw-dashboard-soc.aspx. Accessed December 31, 2024.
   The Children's System of Care Dashboard presents dynamic, linked data for Oregon youth served by Child Welfare, Office of Developmental Disabilities, Oregon Health Authority, and juvenile justice. The dashboard was created in partnership with the System of Care Advisory Council.
7. Jacoby I, Stalcup R. Falling enrollment during the COVID-19 pandemic. Oregon Department of Education. https://www.oregon.gov/ode/students-and-family/GraduationImprovement/Documents/FallingEnrollmentDuringCOVID-19Pandemic.pdf. Published December 2022. Accessed February 14, 2025.
   This report, published by the Oregon Department of Education in December 2022, investigates the significant decline in student enrollment in Oregon's K-12 schools during the COVID-19 pandemic. It identifies patterns of enrollment loss, particularly among younger students, and discusses the long-term implications for the state's educational system. The report highlights the impacts on funding, educational equity, and the potential challenges for school districts in addressing the effects of enrollment shifts.
8. Oregon Department of Education. (2020). *Fall membership report 2019-2020* [Excel file]. Oregon.gov. https://www.oregon.gov/ode/reports-and-data/students/Documents/fallmembershipreport_20192020.xlsx. Accessed December 31, 2024.
   This Excel document, provided by the Oregon Department of Education, contains the Fall Membership Report for the 2019-2020 school year. It includes detailed data on student enrollment, attendance, and other key metrics for public schools in Oregon.
9. Oregon Department of Education. (2021). *Fall membership report 2020-2021* [Excel file]. Oregon.gov. https://www.oregon.gov/ode/reports-and-data/students/Documents/fallmembershipreport_20202021.xlsx. Accessed December 31, 2024.
   This Excel document, provided by the Oregon Department of Education, contains the Fall Membership Report for the 2020-2021 school year. It includes detailed data on student enrollment, attendance, and other key metrics for public schools in Oregon.
10. Oregon Department of Education. (2022). *Fall membership report 2021-2022* [Excel file]. Oregon.gov. https://www.oregon.gov/ode/reports-and-data/students/Documents/fallmembershipreport_20212022.xlsx. Accessed December 31, 2024.
    This Excel document, provided by the Oregon Department of Education, contains the Fall Membership Report for the 2021-2022 school year. It includes detailed data on student enrollment, attendance, and other key metrics for public schools in Oregon.
11. Oregon Department of Education. (2023). *Fall membership report 2022-2023* [Excel file]. Oregon.gov. https://www.oregon.gov/ode/reports-and-data/students/Documents/fallmembershipreport_20222023.xlsx. Accessed December 31, 2024.
    This Excel document, provided by the Oregon Department of Education, contains the Fall Membership Report for the 2022-2023 school year. It includes detailed data on student enrollment, attendance, and other key metrics for public schools in Oregon.
12. Oregon Department of Education. (2024). *Fall membership report 2023-2024* [Excel file]. Oregon.gov. https://www.oregon.gov/ode/reports-and-data/students/Documents/fallmembershipreport_20232024.xlsx. Accessed December 31, 2024.
    This Excel document, provided by the Oregon Department of Education, contains the Fall Membership Report for the 2023-2024 school year. It includes detailed data on student enrollment, attendance, and other key metrics for public schools in Oregon.

13. Child Welfare Information Gateway. Child Welfare practice to address racial disproportionality and disparity. Children's Bureau. https://forchildwelfare.org/wp-content/uploads/racial_disproportionality.pdf. Published April 2021. Accessed December 31, 2024.
This professional bulletin discusses racial disproportionality and disparity in Child Welfare systems across the United States. The report includes research on contributing factors and system - and case-level strategies to address disproportionality and disparity.
14. Oregon Youth Development Division. Racial and Ethnic Disparities (R/ED). https://www.oregon.gov/youthdevelopmentdivision/juvenile-justice/pages/red.aspx. Accessed February 4, 2025.
The Oregon Youth Development Division's webpage on Racial and Ethnic Disparities (R/ED) outlines the state's efforts to address disproportionate minority contact in the juvenile justice system. The page discusses the importance of data collection and analysis at key decision points, such as referral, diversion, detention, secure confinement, and transfer to adult court.
15. U.S. Census Bureau. *American Community Survey 1-Year Estimates, S0101: Age and Sex*. U.S. Census Bureau. https://data.census.gov/table/ACSST1Y2023.S0101?t=Age%20and%20Sex&g=040XX00US41&moe=false. Published 2023. Accessed February 4, 2025.
This data table from the U.S. Census Bureau collects information on age and sex in each state including in Oregon.
16. U.S. Census Bureau. *American Community Survey 1-Year Estimates, B01001A: Sex by Age (White Alone)*. U.S. Census Bureau. https://data.census.gov/table/ACSDT1Y2023.B01001A?q=Race%20and%20Ethnicity. Published 2023. Accessed February 4, 2025.
This dataset from the U.S. Census Bureau provides detailed demographic information about individuals who identify as White alone, focusing on age and sex breakdowns.
17. U.S. Census Bureau. *American Community Survey 1-Year Estimates, S1601: Language Spoken at Home*. U.S. Census Bureau. https://data.census.gov/table?q=language&t=Age%20and%20Sex&g=040XX00US41. Published 2023. Accessed February 4, 2025.
This dataset from the U.S. Census Bureau provides detailed information on languages spoken at home in the United States, focusing on the 2023 American Community Survey's 1-year estimates. It offers insights into the linguistic diversity of the U.S. population, including data on English-speaking households and those where languages other than English are spoken.
18. Child and Adolescent Health Measurement Initiative. Interactive data query: National Survey of Children's Health (2022-present). Data Resource Center for Child & Adolescent Health. https://nschdata.org/browse/survey. Accessed December 31, 2024.
The Survey of Children's Health collects information related to the health and well-being of children in the United States. The referenced interactive platform enables users to make individualized data queries to the survey's database. Data can be queried by question, year, and state.
19. Centers for Disease Control and Prevention. *Children's mental health: Data and research* [Webpage]. U.S. Department of Health & Human Services. https://www.cdc.gov/children-mental-health/data-research/index.html. Accessed December 31, 2024.
This webpage from the Centers for Disease Control and Prevention (CDC) provides access to data and research related to children's mental health. It includes information on the prevalence of mental health conditions among children, risk factors, and the impact of these conditions on overall well-being.
20. The Annie E. Casey Foundation. (2022). 2022 KIDS COUNT® DATA BOOK STATE TRENDS IN CHILD WELL-BEING. https://assets.aecf.org/m/resourcedoc/aecf-2022kidscountdatabook-2022.pdf
The Anne E. Casey Foundation collects information about youth, such as trends in child wellbeing, and other demographic information. This webpage was used to determine rates of mental health needs in Oregon among youth.

21. Reinert M, Fritze D, Nguyen T. The state of mental health in America 2024. *Mental Health America*. 2024. https://mhanational.org/sites/default/files/2024-State-of-Mental-Health-in-America-Report.pdf. Accessed December 31, 2024.
The annual Mental Health America report ranks all 50 U.S. states (plus the District of Columbia) on several metrics related to mental health. Their evaluation primarily uses data from SAMHSA's National Survey on Drug Use and Health and the CDC's Behavioral Risk Factor Surveillance System.
22. Oregon Health Authority. (2022). *State of Oregon 2022: Student Health Survey results* [Webpage]. https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/SURVEYS/Documents/SHS/2022/Reports/State%20of%20Oregon%202022.pdf. Accessed December 31, 2024.
This webpage from the Oregon Health Authority provides the results of the 2022 State Health Survey (SHS). The survey collects data on various health-related behaviors, conditions, and risk factors in Oregon among school-aged youth in grades 6, 8, and 11, such as tobacco use, physical activity, and mental health.
23. Oregon Department of Education. December Special Education Child Count Media Files 2019-2020. https://www.oregon.gov/ode/reports-and-data/SpEdReports/Documents/SECCMediaFiles/2019samediafile.xlsx. Published 2020. Accessed December 31, 2024.
This dataset from the Oregon Department of Education provides access to the December Special Education Child Count Media Files for the 2019–2020 school year. It includes detailed data on the number of school-aged children receiving special education across Oregon.
24. Oregon Department of Education. December Special Education Child Count Media Files 2020-2021. https://www.oregon.gov/ode/reports-and-data/SpEdReports/Documents/SECCMediaFiles/2020samediafile.xlsx. Published 2021. Accessed December 31, 2024.
This dataset from the Oregon Department of Education provides access to the December Special Education Child Count Media Files for the 2020-2021 school year. It includes detailed data on the number of school-aged children receiving special education across Oregon.
25. Oregon Department of Education. December Special Education Child Count Media Files 2021-2022.. https://www.oregon.gov/ode/reports-and-data/SpEdReports/Documents/SECCMediaFiles/2021samediafile.xlsx. Published 2022. Accessed December 31, 2024
This webpage from the Oregon Department of Education provides access to the December Special Education Child Count Media Files for the *2021-2022* school year. It includes detailed data on the number of school-aged children receiving special education across Oregon.
26. Oregon Department of Education. December Special Education Child Count Media Files 2022-2023. https://www.oregon.gov/ode/reports-and-data/SpEdReports/Documents/SECCMediaFiles/2022samediafile.xlsx. Published 2023. Accessed December 31, 2024.
This dataset from the Oregon Department of Education provides access to the December Special Education Child Count Media Files for the *2022-2023* school year. It includes detailed data on the number of school-aged children receiving special education across Oregon.
27. Oregon Department of Education. December Special Education Child Count Media Files 2023-2024. https://www.oregon.gov/ode/reports-and-data/SpEdReports/Documents/SECCMediaFiles/2023samediafile.xlsx. Published 2024. Accessed December 31, 2024.
This dataset from the Oregon Department of Education provides access to the December Special Education Child Count Media Files for the *2023-2024* school year. It includes detailed data on the number of school-aged children receiving special education across Oregon.

28. U.S Department of Health and Human Services. State of Oregon. Medicaid Management Information System (MMIS). Accessed October 4, 2024.
This database from the U.S. Department of Health and Human Services provides data on services provided through the Oregon Health Authority (OHA), such as behavioral health services and services provided through Oregon Department of Developmental Disabilities (ODDS). This data is managed by the State of Oregon.
29. Oregon Health Authority. Measures and Outcomes Tracking System (MOTS). Oregon Data Environment. Accessed October 4, 2024.
This database provides data on services provided through the Oregon Health Authority (OHA), such as behavioral health services.
30. Oregon Department of Developmental Disabilities. Express Payment and Reporting System (eXPRS). Accessed January 2025.
This database provides billing and claims data for services provided through Oregon Department of Developmental Disabilities (ODDS).
31. Office of Reporting, Research, Analytics and Implementation (ORRAI). Identifying capacity needs for children within the Oregon Child Welfare system. Oregon Department of Human Services. 2019. https://www.oregon.gov/odhs/data/cwdata/cw-apsr-2024-att-14.pdf. Accessed December 31, 2024.
This report provided results from the Child Assessment of Strengths and Needs assessment, which measures strengths and needs of youth in foster care. The report uses the clinical information in the report to estimate the number of placement beds needed to serve youth in child welfare.
32. Oregon Youth Authority. Risk Needs Assessment 2.0. Updated May 12, 2024. Accessed December 31, 2024.
The OYA RNA 2.0 Full Assessment document presents a comprehensive review of the risk and needs assessment processes utilized by the Oregon Youth Authority (OYA) to evaluate youth in their care.
33. Substance Abuse and Mental Health Services Administration. Pain Reliever Misuse in Past Year Among Individuals Aged 12 or Older, by State: 2021-2022. U.S. Department of Health and Human Services. https://datatools.samhsa.gov/saes/state. Published 2023. Accessed February 4, 2025.
This map by the Substance Abuse and Mental Health Services Administration shows pain reliever misuse among youth in the U.S. This map is useful for national and statewide comparisons.
34. Juvenile Justice Information System. 2023 Statewide Youth Referrals. Oregon Youth Authority. Published https://www.oregon.gov/oya/jjis/Reports/2023StatewideYouthReferrals.pdf. April 5, 2024. Accessed February 4, 2025.
This report from the Juvenile Justice Information System (JJIS) provides a comprehensive overview of statewide youth referrals to the juvenile justice system in Oregon for the year 2023. The data includes demographic information on the youth involved, and the types of offenses committed.
35. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998;14(4):245-258. https://pubmed.ncbi.nlm.nih.gov/9635069/
This article, part of the Adverse Childhood Experiences (ACE) Study, examines the relationship between childhood abuse, household dysfunction, and the increased risk of leading causes of death in adulthood.
36. Data, Evaluation, and Technical Assistance Team's Intensive In-Home Behavioral Health Treatment REDCap database. Oregon Health & Science University; 2020. Updated December 2025. Accessed December 31, 2024.
This REDCap Database stores data for Oregon's Intensive In-Home Behavioral Health Treatment (IIBHT) program for youth aged 0-20. The data is managed by the OHSU DAETA team.

37. Data, Evaluation, and Technical Assistance Team's Mobile Response and Stabilization Services (MRSS) REDCap database. Oregon Health & Science University; 2023. Updated December 2025. Accessed December 31, 2024.
This REDCap Database stores data for the Mobile Response and Stabilization Services program for youth. The data is managed by the OHSU DAETA team.

38. Dorsey S, Burns BJ, Southerland DG, Cox JR, Wagner HR, Farmer EM. Prior Trauma Exposure for Youth in Treatment Foster Care. J Child Fam Stud. 2012;21(5):816-824. https://pubmed.ncbi.nlm.nih.gov/23730144/
This study explores the prevalence of trauma exposure among youth in treatment foster care (TFC), revealing exceptionally high rates of exposure to various types of traumatic events. These findings underscore the importance of trauma-informed care in TFC and highlight the need for services that address the complex trauma histories of these youth.

39. Oregon Health Authority, Behavioral Health Division. 2023 Youth Suicide Intervention and Prevention Plan Annual Report. https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le8874_2023.pdf. Published June 2024. Accessed December 31, 2024.
The Youth Suicide Intervention and Prevention Plan Annual Report by the Oregon Health Authority provides an overview of the state's efforts to address youth suicide prevention, intervention, and postvention strategies. The report outlines the progress of various programs, interventions, and initiatives aimed at reducing youth suicide rates in Oregon.

40. Data, Evaluation, and Technical Assistance Team's Wraparound Electronic CANS REDCap database. Oregon Health & Science University; 2022. Updated December 2025. Accessed December 31, 2024.
This REDCap Database stores data for the Wraparound Services program for youth. The data is managed by the OHSU DAETA team.

41. Oregon Department of Human Services. ODHS Child Fatality Review. https://www.oregon.gov/odhs/child-fatality-review/pages/default.aspx. Accessed February 4, 2025.
The *Child Fatality Review* page from the Oregon Department of Human Services (ODHS) provides detailed insights into the state's efforts to investigate child fatalities. Through the Critical Incident Review Teams (CIRT), ODHS conducts reviews of child deaths resulting from abuse, neglect, or unsafe practices, particularly in households with prior interactions with Child Welfare.

42. Oregon Health Authority. Youth Suicide Intervention and Prevention Plan 2021–2025. Oregon Health Authority. https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SAFELIVING/SUICIDEPREVENTION/Documents/21-25-youth-suicide-prevention-plan.pdf. Published June 2024. Accessed February 4, 2025.
The *Youth Suicide Intervention and Prevention Plan 2021–2025* by the Oregon Health Authority outlines the state's comprehensive approach to reducing youth suicide rates. The plan builds on previous efforts and incorporates input from stakeholders, including youth, experts, and service providers.

43. Oregon Health Authority. Children's Health Complexity Data. Oregon Health Authority. https://www.oregon.gov/oha/hpa/dsi-tc/pages/child-health-complexity-data.aspx. Accessed February 4, 2025.
The Oregon Health Authority's Children's Health Complexity Data page provides comprehensive data on the medical and social complexity of children enrolled in the Oregon Health Plan (OHP) and Children's Health Insurance Program (CHIP). The data covers children aged 0-20 and highlights the need for coordinated care and community-level interventions.

44. U.S. Census Bureau. Children's Living Arrangements. U.S. Census Bureau. https://www.census.gov/library/visualizations/interactive/childrens-living-arrangements.html. Published November 14, 2023. Accessed February 4, 2025.
The U.S. Census Bureau's interactive visualization on children's living arrangements provides an accessible breakdown of various family structures for children in the United States. The data

includes insights on living arrangements such as children in two-parent families, single-parent families, and other types of household compositions.

45. Oregon Department of Human Services. Child Welfare Data Systems. Accessed January 2025.
This database stores child welfare data and is managed by the Oregon Child Welfare Division under Oregon Department of Human Services.

46. Oregon Department of Education. *McKinney-Vento Act: Homeless education* [Webpage]. Oregon.gov. https://www.oregon.gov/ode/schools-and-districts/grants/esea/mckinney-vento/pages/default.aspx. Accessed December 31, 2024.
This webpage provides information about the McKinney-Vento Homeless Assistance Act, which supports the education of homeless children and youth. It includes details on eligibility, resources, and guidance for Oregon schools and districts working to ensure educational stability for students experiencing homelessness.

47. U.S. Department of Housing and Urban Development. The 2023 Annual Homeless Assessment Report (AHAR) to Congress: Part 1 - Point-in-Time Estimates of Homelessness in the United States. https://www.huduser.gov/portal/portal/sites/default/files/pdf/2023-AHAR-Part-1.pdf. Published December 2023. Accessed February 4, 2025.
The 2023 Annual Homeless Assessment Report (AHAR) to Congress, Part 1, provides point-in-time estimates of homelessness in the United States. It includes data on the number of people experiencing homelessness, broken down by demographics and geographic locations, offering a comprehensive overview of the state of homelessness as of 2023.

48. Oregon Department of Human Services. Oregon Child Welfare Data and Reports. https://www.oregon.gov/odhs/data/pages/cw-data.aspx. Accessed February 4, 2025.
The Oregon Department of Human Services' Oregon Child Welfare Data and Reports page provides access to various reports and statistics related to child welfare in the state, including data on child abuse, foster care, and service outcomes, offering insights into trends within Oregon's child welfare system.

49. Greenwald M. Prevalence of Unstable Housing Amongst Youth Committed to the Oregon Youth Authority (OYA). Memorandum issued by Oregon Youth Authority. Issued May 17, 2024.
This memorandum from the Oregon Youth Authority describes housing status of youth committed to OYA.

50. Center for American Progress. Data on Poverty in the United States. https://www.americanprogress.org/data-view/poverty-data/. Accessed February 4, 2025.
The Center for American Progress' Data on Poverty in the United States page provides key statistics and trends related to poverty, including information on income inequality, economic mobility, and poverty rates. It offers a thorough overview of the factors affecting poverty across various demographics in the U.S.

51. U.S. Census Bureau. (2024). *Poverty in states and metropolitan areas: 2023* [PDF]. U.S. Department of Commerce. https://www2.census.gov/library/publications/2024/demo/acsbr-022.pdf. Accessed December 31, 2024.
This report, published by the U.S. Census Bureau in 2024, provides an analysis of poverty in states and metropolitan areas based on data from the 2023 American Community Survey (ACS). It offers detailed statistics on poverty rates across different regions of the United States, disaggregating the data by factors such as age, race, and geographic location.

52. Oregon Child Integrated Dataset. Child Maltreatment: Early Childhood. Center for Evidence-based Policy, Oregon Health & Science University. https://www.ocid-cebp.org/outcome/child-maltreatment-early-childhood/ . Accessed February 4, 2025.
The Oregon Child Integrated Dataset webpage on child maltreatment in early childhood provides valuable insights into the impact of maltreatment on child development. It covers key data and

factors associated with early childhood abuse, outlining the long-term consequences on physical, emotional, and cognitive growth.

53. Oregon Child Welfare Division. Vision for transformation. Oregon Department of Human Services. 2020. https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/de2445.pdf. Accessed December 31, 2024.
The Vision for Transformation outlines several guiding principles, strategic initiatives, and measurable outcomes for Oregon's Child Welfare system. Information about the youth served and strategies to best support them (including trauma-informed care), are presented throughout the document.

54. Child Welfare Information Gateway. Separating Poverty from Neglect. https://www.childwelfare.gov/topics/prevention/separating-poverty-neglect/?top=89. Accessed February 4, 2025.
This source focuses on poverty and child neglect. It highlights that a significant proportion of child protective services (CPS) reports involve neglect, which can occur when caregivers fail to provide basic needs such as food, shelter, or medical care. The source emphasizes that families living in poverty are disproportionately reported for neglect.

55. Cooper H, Allen T. Child welfare systems' challenges: Differentiating between poverty and neglect. Bipartisan Policy Center. 2024. https://bipartisanpolicy.org/blog/child-welfare-systems-challenges-differentiating-between-poverty-and-neglect/#:~:text=When%20poverty%20is%20mistaken%20for,neglect%20impact%20child%20welfare%20systems. Accessed December 31, 2024.
This webpage describes the Bipartisan Policy Center's data gathering and advocacy efforts related to differentiating between poverty and neglect. Select quotes from experts are presented.

56. Oregon Department of Human Services (ODHS). *Self-Sufficiency Programs (SSP).* Oregon Department of Human Services, https://www.oregon.gov/odhs/agency/pages/ssp.aspx. Accessed December 31, 2024.
The Oregon Department of Human Services' Self-Sufficiency Programs (SSP) webpage provides an overview of services designed to help individuals and families achieve economic stability and independence. The programs offer a range of support, including assistance with food, cash benefits, and employment services. The SSP aims to empower individuals to overcome barriers to self-sufficiency and improve long-term outcomes through various resources and programs.

57. Oregon Youth Authority. *The OYA Feeder System Project: Overview of Juvenile Justice Involvement and Adult Felony Convictions among Oregon Youth*. Oregon Youth Authority, https://www.oregon.gov/oya/Research/2019%20D%20Overview-Criminal-Justice-Involvement.pdf. Accessed December 31, 2024.
This report from the Oregon Youth Authority examines the relationship between juvenile justice involvement and later adult felony convictions among youth in Oregon. It highlights trends in the "feeder system," exploring how early contact with the juvenile justice system may increase the likelihood of adult criminal behavior. The findings provide valuable insights into the long-term impacts of juvenile justice system interactions, with the goal of informing prevention and intervention strategies to reduce future adult criminality.

58. Oregon Youth Authority. *Using Education Data to Predict Juvenile Justice Involvement: Full Report*. Oregon Youth Authority, https://www.oregon.gov/oya/Research/Using%20Education%20Data%20to%20Predict%20JJ%20Involvement%20-%20Full%20Report.pdf. Accessed December 31, 2024.
This report by the Oregon Youth Authority explores how education data can be used to predict juvenile justice involvement. It highlights the correlation between academic performance, attendance, and other school-related factors with the likelihood of future juvenile justice system involvement. The findings aim to help inform early intervention strategies and policy decisions to reduce juvenile delinquency through targeted educational support and preventive measures.

59. Rabbit MP, Hales LJ, Deed-Jones M. Food security and nutrition assistance. United States Department of Agriculture. 2024. https://www.ers.usda.gov/data-products/ag-and-food-statistics-charting-the-essentials/food-security-and-nutrition-assistance#:~:text=The%20prevalence%20of%20food%20insecurity,of%20a%20lack%20of%20resources. Accessed December 31, 2024.
This webpage provides an overview of food insecurity in the United States. Food insecurity is measured using an annual, national survey conducted by the Economic Research Service division of the United States Department of Agriculture.

60. National Center for Education Statistics. (2023). *Percentage of students who were eligible for free or reduced-price lunch, by selected characteristics: 2021–22*. Digest of Education Statistics. U.S. Department of Education, Institute of Education Sciences. https://nces.ed.gov/programs/digest/d23/tables/dt23_204.10.asp . Accessed December 31, 2024.
This NCES table provides data on the percentage of students eligible for free or reduced-price lunch, broken down by various demographic characteristics for the 2021–22 school year. It offers insights into the socio-economic disparities in U.S. education by illustrating how eligibility for these meal programs varies by factors such as race/ethnicity, school type, and geographic location.

## Neighborhood & Community

61. Center for Disease Control. Risk and protective factors for suicide. https://www.cdc.gov/suicide/risk-factors/. Published April 25, 2024. Accessed December 31, 2024.
The Center for Disease Control, which is a government agency under the Department of Health and Human Services, publishes research, guidance, and resources on public health matters. The referenced article provides a high-level overview of risk and protective factors for suicide, including individual, relationship, community, and societal-level factors.

62. Wickramaratne PJ, Yangchen T, Lepow L, et al. Social connectedness as a determinant of mental health: A scoping review. *PLoS One*. 2022;19(11). doi: 10.1371/journal.pone.0314220
This scoping review analyzed research from 66 studies related to social connectedness and overall health. One of the main takeaways from this publication is that there is ample research demonstrating that social connectedness is a protective factor for depressive and other mental health symptoms.

63. Moll A, Collado S, Staats H, Corraliza JA. *Restorative effects of exposure to nature on children and adolescents: A systematic review. Environmental Psychology*. Published October 11, 2022. doi:10.1016/j.jenvp.2022.101494. https://www.sciencedirect.com/science/article/pii/S0272494422001293?via%3Dihub. Accessed February 4, 2025.
This systematic review explores the restorative effects of nature exposure on children and adolescents, analyzing studies that demonstrate how natural environments positively impact mental health, emotional well-being, and behavioral development in younger populations. It highlights the role of nature in fostering healthier developmental outcomes.

64. Wales M, Mårtensson F, Hoff E, Jansson M. Elevating the Role of the Outdoor Environment for Adolescent Wellbeing in Everyday Life. *Frontiers in Psychology*. Published March 3, 2022. doi:10.3389/fpsyg.2022.774592. https://pmc.ncbi.nlm.nih.gov/articles/PMC8928541/. Accessed February 4, 2025.
This article examines how the outdoor environment contributes to adolescent wellbeing. It explores the positive effects of nature on physical, emotional, and mental health, emphasizing the importance of outdoor activities in promoting holistic wellbeing during adolescence.

65. Li D, Deal B, Zhou X, Slavenas M, Sullivan WC. Moving beyond the neighborhood: Daily exposure to nature and adolescents' mood. *Landscape and Urban Planning*. 2018;173:33-43. doi:10.1016/j.landurbplan.2018.01.009. https://www.sciencedirect.com/science/article/pii/S0169204618300318. Accessed February 4, 2025.
This study by explores how daily exposure to nature influences adolescents' mood, extending the focus beyond neighborhood environments. The research highlights the psychological benefits of nature and suggests that regular exposure to natural settings can significantly improve mood and emotional well-being in adolescents.

66. Jackson SB, Stevenson KT, Larson LR, Peterson MN, Seekamp E. Outdoor Activity Participation Improves Adolescents' Mental Health and Well-Being during the COVID-19 Pandemic. *International Journal of Environmental Research and Public Health*. Published March 3, 2021. doi:10.3390/ijerph18052506. https://www.mdpi.com/1660-4601/18/5/2506. Accessed February 4, 2025
This article examines how outdoor activity participation helped improve adolescents' mental health and well-being during the COVID-19 pandemic. The study highlights the positive effects of nature-based activities on adolescents' emotional resilience, providing crucial insights into the role of outdoor engagement during times of crisis.

67. Twohig-Bennett C, Jones A. The health benefits of the great outdoors: A systematic review and meta-analysis of greenspace exposure and health outcomes. *Environ Int*. 2018;120:214-228. doi:10.1016/j.envres.2018.06.030. Accessed February 4, 2025. https://www.sciencedirect.com/science/article/pii/S0013935118303323.
This systematic review and meta-analysis examine the health benefits of greenspace exposure, evaluating studies that link access to outdoor green spaces with improved physical and mental health outcomes, such as reduced stress, enhanced well-being, and lower rates of chronic diseases.

68. Oregon Parks and Recreation Department. Outdoor recreation in Oregon: Responding to demographic and societal change. 2019. https://www.oregon.gov/oprd/prp/pages/pla-scorp.aspx. Accessed December 31, 2024.
The Statewide Comprehensive Outdoor Recreation Plan is published by the Oregon Parks and Recreation Department every five years. The report includes data, guidance and recommendations for the state. Results from the Oregon Outdoor Recreation Survey are included in the report.

69. Oregon Department of Education. Digital learning: Resources for Oregon's educators. https://www.oregon.gov/ode/educator-resources/teachingcontent/Pages/default.aspx. Accessed December 31, 2024.
The Oregon Department of Education publishes resources related to education technology, digital instruction, digital pedagogy and school design. This website has information about remote learning and how the digital divide impacts students.

70. BroadbandNow Research. National broadband map. https://broadbandnow.com/research/national-broadband-map. Accessed December 31, 2024.
BroadbandNow's Research Division studies the social, economic, and political issues related to internet access and the digital divide. They integrate data from internet service providers, the Federal Communications Commission's Form 477 deployment information, and community demographics into their analyses.

71. FCC increases broadbands speed benchmark. Press release. Federal Communications Commission. Published March 14, 2024. https://docs.fcc.gov/public/attachments/DOC-401205A1.pdf . Accessed December 31, 2024.
The Federal Communications Commission is the government agency that regulates radio, television, wire, satellite, and cable across the United States. This press release describes the change in the high-speed fixed broadband definition to reflect adapting needs and standards.

72. Oregon Department of Transportation. State of the system. https://www.oregon.gov/odot/planning/state-of-the-system/pages/mobility.aspx. Accessed December 31, 2024.
This website describes Oregon's progress on seven key transportation areas identified in the Oregon Transportation Plan, which is developed by the Oregon Department of Transportation. The Mobility subpage was the source for the information cited, which includes information on the mobility and accessibility of transit.
73. Oregon Department of Transportation. Oregon public transportation plan. September 20, 2018. https://www.oregon.gov/odot/Planning/Documents/OPTP_V1_FINAL_Feb2019.pdf. Accessed December 31, 2024.
The Oregon Public Transportation Plan is an element of the broader Oregon Transportation Plan. In this report, the Oregon Department of Transportation outlines current usage data and strategic planning efforts related to public transportation.
74. Oregon Health Authority. Oregon Health Plan (OHP) and Travel Help. https://www.oregon.gov/oha/hsd/ohp/pages/nemt.aspx. Accessed December 31, 2024.
The Oregon Health Plan travel help webpage outlines ways in which members can access non-emergent medical transportation. The site includes coverage information, a searchable list of providers by county, and instructions for getting rides to appointments.
75. Oregon Health Authority. Non-Emergency Medical Transportation (NEMT) Technical Advisory Committee (TAC). https://www.oregon.gov/oha/hsd/ohp/pages/nemt-tac.aspx. Accessed February 4, 2025.
This webpage from the Oregon Health Authority provides information about the Non-Emergency Medical Transportation (NEMT) Technical Advisory Committee (TAC). It outlines the committee's role in advising on policies and programs related to non-emergency medical transportation services for Medicaid recipients.
76. Oregon Department of Veterans' Affairs. Transportation Services. https://www.oregon.gov/odva/benefits/pages/transportation.aspx#:~:text=Reservations%20are%20needed%20for%20transportation,%2D826%2D2111%2C%20ext. Accessed February 4, 2025.
This webpage from the Oregon Department of Veterans' Affairs provides information on transportation services available to veterans. It outlines the process for scheduling transportation, including the need for reservations, and offers contact details for arranging rides.
77. Oregon Department of Veterans' Affairs. Highly Rural Transportation Grant Program crosses 2 million-mile mark for Oregon veterans. Published September 19, 2022. https://oregondva.com/2022/09/19/highly-rural-transportation-grant-program-crosses-2-million-mile-mark-for-oregon-veterans/. Accessed February 4, 2025.
This article discusses the success of the Highly Rural Transportation Grant Program, which has helped Oregon veterans by providing transportation services. The program recently surpassed the 2-million-mile mark, facilitating travel for veterans in rural areas to access medical care and other vital services.
78. Annie E. Casey Foundation. The Impact of the High Cost of Child Care. Published June 14, 2023. Accessed https://www.aecf.org/blog/how-the-high-cost-of-child-care-hurts-families-workers-economy. February 4, 2025.
This article from the Annie E. Casey Foundation discusses the significant economic and social impacts of high childcare costs on families, workers, and the broader economy. It highlights how the burden of expensive childcare can limit parents' ability to work, particularly for low-income families, and underscores the need for policy changes to address affordability.
79. Center for American Progress. U.S. child care desert interactive map. https://childcaredeserts.org/. Accessed December 31, 2024.
This interactive tool enables users to search for childcare deserts by city or town. There is also a poverty indicator overlay feature, which demonstrates how poverty and childcare supply are

related. The Center for American Progress utilizes an enhanced two-stage floating catchment area method to identify childcare deserts, which "measures the supply of slots within a family-specific catchment area and adjusts each nearby provider's capacity based on the number of young children near that provider".

80. Oregon Department of Early Learning and Care. Dashboards. https://www.oregon.gov/delc/data/Pages/default.aspx. Accessed December 31, 2024.
The Oregon Department of Early Learning and Care's dashboards webpage includes data on several programs/projects: Employment Related Day-Care, Child-Care Licensing Division, Preschool Promise, Early Learning Map of Oregon, and Raise Up Oregon. Data from the Licensing Division dashboard was used to understand how many licensed facilities are in Oregon and how licensed capacity shifts over time.

81. Oregon Department of Early Learning and Care. Employment-Related Day Care (ERDC) Program. https://www.oregon.gov/delc/programs/Pages/erdc.aspx. Accessed February 4, 2025.
This webpage from the Oregon Department of Early Learning and Care provides information on the Employment-Related Day Care (ERDC) program, which helps low-income families access affordable childcare while they work or attend school. It outlines eligibility requirements, how to apply, and the financial assistance available to qualifying families.

82. Oregon Department of Early Learning and Care. Relief Nurseries Program. https://www.oregon.gov/delc/programs/pages/relief-nurseries.aspx. Accessed February 4, 2025.
This webpage from the Oregon Department of Early Learning and Care provides details about the Relief Nurseries Program, which offers support to families facing stress, abuse, or neglect. The program provides a range of services, including early childhood education, family support, and crisis intervention.

83. National Institute of Child Health and Human Development. Why is early learning important? Accessed https://www.nichd.nih.gov/health/topics/early-learning/conditioninfo/matter. February 4, 2025.
This webpage explains the importance of early learning for a child's development. It highlights how early experiences shape brain development and impact cognitive, social, and emotional skills.

84. Oregon Department of Early Learning and Care. *Preschool Promise*. https://www.oregon.gov/delc/programs/pages/preschool-promise.aspx. Accessed December 31, 2024.
This webpage provides information about Oregon's Preschool Promise program, which offers free, high-quality preschool education to children from low-income families. It highlights eligibility criteria, program benefits, and the goal of increasing access to early childhood education to help prepare young children for success in school.

85. Oregon Department of Early Learning and Care. Oregon Preschool to Kindergarten (OPK). Data Dashboard. https://app.powerbigov.us/view?r=eyJrIjoiYTEzNWVhYzEtNWY1YS00NjYwLTg1YmQtNDA2M2Q5YWUxNTBhIiwidCI6ImFhM2Y2OTMyLWZhN2MtNDdiNC1hMGNlLWE1OThjYWQxNjFjZiJ9. Updated January 15, 2025. Accessed February 4, 2025.
This data dashboard describes Oregon Preschool to Kindergarten (OPK) program and provides state-level and county-level enrollment data. This dashboard also provides child and family data such as medical and dental insurance information.

86. National Institute for Early Education Research (NIEER). (2024). *The state of preschool 2023: Oregon*. https://nieer.org/sites/default/files/2024-04/oregon_2023.pdf. Accessed December 31, 2024.
This report from the National Institute for Early Education Research (NIEER) provides an analysis of Oregon's preschool programs in 2023, including key metrics such as enrollment, funding, and quality standards. It evaluates the state's progress in early childhood education and identifies areas for improvement, offering insights into the effectiveness of Oregon's preschool initiatives.

87. Oregon Department of Early Learning and Care. Preschool Promise. Data Dashboard. https://app.powerbigov.us/view?r=eyJrIjoiNmZlYzJlOTItYjA2Zi00YzZkLThkMTAtMGIxZTI3NWIzZGM5Ii

widCI6ImFhM2Y2OTMyLWZhN2MtNDdiNC1hMGNlLWE1OThjYWQxNjFjZiJ9. Accessed February 4, 2025.
This data dashboard describes the Preschool Promise program and provides state-level and county-level enrollment data.

88. Preschool for All Multnomah County. Implementation Update. https://drive.google.com/file/d/1UaYArTl8iVFPMurjhJ7apoSIJ9z4E_zH/view
This source outlines the *Preschool for All* program in Multnomah County, designed to provide free, high-quality preschool to all families. It highlights the program's expansion, goals for universal access by 2030, and its benefits for children's education, parental workforce participation, and the local economy.

89. Irwin V, Wang K, Tezil T, et al. The Condition of Education 2023: Enrollment Rates of Young Children. National Center for Education Statistics. https://nces.ed.gov/programs/coe/pdf/2023/cfa_508.pdf. Published August 2023. Accessed February 4, 2025
This report provides a comprehensive overview of the current state of education in the United States. It highlights key trends in early childhood, K-12, and postsecondary education, including enrollment, academic performance, and access to educational resources. The report also examines disparities across various demographic groups and offers insights into factors influencing educational outcomes.

90. Citizens for Safe Schools. About us. https://citizensforsafeschools.org/about/. Accessed December 31, 2024.
Citizens for Safe Schools offers youth and young adult drop-in services. This webpage was used to gather data on locations, ages served, and services provided.

91. Connected Lane County. Creating opportunities for youth. https://connectedlane.org/. Accessed December 31, 2024.
Connected Lane County offers youth and young adult drop-in services. This webpage was used to gather data on locations, ages served, and services provided.

92. Community Outreach through Radical Empowerment. Zephyr House. https://coreeugene.org/. Accessed December 31, 2024.
Community Outreach through Radical Empowerment offers youth and young adult drop-in services. This webpage was used to gather data on locations, ages served, and services provided.

93. Deschutes County. The Drop. https://www.deschutes.org/health/page/drop. Accessed December 31, 2024.
Deschutes County offers youth and young adult drop-in services. This webpage was used to gather data on locations, ages served, and services provided.

94. Jackson Street Youth Services. Helping youth 24/7/365. https://www.jacksonstreet.org/. Accessed December 31, 2024.
Jackson Street Youth Services offers youth and young adult drop-in services. This webpage was used to gather data on locations, ages served, and services provided.

95. Home Plate Youth Services. https://www.homeplateyouth.org/. Accessed December 31, 2024.
Home Plate Youth Services offers youth and young adult drop-in services. This webpage was used to gather data on locations, ages served, and services provided.

96. Hosea Youth Services. Resource center. https://www.hoseayouth.org/drop-in-center/. Accessed December 31, 2024.
Hosea Youth Services offers youth and young adult drop-in services. This webpage was used to gather data on locations, ages served, and services provided.

97. Looking Glass Community Services. New Roads. https://www.lookingglass.us/new-roads. Accessed December 31, 2024.
Looking Glass Community Services offers youth and young adult drop-in services. This webpage was used to gather data on locations, ages served, and services provided.

98. New Avenues for Youth. Drop-in day services https://newavenues.org/drop-in-day/. Accessed December 31, 2024.
New Avenues for Youth offers youth and young adult drop-in services. This webpage was used to gather data on locations, ages served, and services provided.
99. Ophelia's Place. After & out-of-school programs. https://www.opheliasplace.net/after-school-programs. Accessed December 31, 2024.
Ophelia's Place offers youth and young adult drop-in services. This webpage was used to gather data on locations, ages served, and services provided.
100. Yamhill Community Action Partnership. Our drop-in centers. https://yamhillcap.org/youth-drop-in-center. Accessed December 31, 2024.
The Yamhill Community Action Partnership offers youth and young adult drop-in services. This webpage was used to gather data on locations, ages served, and services provided.
101. Youth Era. Drop-in centers. https://www.youthera.org/drop-in-centers. Accessed December 31, 2024.
Youth Era offers youth and young adult drop-in services. This webpage was used to gather data on locations, ages served, and services provided.
102. Youth Motivating Others through Voices of Experience (M.O.V.E.) Oregon. Drop-in centers. https://www.youthmoveoregon.org/drop-in/. Accessed December 31, 2024.
Youth M.O.V.E. offers youth and young adult drop-in services. This webpage was used to gather data on locations, ages served, and services provided.
103. Youth Rising. Drop-ins. https://www.youthrising.org/dropins, Accessed December 31, 2024.
Youth Rising offers youth and young adult drop-in services. This webpage was used to gather data on locations, ages served, and services provided.
104. U.S. Department of Health and Human Services. Parents Under Pressure: The Impact of Parental Stress on Families. https://www.hhs.gov/sites/default/files/parents-under-pressure.pdf. Published 2024. Accessed February 4, 2025
This report from the U.S. Department of Health and Human Services explores the effects of parental stress on families. It highlights how stressors such as financial instability, lack of support, and work-life imbalance impact parents' well-being and, in turn, their children's development.
105. 211info. https://www.211info.org/. Accessed December 31, 2024.
211info helps parents connect to resources. This webpage was used to determine the types and locations of services offered.
106. Oregon Center for Children and Youth with Special Health Needs. CaCoon. https://www.ohsu.edu/occyshn/cacoon-carecoordination. Accessed December 31, 2024.
Oregon Center for Children and Youth with Special Health Needs' CaCoon program offers parent educational and support services. This webpage was used to determine the types and locations of services offered.
107. Oregon Health Authority. Collaborative Problem Solving. https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/Collaborative%20Problem%20Solving%20Fact%20Sheet%202024.pdf. Accessed December 31, 2024.
Collaborative Problem Solving offers parent educational and support services. This webpage was used to determine the types and locations of services offered.
108. Lives in the Balance. Parents and Families. https://livesinthebalance.org/parents-and-families/. Accessed February 4, 2025
This webpage from Lives in the Balance offers resources and guidance for parents and families, focusing on strategies for managing challenging behaviors in children. It emphasizes a collaborative approach to parenting, advocating for empathy, understanding, and proactive communication.
109. FACT Oregon. https://factoregon.org/. Accessed December 31, 2024.

FACT Oregon offers parent educational and support services. This webpage was used to determine the types and locations of services offered

110. Oregon Department of Human Services. Family support and connections program. https://www.oregon.gov/odhs/children-youth/pages/family-support.aspx. Accessed December 31, 2024.
The Family Support and Connections Program through the Oregon Department of Human Services offers parent educational and support services. This webpage was used to determine the types and locations of services offered

111. National Alliance on Mental Illness Oregon. https://namior.org/. Accessed December 31, 2024.
The National Alliance on Mental Illness in Oregon offers parent educational and support services. This webpage was used to determine the types and locations of services offered

112. Oregon Consortium of Family Networks. Oregon Council on Developmental Disabilities. https://www.ocdd.org/families-supporting-families/. Accessed February 4, 2025.
The webpage by the Oregon Consortium of Family Networks provides resources and support for families of individuals with developmental disabilities. It emphasizes the importance of peer support, education, and advocacy, offering a network to connect families with valuable resources.

113. Oregon Family Support Network. https://ofsn.org/. Accessed December 31, 2024.
The Oregon Family Support Network offers parent educational and support services. This webpage was used to determine the types and locations of services offered

114. Oregon Health & Science University. Oregon Family-to-Family Health Information Center. https://www.ohsu.edu/oregon-family-to-family-health-information-center/resources-age. Accessed December 31, 2024.
Oregon Health & Science University's Oregon Family-to-Family Health Information Center offers parent educational and support services. This webpage was used to determine the types and locations of services offered

115. Oregon State University College of Health. Oregon Parenting Education Collaborative. https://health.oregonstate.edu/opec. Accessed December 31, 2024.
Oregon State University's Oregon Parent Education Collaborative offers parent educational and support services. This webpage was used to determine the types and locations of services offered

116. Reach Out Oregon. https://www.reachoutoregon.org/. Accessed December 31, 2024.
Reach Out Oregon offers parent educational and support services. This webpage was used to determine the types and locations of services offered

117. Providence Health & Services. Swindells Resource Center. https://www.providence.org/locations/or/childrens-health/swindells-resource-center. Accessed December 31, 2024.
Providence's Swindells Resource Center offers parent educational and support services. This webpage was used to determine the types and locations of services offered

118. System of Care Advisory Council. Youth Respite Policy in Oregon. Oregon Health Authority. https://www.oregon.gov/oha/HSD/BH-Child-Family/SOCReports/Respite%20FINAL%20report%20(1).pdf. Published March 2024. Accessed February 4, 2025.
This report discusses the state's Youth Respite Policy, which provides essential support to families of children with behavioral health needs. This document outlines current policies, gaps in services, and provides recommendations for improving respite care accessibility and effectiveness in Oregon, emphasizing the importance of a coordinated approach within the state's System of Care.

## Education System


119. U.S. Department of Homeland Security. *Bullying Prevention Strategies and Resources for K-12 Schools*. https://www.schoolsafety.gov/sites/default/files/2023-03/SchoolSafety.gov%20Bullying%20Prevention%20Resource%20Infographic_March%202023.pdf. Published March 2023. Accessed February 4, 2025.

    This resource from the U.S. Department of Homeland Security provides strategies and tools for preventing bullying in K-12 schools. It includes practical recommendations for creating safe and supportive school environments, addressing various forms of bullying, and engaging students, staff, and families in prevention efforts.

120. Daily SM, Mann MJ, Lilly CL, et al. School climate as a universal intervention to prevent substance use initiation in early adolescence: A longitudinal study. *PMC*. Published April 12, 2020. https://pmc.ncbi.nlm.nih.gov/articles/PMC7427833/. Accessed February 4, 2025.

    This study examines the impact of school climate on preventing substance use initiation during early adolescence. The research highlights how positive school environments, characterized by supportive relationships, clear expectations, and safety, can serve as an effective universal intervention to reduce the likelihood of substance use.

121. Centers for Disease Control and Prevention (CDC). Promoting Mental Health and Well-Being in Schools: An Action Guide for School and District Leaders. https://stacks.cdc.gov/view/cdc/136371 . Published December 3, 2023. Accessed December 31, 2024.

    Through this report the CDC provides information on mental health and wellbeing in schools. Specifically, it outlines why mental health is important in school, some school-based strategies that can be implemented, and explains multi-tiered systems of support.

122. Organization for Economic Co-operation and Development (OECD) Better Life Index. Education. https://www.oecdbetterlifeindex.org/topics/education/#:~:text=Education%20plays%20a%20key%20role,rely%20less%20on%20social%20assistance. Accessed December 31, 2024.

    The OECD's Better Life Index offers data on key areas such as wellbeing, environmental quality, public services, and security, and includes an interactive tool for users to create personalized indexes based on their priorities. This webpage was used to explain the importance of Education on the quality of life.

123. Oregon Department of Education. Schools & Districts Home. https://www.oregon.gov/ode/schools-and-districts/pages/default.aspx. Accessed December 31, 2024.

    This webpage is maintained by the Oregon Department of Education (ODE) and serves as a comprehensive resource for schools and districts in Oregon. It provides information on various educational programs, policies, and services available to local schools and districts. The site also includes updates on educational initiatives, grants, and resources for educators.

124. Oregon Department of Education. (2024). Oregon Department of Education directory [PDF]. Oregon.gov. https://www.oregon.gov/ode/about-us/Documents/CombinedDirectory_20241120_032854.pdf. Accessed December 31, 2024.

    This document is a directory published by the Oregon Department of Education (ODE) that lists key contacts, departments, and services within the agency. The directory includes detailed information such as names, titles, phone numbers, and email addresses, making it a useful tool for educators, administrators, and other stakeholders looking to navigate the ODE structure.

125. Oregon Department of Education. *Correctional, Hospital and Treatment Sites*. https://www.oregon.gov/ode/learning-options/schooltypes/CHaTS/Pages/default.aspx. Accessed February 4, 2025.

    This webpage from the Oregon Department of Education provides information on correctional, hospital, and treatment sites for students in Oregon. It outlines the services and educational

opportunities available to students in these settings, aiming to ensure they receive the necessary support to continue their education while dealing with unique challenges.

126. Oregon AfterSchool for Kids (OregonASK). (2020). Access and equity in afterschool programs: A report on disparities and opportunities. https://oregonask.org/wp-content/uploads/2020/09/access-equity-report_final-1-1.pdf. Accessed December 31, 2024.
This report from Oregon AfterSchool for Kids (OregonASK) examines disparities in access to afterschool programs across Oregon, highlighting inequities based on race, socio-economic status, and geography. It provides insights into how these disparities affect educational outcomes and suggests strategies to enhance equity in afterschool programming.

127. Oregon Department of Education. Early intervention and Early Childhood Special Education (EI/ECSE). https://www.oregon.gov/ode/students-and-family/specialeducation/earlyintervention/pages/default.aspx. Accessed December 31, 2024.
This webpage provides an overview of Oregon's (EI/ECSE) program, which serves children with disabilities from birth to age five. It details the services offered, eligibility requirements, and the program's goal of supporting early development and preparing children for success in school.

128. Oregon Department of Education. Early Intervention/Early Childhood Special Education (EI/ECSE). https://www.oregon.gov/ode/reports-and-data/SpEdReports/Documents/SECCMediaFiles/2019eimediafile.xlsx. Published 2020. Accessed December 31, 2024.
This dataset from the Oregon Department of Education provides access to the December Special Education Child Count Media Files for the 2019–2020 school year. It includes detailed data on the number of children receiving early intervention (EI), and early childhood special education (ECSE).

129. Oregon Department of Education. Early Intervention/Early Childhood Special Education (EI/ECSE). https://www.oregon.gov/ode/reports-and-data/SpEdReports/Documents/SECCMediaFiles/2020eimediafile.xlsx. Published 2021. Accessed December 31, 2024.
This dataset from the Oregon Department of Education provides access to the December Special Education Child Count Media Files for the 2020–2021 school year. It includes detailed data on the number of children receiving early intervention (EI), and early childhood special education (ECSE).

130. Oregon Department of Education. Early Intervention/Early Childhood Special Education (EI/ECSE). https://www.oregon.gov/ode/reports-and-data/SpEdReports/Documents/SECCMediaFiles/2021eimediafile.xlsx. Published 2022. Accessed December 31, 2024.
This dataset from the Oregon Department of Education provides access to the December Special Education Child Count Media Files for the 2021–2022 school year. It includes detailed data on the number of children receiving early intervention (EI), and early childhood special education (ECSE).

131. Oregon Department of Education. Early Intervention/Early Childhood Special Education (EI/ECSE). https://www.oregon.gov/ode/reports-and-data/SpEdReports/Documents/SECCMediaFiles/2022eimediafile.xlsx. Published 2023. Accessed December 31, 2024.
This dataset from the Oregon Department of Education provides access to the December Special Education Child Count Media Files for the 2022–2023 school year. It includes detailed data on the number of children receiving early intervention (EI), and early childhood special education (ECSE).

132. Oregon Department of Education. Early Intervention/Early Childhood Special Education (EI/ECSE). https://www.oregon.gov/ode/reports-and-data/SpEdReports/Documents/SECCMediaFiles/2023eimediafile.xlsx. Published 2024. Accessed December 31, 2024.
This dataset from the Oregon Department of Education provides access to the December Special Education Child Count Media Files for the 2023–2024 school year. It includes detailed data on the number of children receiving early intervention (EI), and early childhood special education (ECSE).

133. Secretary of State. Oregon Audits Division. *ODE Can Better Support Students Experiencing Disabilities Through Improved Coordination and Monitoring of Services* (Report No. 2020-24). https://sos.oregon.gov/audits/Documents/2020-24.pdf. Published June 2020. Accessed February 4, 2025.

This audit report from the Oregon Audits Division examines how the Oregon Department of Education (ODE) can better support students with disabilities. It highlights the need for improved coordination and monitoring of services to ensure these students receive appropriate educational support.

134. ASK Resource Center. *Six Principles of IDEA: The Individuals with Disabilities Education Act*. https://www.askresource.org/resources/six-principles-of-idea. Accessed February 4, 2025.

This resource from the ASK Resource Center explains the six core principles of the Individuals with Disabilities Education Act (IDEA). It outlines how IDEA ensures that students with disabilities have access to free and appropriate public education.

135. Oregon Department of Education. Four-Year Cohort Graduation Rate Trends. https://www.oregon.gov/ode/reports-and-data/students/Documents/CohortTrends22-23.pdf. Published 2023. Accessed December 31, 2024.

This report from the Oregon Department of Education provides data on cohort trends from the 2010-2020 school years. It includes key metrics such as graduation rates, retention, and other student outcomes, offering a comprehensive analysis of student progress across multiple years.

136. Oregon Department of Education. Regular attenders 2020-2021. https://www.oregon.gov/ode/schools-and-districts/reportcards/reportcards/Pages/Regular-Attenders-2021.aspx. Published 2021. Accessed December 31, 2024.

This webpage from the Oregon Department of Education presents data on student attendance for the 2020-2021 school year, specifically focusing on regular attenders. It provides insights into the percentage of students who attended school consistently, highlighting the impact of various factors on attendance patterns.

137. Oregon Department of Education. Regular attenders 2021-2022. https://www.oregon.gov/ode/schools-and-districts/reportcards/reportcards/Pages/Regular-Attenders-2021.aspx. Published 2022. Accessed December 31, 2024.

This webpage from the Oregon Department of Education presents data on student attendance for the 2021-2022 school year, specifically focusing on regular attenders. It provides insights into the percentage of students who attended school consistently, highlighting the impact of various factors on attendance patterns.

138. Oregon Department of Education. Regular attenders 2022-2023. https://www.oregon.gov/ode/schools-and-districts/reportcards/reportcards/Pages/Regular-Attenders-2021.aspx. Published 2023. Accessed December 31, 2024.

This webpage from the Oregon Department of Education presents data on student attendance for the 2022-2023 school year, specifically focusing on regular attenders. It provides insights into the percentage of students who attended school consistently, highlighting the impact of various factors on attendance patterns.

139. Oregon Department of Education. Regular attenders 2023-2024. https://www.oregon.gov/ode/schools-and-districts/reportcards/reportcards/Pages/Regular-Attenders-2021.aspx. Published 2024. Accessed December 31, 2024.

This webpage from the Oregon Department of Education presents data on student attendance for the 2023-2024 school year, specifically focusing on regular attenders. It provides insights into the percentage of students who attended school consistently, highlighting the impact of various factors on attendance patterns.

140. Oregon Department of Education. Discipline, Restraint, and Seclusion Collections. https://www.oregon.gov/ode/students-and-

family/healthsafety/Documents/DisciplineRestraintSeclusion/2019-2020DisciplineDataMedia.xlsx. Published 2020. Accessed December 31, 2024.
This dataset from the Oregon Department of Education presents data on disciplinary incidents that occur in school, such as in-school suspensions, out-of-school suspensions, and expulsions for the 2019-2020 school-year. The data is presented by race/ethnicity, grade, gender, district counts, and statewide counts.

141. The Oregon Department of Education. Discipline, Restraint, and Seclusion Collections. https://www.oregon.gov/ode/students-and-family/healthsafety/Documents/DisciplineRestraintSeclusion/2020-2021DisciplineDataMedia.xlsx. Published 2021. Accessed December 31, 2024.
This dataset from the Oregon Department of Education presents data on disciplinary incidents that occur in school, such as in-school suspensions, out-of-school suspensions, and expulsions for the 2020-2021 school-year. The data is presented by race/ethnicity, grade, gender, district counts, and statewide counts.

142. The Oregon Department of Education. Discipline, Restraint, and Seclusion Collections. https://www.oregon.gov/ode/students-and-family/healthsafety/Documents/DisciplineRestraintSeclusion/2021-2022DisciplineDataMedia.xlsx. Published 2022. Accessed December 31, 2024.
This dataset from the Oregon Department of Education presents data on disciplinary incidents that occur in school, such as in-school suspensions, out-of-school suspensions, and expulsions for the 2021-2022 school-year. The data is presented by race/ethnicity, grade, gender, district counts, and statewide counts.

143. The Oregon Department of Education. Discipline, Restraint, and Seclusion Collections. https://www.oregon.gov/ode/students-and-family/healthsafety/Documents/DisciplineRestraintSeclusion/2022-2023DisciplineMediaFile.xlsx. Published 2023. Accessed December 31, 2024.
This dataset from the Oregon Department of Education presents data on disciplinary incidents that occur in school, such as in-school suspensions, out-of-school suspensions, and expulsions for the 2022-2023 school-year. The data is presented by race/ethnicity, grade, gender, district counts, and statewide counts.

144. The Oregon Department of Education. Dropout/Pushout Rates in Oregon High Schools. *Dropout tables 2019-2020*. https://www.oregon.gov/ode/reports-and-data/students/Documents/dropouttables2019-2020.xlsx . Published 2020. Accessed December 31, 2024.
This Excel file from the Oregon Department of Education provides detailed data on student dropouts for the 2019-2020 school year. It includes breakdowns by demographic factors such as grade level, ethnicity, and school district, offering insights into trends and disparities in student retention.

145. The Oregon Department of Education. Dropout/Pushout Rates in Oregon High Schools. *Dropout tables* 2020-2021. https://www.oregon.gov/ode/reports-and-data/students/Documents/dropouttables2019-2020.xlsx. Published 2021. Accessed December 31, 2024.
This Excel file from the Oregon Department of Education provides detailed data on student dropouts for the 2020-2021 school year. It includes breakdowns by demographic factors such as grade level, ethnicity, and school district, offering insights into trends and disparities in student retention.

146. The Oregon Department of Education. (2022). Dropout/Pushout Rates in Oregon High Schools. *Dropout tables 2021-2022*. https://www.oregon.gov/ode/reports-and-data/students/Documents/dropouttables2019-2020.xlsx. Published 2022. Accessed December 31, 2024.
This Excel file from the Oregon Department of Education provides detailed data on student dropouts for the *2021-2022* school year. It includes breakdowns by demographic factors such as

grade level, ethnicity, and school district, offering insights into trends and disparities in student retention

147. The Oregon Department of Education. (2023). Dropout/Pushout Rates in Oregon High Schools. *Dropout tables 2022-2023*. https://www.oregon.gov/ode/reports-and-data/students/Documents/dropouttables2019-2020.xlsx. Published 2023. Accessed December 31, 2024.
This Excel file from the Oregon Department of Education provides detailed data on student dropouts for the *2022-2023* school year. It includes breakdowns by demographic factors such as grade level, ethnicity, and school district, offering insights into trends and disparities in student retention

148. The Oregon Department of Education. (2024). Dropout/Pushout Rates in Oregon High Schools. *Dropout tables 2023-2024*.. https://www.oregon.gov/ode/reports-and-data/students/Documents/dropouttables2019-2020.xlsx. Accessed December 31, 2024
This Excel file from the Oregon Department of Education provides detailed data on student dropouts for the *2023-2024* school year. It includes breakdowns by demographic factors such as grade level, ethnicity, and school district, offering insights into trends and disparities in student retention

149. FutureEd. (2023). *Tracking state trends in chronic absenteeism*. https://www.future-ed.org/tracking-state-trends-in-chronic-absenteeism/. Accessed December 31, 2024.
This article from FutureEd analyzes state-level trends in chronic absenteeism in U.S. schools, focusing on the factors contributing to high absentee rates and the impact on student achievement. It provides insights into how different states are addressing absenteeism and highlights policies aimed at improving attendance.

150. National Center for Education Statistics. Percentage of students suspended and expelled from public elementary and secondary schools, by sex, race/ethnicity, and state or jurisdiction: School year 2020-21. Published February 2024. Digest of Education Statistics. U.S. Department of Education, Institute of Education Sciences. https://nces.ed.gov/programs/digest/d23/tables/dt23_233.40.asp. Accessed December 31, 2024.
This NCES table provides data on public school student enrollment, including charter schools, for the 2021–22 school year. It highlights enrollment trends and charter school growth, offering insights useful for policymakers, researchers, and educators analyzing U.S. education patterns

151. National Center for Education Statistics. *Fast facts: Dropout Rates*. https://nces.ed.gov/fastfacts/display.asp?id=16. Accessed December 31, 2024.
This webpage from the National Center for Education Statistics presents key data on high school dropout rates in the U.S., including trends by demographic factors such as race/ethnicity, gender, and socioeconomic status.

152. The Oregon Department of Education. Oregon Statewide Report Card 2023-24. https://www.oregon.gov/ode/schools-and-districts/reportcards/Documents/rptcd2024.pdf. Published November 25, 2024. Accessed December 31, 2024.
This document from the Oregon Department of Education provides the 2023-2024 school and district report cards, offering detailed data on academic performance, student outcomes, and school characteristics across Oregon. It includes information on key indicators such as graduation rates, student achievement, and equity measures. This report is essential for understanding the performance and progress of Oregon schools, helping educators, policymakers, and the public make informed decisions to support educational improvement and equity.

153. Oregon Department of Education. *Appendix B: Targeted Universalism & Snapshots of Focal Student Groups*. https://www.oregon.gov/ode/StudentSuccess/Documents/AppendixB_TargetedUniversalism.pdf. Accessed February 4, 2025.

This document from the Oregon Department of Education outlines the concept of Targeted Universalism and its application in educational settings. It discusses strategies to address the needs of specific student groups while working toward universal goals for all students.

154. National Center for Education Statistics. (2024). *Percentage of high school students who graduated on time, by selected characteristics: 2021–22*. Digest of Education Statistics. U.S. Department of Education, Institute of Education Sciences. https://nces.ed.gov/programs/digest/d24/tables/dt24_219.10.asp?current=yes. Accessed December 31, 2024.
This table from the National Center for Education Statistics provides data on the on-time graduation rates for high school students in the 2021–22 school year, broken down by various demographic characteristics such as race, gender, and socio-economic status.

155. The Oregon Department of Education. Cohort Graduation Rate 2019-2020 Media File. https://www.oregon.gov/ode/reports-and-data/students/Documents/cohortmediafile2019-2020_revised.xlsx. Published 2020. Accessed December 31, 2024.
This dataset from the Oregon Department of Education provides data on graduation rates for the 2019-2020 school-year. This data includes information on race/ethnicity, student group, gender, statewide rates, county rates, district rates, and school rates.

156. The Oregon Department of Education. Cohort Graduation Rate 2020-2021 Media File. https://www.oregon.gov/ode/reports-and-data/students/Documents/cohortmediafile2020-2021.xlsx. Published 2021. Accessed December 31, 2024.
This dataset from the Oregon Department of Education provides data on graduation rates for the 2020-2021 school-year. This data includes information on race/ethnicity, student group, gender, statewide rates, county rates, district rates, and school rates.

157. The Oregon Department of Education. Cohort Graduation Rate 2021-2022 Media File. https://www.oregon.gov/ode/reports-and-data/students/Documents/cohortmediafile2021-2022.xlsx. Published 2022. Accessed December 31, 2024.
This dataset from the Oregon Department of Education provides data on graduation rates for the 2021-2022 school-year. This data includes information on race/ethnicity, student group, gender, statewide rates, county rates, district rates, and school rates.

158. The Oregon Department of Education. Cohort Graduation Rate 2022-2023 Media File. https://www.oregon.gov/ode/reports-and-data/students/Documents/cohortmediafile2022-2023trends.xlsx. Published 2023. Accessed December 31, 2024.
This dataset from the Oregon Department of Education provides data on graduation rates for the 2022-2023 school-year. This data includes information on race/ethnicity, student group, gender, statewide rates, county rates, district rates, and school rates.

159. The Oregon Department of Education. Cohort Graduation Rate 2023-2024 Media File. https://www.oregon.gov/ode/reports-and-data/students/Documents/cohortmediafile2023-2024.xlsx. Published 2024. Accessed December 31, 2024.
This dataset from the Oregon Department of Education provides data on graduation rates for the 2023-2024 school-year. This data includes information on race/ethnicity, student group, gender, statewide rates, county rates, district rates, and school rates.

160. Panchal N, Cox C, Rudowitz R. *The Landscape of School-Based Mental Health Services*. Kaiser Family Foundation. https://www.kff.org/mental-health/issue-brief/the-landscape-of-school-based-mental-health-services/. Published September 6, 2022. Accessed February 4, 2025.
This report from the Kaiser Family Foundation explores the state of school-based mental health services in the United States. It discusses the growing demand for mental health support in schools, particularly in light of the COVID-19 pandemic, and examines the challenges schools face in providing these services.

161. Oregon Department of Education. *Mental and Behavioral Health Services in Schools*. https://www.oregon.gov/ode/students-and-family/mental-

health/Documents/Mental%20and%20Behavioral%20Health%20Services%20in%20Schools.pdf. Accessed February 4, 2025.
This document outlines mental and behavioral health services available in schools across Oregon. It provides information on how these services are integrated into the educational system, the roles of school-based professionals, and the support available for students experiencing mental health challenges.

162. Oregon Health Authority. *School-Based Health Centers*. https://www.oregon.gov/oha/ph/healthypeoplefamilies/youth/healthschool/schoolbasedhealthcenters/pages/index.aspx. Accessed February 4, 2025.
This page from the Oregon Health Authority provides information about School-Based Health Centers (SBHCs) in Oregon. It outlines how these centers offer comprehensive health services, including medical, mental, and dental care, directly within schools.

163. Oregon Health Authority. *School-Based Health Centers Certification Map*. https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/YOUTH/HEALTHSCHOOL/SCHOOLBASEDHEALTHCENTERS/Documents/SBHC%20Certification/SBHC%20Map.pdf. Published September 2024. Accessed February 4, 2025.
This map from the Oregon Health Authority provides a visual representation of certified School-Based Health Centers (SBHCs) across Oregon. It helps identify the locations of these centers, which offer a range of health services, including medical, mental, and dental care, to students in various school districts.

164. Oregon Health Authority. (2024). *School-Based Health Centers Reports and Publications*. https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/YOUTH/HEALTHSCHOOL/SCHOOLBASEDHEALTHCENTERS/Pages/publications.aspx. Accessed December 31, 2024.
This webpage from the Oregon Health Authority provides annual reports and publications for School-Based Health Centers (SBHCs) in Oregon. It includes data on the number of centers, services provided, and the impact of these centers on student health and well-being. The reports highlight the role of SBHCs in improving access to healthcare for students, particularly in underserved areas.

165. Oregon Health Authority. *School-based mental health partnerships*. https://www.oregon.gov/oha/HSD/BH-Child-Family/Pages/Schools.aspx. Accessed December 31, 2024.
This webpage from the Oregon Health Authority outlines the framework for school-based mental health partnerships in Oregon, detailing how schools and mental health providers can collaborate to deliver services to students. It highlights the benefits of these partnerships, including improved access to mental health care, support for students' emotional well-being, and resources for schools in addressing mental health challenges.

166. Foxcroft DR, Tsertsvadze A. *Universal family-based prevention programs for alcohol misuse in young people.* Cochrane Database Syst Rev. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD009308/full. Published September 7, 2011. Accessed February 4, 2025.
This systematic review highlights the potential benefits of involving families in prevention efforts, examining various programs designed to support healthy behaviors and reduce the risk of alcohol misuse.

167. Oregon Department of Education. *2023 Oregon Health Standards: K-12 Health Education*. https://www.oregon.gov/ode/educator-resources/standards/health/Documents/Health%20Standards%20Adopted%2010.19.23.pdf. Published October 19, 2023. Accessed February 4, 2025.
This document provides a framework for health education that supports students' physical, emotional, and mental well-being, emphasizing skills development in areas like nutrition, physical activity, substance abuse prevention, and social-emotional health.

168. Oregon Department of Education. *Annually required lessons for the 2024-2025 school year*. https://www.oregon.gov/ode/educator-resources/standards/health/Pages/default.aspx. Accessed December 31, 2024.
This webpage from the Oregon Department of Education outlines the annually required substance use education lessons for the 2024-2025 school year. It provides guidance on the specific lessons and content areas that must be taught.

169. Hersh, R. (2024, January 16). *Investigation: Most Oregon drug-use prevention programs for kids not science-backed*. OPB.. https://www.opb.org/article/2024/01/16/investigation-most-oregon-drug-use-prevention-programs-for-kids-not-science-backed/. Accessed December 31, 2024
This article from OPB investigates the effectiveness of drug-use prevention programs for children in Oregon, revealing that most of these programs are not supported by scientific evidence. It discusses the gap between the programs implemented in schools and those proven to be effective through research.

170. Green, E., & Yost, E. *Drug prevention in Oregon classrooms*. The Lund Report. https://www.thelundreport.org/prevention-project. Accessed December 31, 2024.
This article discusses drug prevention programs implemented in Oregon classrooms, focusing on their effectiveness and the challenges of implementing evidence-based approaches. It examines various prevention strategies and the need for better alignment with scientific research.

171. Oregon Secretary of State. *OAR 581-022-2045: Health Education*. OregonLaws. https://oregon.public.law/rules/oar_581-022-2045. . Accessed February 4, 2025
This state law, *OAR 581-022-2045*, establishes the requirements for health education in Oregon's K-12 schools. It outlines the standards for teaching health education, including the topics to be covered, such as physical health, mental and emotional well-being, and safety.

172. Oregon Department of Education. *Student Educational Equity Development (SEED) Survey 2023-2024 State Report*. Published November 2024. https://www.oregon.gov/ode/educator-resources/assessment/Documents/TestResults2324/SEED_ElevatingStudentVoice_2324.pdf. Accessed February 4, 2025.
The *Student Educational Equity Development (SEED) Survey 2023-2024 State Report* presents findings on the experiences and perspectives of students regarding educational equity in Oregon. The report highlights student voices on topics such as inclusivity, engagement, access to resources, and overall educational experiences.

173. Oregon Health Authority. *Variables for the Student Health Survey Data Portal*. https://www.bach-harrison.com/SHSDataPortal/Variables.aspx. Accessed December 31, 2024.
This resource from the Oregon Health Authority provides access to the Student Health Survey Data Portal, where users can explore specific variables asked in the survey. The portal allows users to view detailed data on topics such as student health, behavior, and wellness, offering a tool for researchers and policymakers to analyze trends and assess the effectiveness of health programs in schools.

174. American Psychological Association. Students experiencing stress. https://www.apa.org/ed/schools/primer/stress. Accessed December 31, 2024.
This webpage from the American Psychological Association explores the factors contributing to stress among students, its impact on learning and well-being, and ways to address it. It provides valuable information for educators, school administrators, and mental health professionals about recognizing signs of stress in students and implementing strategies to reduce its effects. The resource emphasizes the importance of fostering a supportive school environment to help students manage stress effectively.

## Physical Health Care System


175. Oregon Health Authority. Patient-Centered Primary Care Home Program. https://www.oregon.gov/oha/hpa/dsi-pcpch/pages/index.aspx. Accessed February 4, 2025.
    This webpage outlines Oregon's initiative to improve primary care through patient-centered models. It focuses on enhancing care coordination, accessibility, and patient outcomes by supporting primary care homes that deliver comprehensive and personalized services.
176. Oregon Health Authority. Patient-Centered Primary Care Home Program 2025 Recognition Criteria Technical Specifications and Reporting Guide. https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/2025-PCPCH-TA-Guide.pdf. Published January 2025. Accessed February 4, 2025.
    This guide outlines the 2025 recognition criteria, technical specifications, and reporting requirements for the Patient-Centered Primary Care Home Program in Oregon. The guide also provides essential information for healthcare providers to meet the program's standards, focusing on quality improvement, care coordination, and patient-centered care.
177. National Institute of Child Health and Human Development. *Prenatal care* [Webpage]. U.S. Department of Health and Human Services. https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/prenatal-care. Accessed December 31, 2024.
    This webpage from the National Institute of Child Health and Human Development provides comprehensive information about the importance of prenatal care during pregnancy. It explains the benefits of regular prenatal visits for monitoring the health of both the mother and the developing baby. The page also covers key topics such as screenings, tests, nutrition, and lifestyle factors that contribute to a healthy pregnancy.
178. America's Health Rankings. *Prenatal care: Adequacy of care in Oregon* [Webpage]. United Health Foundation. https://www.americashealthrankings.org/explore/measures/prenatalcare_adquate/OR#measure-trend-summary. Accessed December 31, 2024.
    This webpage from America's Health Rankings provides data on the adequacy of prenatal care in Oregon, offering insights into trends in maternal health and the availability of sufficient prenatal care services. The page highlights changes over time and compares Oregon's performance with national averages.
179. Oregon Health Authority. 2023 CCO Performance Metrics Dashboard. https://visual-data.dhsoha.state.or.us/t/OHA/views/CCOPerformanceMetrics/raceethnicity?%3Aembed=y&%3AisGuestRedirectFromVizportal=y. Accessed December 31, 2024.
    This dashboard from Oregon Health Authority collects information on 2023 CCO performance. Each metric can be filtered by race/ethnicity, language, and disability. The dashboard also allows for comparison across CCOs.
180. Lopez-Gonzalez DM, Kopparapu AK. Postpartum Care of the New Mother. Published December 2022. National Library of Medicine. National Institutes of Health. https://www.ncbi.nlm.nih.gov/books/NBK565875/. Accessed December 31, 2024.
    This article provides updated guidance on the physical and emotional aspects of postpartum care, including managing common challenges and complications, as well as the importance of follow-up care for ensuring maternal well-being.
181. Oregon Pregnancy Risk Assessment Monitoring System (PRAMS). 2020 Oregon Births Results by Topic. https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/DATAREPORTS/PRAMS/SiteAssets/Pages/index/Oregon%20PRAMS%202020%20Frequencies.pdf . Published 2021. Accessed December 31, 2024.
    This document presents frequency data from the 2020 Oregon Pregnancy Risk Assessment Monitoring System (PRAMS) survey, highlighting maternal health and behaviors. It is useful for understanding trends in maternal and infant health to inform public health interventions.

182. Oregon Health Authority. Oregon Pregnancy Risk Assessment Monitoring System (PRAMS)2021 frequencies. https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/DATAREPORTS/PRAMS/Documents/Oregon%20P. Published 2022. Accessed December 31, 2024.
This document provides frequency data from the 2021 Oregon Pregnancy Risk Assessment Monitoring System (PRAMS) survey, focusing on maternal health behaviors, experiences, and outcomes.

183. Oregon Health Authority. CCO metrics 2023 Final Report. https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2023-CCO-Metrics-Annual-Report.pdf. Published August 2024. Accessed December 31, 2024.
This report provides an analysis of the performance metrics for Coordinated Care Organizations (CCOs) in Oregon for 2023. It includes data on health outcomes, service delivery, and the quality of care provided by CCOs to Oregon's Medicaid population.

184. Oregon Health Authority. Metrics and Scoring Committee. https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metrics-Scoring-Committee.aspx. Accessed February 4, 2025.
This webpage from the Oregon Health Authority describes Oregon's Quality Incentive program, which rewards coordinated care organizations (CCOs) for providing exceptional care.

185. Fairbrother, N., Young, A.H., Janssen, P. et al. *Depression and anxiety during the perinatal period.* BMC Psychiatry 15, 206. Published August 25, 2015. https://doi.org/10.1186/s12888-015-0526-6. Accessed December 31, 2024.
This study explores the prevalence and impact of depression and anxiety during the perinatal period, addressing the mental health challenges faced by women during pregnancy and the postpartum phase. The authors discuss risk factors, screening tools, and treatment options, providing insights into improving mental health care for expectant and new mothers.

186. Mathematica. (2020). Societal costs of untreated perinatal mood and anxiety disorders in the United States. Mathematica. https://mathematica.org/publications/societal-costs-of-untreated-perinatal-mood-and-anxiety-disorders-in-the-united-states
This report by Mathematica estimates the societal costs associated with untreated perinatal mood and anxiety disorders (PMADs) in the United States. The analysis highlights the economic burden of these conditions, including healthcare costs, lost productivity, and the impact on families. It underscores the importance of early detection and treatment of PMADs to reduce long-term costs and improve maternal and child well-being.

187. Oregon Public Health Division. Perinatal Depression Initiative. https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/WOMEN/MATERNALMENTALHEALTH/Documents/perinatal-depression-initiative.pdf. Revised March 2009. Accessed February 4, 2025.
This document from Oregon's Public Health Division describes perinatal depression and highlights the importance of screening and treatment.

188. Oregon Health Authority. Depression Screening and Follow-up Plan Guidance Document. Oregon Health Plan. https://www.oregon.gov/oha/ph/HealthyPeopleFamilies/Youth/HealthSchool/SchoolBasedHealthCenters/Documents/HST/Depression_Screening_Guidance_Document.pdf. Published December 2014. Accessed February 4, 2025.
This document provides Coordinated Care Organizations (CCOs), Oregon clinics, and administrative staff with guidance on implementing depression screenings and follow-up planning in primary care settings.

189. Docherty, A., Najjar, R., Combs, S., Woolley, R., & Stoyles, S. Postpartum depression screening in the first year: A cross-sectional provider analysis in Oregon. Journal of the American Association of Nurse Practitioners, 32(4), 308–315. https://doi.org/10.1097/JXX.0000000000000250. Published April 2020. Accessed December 31, 2024.

This study explores postpartum depression (PPD) screening practices during the first year after childbirth among healthcare providers in Oregon. It highlights the variability in screening approaches and identifies key factors influencing provider decisions to screen for PPD.

190. Oregon Health Authority. Community Strategies. https://www.oregon.gov/oha/ph/healthypeoplefamilies/women/maternalmentalhealth/pages/communitystrategies.aspx. Accessed December 31, 2024.
This webpage from the Oregon Health Authority provides valuable information and resources for addressing maternal mental health issues in communities across Oregon. It offers strategies for building supportive systems for women experiencing mental health challenges during pregnancy and postpartum periods.

191. Oregon Health Authority. *Early and periodic screening, diagnostic, and treatment (EPSDT)*. https://www.oregon.gov/oha/hsd/ohp/pages/epsdt.aspx. Accessed December 31, 2024.
This webpage from the Oregon Health Authority provides information on the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, which is designed to ensure that children enrolled in Medicaid receive necessary preventive health services and treatments. It covers guidelines for screening, diagnosing, and treating health conditions, with an emphasis on ensuring access to comprehensive healthcare for children.

192. Agarwal S. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Team. Email Communication. January 30, 2025.

193. Oregon Health Authority. *CCO Quality Incentive Program Resources*. https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx. Accessed December 31, 2024.
This webpage from the Oregon Health Authority provides resources on various social needs screening tools used to assess and address social determinants of health for individuals and families. The page highlights the importance of identifying factors such as housing, food security, and access to healthcare, which can significantly affect health outcomes.

194. 2024 CCO Incentive Measures and Benchmarks. Oregon Health Authority. https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2024%20CCO%20Incentive%20Measures%20and%20Benchmarks_10.23.2023.pdf. Published October 2023. Accessed December 31, 2024.
This document from the Oregon Health Authority outlines the incentive measures and benchmarks for the 2024 Coordinated Care Organizations (CCOs). It provides detailed information on the performance metrics that CCOs must meet to qualify for incentive payments, including benchmarks related to quality of care, health outcomes, and system improvements.

195. Oregon Pediatric Improvement Partnership (OPIP). https://oregon-pip.org/. Accessed December 31, 2024.
The OPIP website provides valuable resources and information on programs and initiatives aimed at improving pediatric health in Oregon. It focuses on integrating prevention, intervention, and recovery services, and it serves as a hub for both individuals and professionals seeking mental health services and strategies for addiction recovery.

196. Children's Institute. Accessed December 31, 2024. https://childinst.org/. Accessed December 31, 2024.
The Children's Institute is a nonprofit organization focused on improving the mental health, development, and overall well-being of children. It offers a variety of resources, including research, training programs, and community-based initiatives, aimed at enhancing early childhood education and mental health services.

197. Health Aspects of Kindergarten Readiness Measurement Strategy Proposal. Oregon Pediatric Improvement Partnership (OPIP). https://childinst.org/wp-content/uploads/2021/01/UpdatedHAKR_Graphic112119.pdf. Accessed December 31, 2024.
This proposal from the Children's Institute outlines a strategy for measuring health aspects critical to kindergarten readiness. It emphasizes the role of health and well-being in early childhood

development, providing a framework for assessing how physical, emotional, and cognitive health impacts a child's preparedness for school.

198. Social emotional health metric data and reports. Oregon Health Authority. https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Social-Emotional-Metric-Data-and-Reports.aspx. Accessed December 31, 2024.
This page from the Oregon Health Authority provides statewide and Coordinated Care Organization (CCO)-specific data on social-emotional health metrics. The data is valuable for healthcare providers, policymakers, and community organizations working to address mental health disparities and promote emotional resilience at the state and local levels.

199. Oregon Health Authority. *2023 statewide social-emotional health report*. https://www.oregon.gov/oha/HPA/dsi-tc/SocialEmotionalHealthMetricReports/_2023-Statewide-Social-Emotional-Report.pdf. Published 2023. Accessed December 31, 2024.
This document outlines the rates and findings related to the assessment and screening of children's social-emotional (SE) development, as well as the availability of issue-focused intervention and treatment services in Oregon. It presents data on the frequency of these services provided to youth.

200. National Alliance on Mental Illness (NAMI). Mental Health Screening. https://www.nami.org/advocacy/policy-priorities/improving-health/mental-health-screening/. Accessed December 31, 2024.
This page from the National Alliance on Mental Illness (NAMI) highlights the importance of mental health screening as part of comprehensive healthcare. It emphasizes the need for early identification and treatment of mental health conditions to improve outcomes, particularly for children and adolescents.

201. Oregon Health Authority. *Screening, brief intervention, and referral to treatment (SBIRT)*. https://www.oregon.gov/oha/hsd/amh/pages/sbirt.aspx. Accessed December 31, 2024.
This page from the Oregon Health Authority outlines the state's Screening, Brief Intervention, and Referral to Treatment (SBIRT) program, which is designed to identify and address substance use and mental health concerns early. SBIRT provides healthcare providers with a structured approach to screen individuals for risky behaviors, offer brief interventions, and refer them to appropriate treatment when necessary.

202. Oregon Health & Science University. Oregon psychiatric access line (OPAL). https://www.ohsu.edu/school-of-medicine/child-and-adolescent-psychiatry/oregon-psychiatric-access-line-opal. Accessed December 31, 2024.
The Oregon Psychiatric Access Line (OPAL) is a service provided by Oregon Health & Science University (OHSU) to support primary care providers in managing pediatric behavioral health concerns. OPAL offers free, confidential consultation with child and adolescent psychiatrists, helping providers navigate complex cases and improve mental health care for children and adolescents.

203. Sedighi B. Oregon Psychiatric Access Line (OPAL) email communication. January 28, 2025.

204. Think Kids. Collaborative Problem-Solving Resources in Oregon. https://www.ohsu.edu/sites/default/files/2020-01/CPS%20Oregon%20Resource%20Guide%20updated%20January%202020.pdf. Updated January 2020. Accessed December 31, 2024.
Think Kids offers resources and community support for parents and caregivers of children with behavioral challenges. The organization provides training and tools to help families better understand and manage their child's behavior through the Collaborative & Proactive Solutions (CPS) model. This page highlights various services available to support parents, including workshops, consultations, and a network of caregivers.

205. Reuland C. The Oregon Pediatric Improvement Partnership (OPIP) email communication. February 4, 2025.
206. Remote Patient Monitoring. Center for Connected Health Policy. Oregon Health Authority. https://www.cchpca.org/oregon/?category=medicaid-medicare&topic=remote-patient-monitoring. Accessed December 31, 2024.
This resource from the Center for Connected Health Policy discusses the use of remote patient monitoring (RPM) in Oregon's Medicaid and Medicare programs. It explores how RPM is being used to enhance healthcare delivery, especially for rural and underserved populations, by allowing providers to monitor patients remotely.
207. Li T, Luck J, Irvin V, Peterson C, Kaiser A. Oregon's Health Care Workforce Needs Assessment 2023. https://health.oregonstate.edu/sites/health.oregonstate.edu/files/healthcareworkforce/pdf/health-care-workforce-needs-assessment-report-2023.pdf. Published February 2023. Accessed February 4, 2025.
This report provides an in-depth analysis of the health care workforce needs in Oregon for 2023, specifically focusing on identifying shortages and forecasting future demand for healthcare professionals.
208. Li T, Irvin V, Luck J, Bahl A. Oregon's Health Care Workforce Needs Assessment 2025. https://health.oregonstate.edu/sites/health.oregonstate.edu/files/2025-01/2025-oregon-health-care-workforce-needs-assessment-report.pdf. Published January 2025. Accessed February 4, 2025.
This report provides an in-depth analysis of the health care workforce needs in Oregon for 2025, specifically focusing on identifying shortages and forecasting future demand for healthcare professionals.
209. Vogels, E.A. Digital divide persists even as Americans with lower incomes make gains in tech adoption. Pew Research Center. https://www.pewresearch.org/short-reads/2021/06/22/digital-divide-persists-even-as-americans-with-lower-incomes-make-gains-in-tech-adoption/. Accessed December 31, 2024.
This report from the Pew Research Center examines the ongoing digital divide in the U.S., focusing on how lower-income Americans have made gains in technology adoption while still facing significant barriers, particularly in terms of internet access. The report highlights how these disparities continue to impact opportunities in education, healthcare, and employment, emphasizing the need for policies to address the gap in digital access and equity.
210. Oregon Rural Health Clinic (RHC) Telehealth: 2020. Office of Rural Health. *Map*. https://www.arcgis.com/apps/MapSeries/index.html?appid=9b840ed48c764c1dad642805ed26918c. Updated July 2021. Accessed December 31, 2024.
This interactive Story Map from the Oregon Health Authority highlights the utilization of telehealth by Rural Health Clinics (RHCs) in Oregon during the COVID-19 pandemic. The map provides a visual representation of RHC locations and their roles in telehealth delivery, offering insights into the temporary changes made to support rural healthcare during the public health emergency.

## Behavioral Health Care System

211. Oregon Secretary of State. Health Systems Division: Behavioral Health Services - Chapter 309. https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=88. Accessed February 4, 2025.
This webpage outlines regulations related to the provision of behavioral health services in Oregon, including guidelines for program implementation, service delivery, and compliance requirements. This source is essential for understanding the state's behavioral health policies and regulations.

212. OregonLaws. OAR 309-014-0005. https://oregon.public.law/rules/oar_309-014-0005. Accessed February 4, 2025.
This webpage provides the text of OAR 309-014-0005, which outlines regulations related to behavioral health services in Oregon. It details specific rules under the Health Systems Division, guiding the provision and management of behavioral health services.
213. Oregon Health Authority. Certified Community Behavioral Health Clinics (CCBHC). https://www.oregon.gov/oha/hsd/bhp/pages/community-bh-clinics.aspx. Accessed February 4, 2025.
This webpage provides information about Oregon's Certified Community Behavioral Health Clinics (CCBHC), which offer comprehensive behavioral health services to individuals in need. It outlines the program's goals, services provided, and the criteria for certification.
214. Substance Abuse and Mental Health Services Administration. 2023 Uniform Reporting Summary. https://www.samhsa.gov/data/sites/default/files/reports/rpt53141/Oregon.pdf. Published 2023. Accessed February 4, 2025.
This report from the Substance Abuse and Mental Health Services Administration (SAMHSA) provides an overview of Oregon's behavioral health data for 2023. It includes key statistics on mental health and substance use in the state, along with trends and highlights from statewide reporting.
215. Oregon Health Authority. Mental Health Statistics Improvement Program Survey. https://www.oregon.gov/oha/hpa/analytics/pages/mental-health-statistics-improvement-program-survey.aspx. Accessed February 4, 2025.
This webpage provides information about the Mental Health Statistics Improvement Program (MHSIP) Survey, which collects data on the mental health experiences of individuals receiving services in Oregon. The survey helps to assess the quality of care, identify areas for improvement, and support the development of policies aimed at enhancing mental health services across the state.
216. Centers for Disease Control and Prevention. Why Act Early? https://www.cdc.gov/ncbddd/actearly/whyActEarly.html. Accessed February 4, 2025.
This webpage from the Centers for Disease Control and Prevention (CDC) highlights the importance of early developmental monitoring and intervention for children. It emphasizes the benefits of acting early to identify potential developmental delays and the role of parents, caregivers, and healthcare providers in supporting children's health and development.
217. Oregon Health Authority. Early childhood mental health. https://www.oregon.gov/oha/HSD/BH-Child-Family/Pages/Early-Childhood.aspx. Accessed December 31, 2024.
This webpage from the Oregon Health Authority provides information on early childhood mental health services, focusing on the importance of mental and emotional well-being in young children. It outlines initiatives to support mental health in early childhood settings and offers resources for families, caregivers, and providers working with young children.
218. The Incredible Years. Evidence-Based Early Intervention Programs. https://www.incredibleyears.com/. Accessed February 4, 2025.
The Incredible Years website provides information on a series of evidence-based early intervention programs aimed at improving the social-emotional learning, academic skills, and behavioral outcomes of children. The programs, designed for parents, teachers, and children, are grounded in over 40 years of research and are implemented worldwide.
219. Oregon Parenting Education Collaborative. OPEC Hubs. Oregon State University. https://health.oregonstate.edu/opec/hubs. Accessed February 4, 2025.
The Oregon Parenting Education Collaborative (OPEC) supports a statewide network of parenting hubs, which provide resources, professional development, and community collaboration to improve access to parenting education programs. These hubs offer evidence-based and culturally-responsive programs to families, and they work to coordinate services across sectors.

220. Early Assessment and Support Alliance. https://easacommunity.org/. Accessed February 4, 2025.
The Early Assessment and Support Alliance (EASA) website provides information and resources for supporting young individuals experiencing early signs of psychosis. EASA offers a community-based approach to mental health, focusing on early intervention and support to improve outcomes for youth.
221. Early Assessment and Support Alliance (EASA) Center for Excellence's REDCap databases. Oregon Health & Science University, Portland State University. February 2025.
This REDCap Database for the Early Assessment and Support Alliance (EASA) stores data for this program. The data is managed by Oregon Health and Science University and Portland State University.
222. Oregon Health Authority. School-Based Mental Health Partnerships. https://www.oregon.gov/oha/hsd/bh-child-family/pages/schools.aspx#:~:text=Overview,with%20the%20criminal%20justice%20system. Accessed February 4, 2025.
This webpage from the Oregon Health Authority outlines the School-Based Mental Health Partnerships program, which aims to provide mental health services in schools across Oregon. The initiative focuses on supporting students with behavioral health needs, helping prevent school disruptions, and connecting students with services to address mental health challenges.
223. Oregon Health Authority. *Youth suicide prevention*. Oregon.gov. https://www.oregon.gov/oha/hsd/bh-child-family/pages/youth-suicide-prevention.aspx
This webpage provides essential information about youth suicide prevention efforts in Oregon, highlighting key programs, resources, and strategies aimed at reducing suicide rates among young people. It includes details on collaborative efforts between public health agencies, schools, and community organizations to promote mental health awareness, intervention, and support for youth at risk.
224. Baker J. Big River suicide prevention, intervention, and treatment programs. Email Communication. February 14, 2025.
225. Oregon Health Authority. CSAC Family Representative Recommendations. https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/Work-Plan-Recommendations-2022.pdf. Published October 22, 2021. Accessed February 4, 2025.
This document from the Oregon Health Authority outlines recommendations from the CSAC (Child and Family Services Advisory Committee) Family Representatives. It focuses on strategies to improve the delivery of behavioral health services for children and families in Oregon.
226. Oregon Health Authority. Child & Family Behavioral Health Policy Vision. https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/draft-vision-paper2020.pdf. Published October 2020. Accessed February 4, 2025.
This document from the Oregon Health Authority outlines a strategic vision for improving behavioral health services for children and families in Oregon. It highlights goals for enhancing access to care, integrating services across systems, and promoting resilience in youth and families.
227. Centers for Medicare & Medicaid Services. *Psychotherapy and crisis psychotherapy under the physician fee schedule*. https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/psychotherapy-crisis. Accessed December 31, 2024.
This CMS webpage outlines the Medicare payment policies for psychotherapy services, including crisis psychotherapy, under the Physician Fee Schedule. It provides detailed information about reimbursement rates, eligible services, and coding requirements for mental health professionals.
228. CMS Manual System. Pub 100-04 Medicare Claims Processing. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017downloads/R3873CP.pdf. October 6, 2017. Accessed December 31, 2024.

This CMS document provides guidance on the implementation of Medicare's coverage for telehealth services, specifically for psychotherapy and crisis psychotherapy. It includes instructions for healthcare providers on billing, service eligibility, and compliance with telehealth regulations under the Medicare program.

229. Palma L. 988 & BH Crisis System Operations Strategy and Policy Lead. Email Communication. December 19, 2024.
230. Oregon Health Authority. 988 Suicide & Crisis Lifeline. https://www.oregon.gov/oha/hsd/amh/pages/988.aspx. Accessed December 31, 2024.
This webpage from the Oregon Health Authority provides information about the 988 Suicide & Crisis Lifeline, a national helpline designed to offer mental health support and crisis intervention services. It details how Oregonians can access support via this free, confidential service, offering immediate assistance for those in emotional distress or experiencing a crisis.
231. Data, Evaluation, and Technical Assistance Team's Mobile Crisis Intervention Services (MCIS) REDCap database. Oregon Health & Science University; 2023. Updated December 2025. Accessed December 31, 2024.
This REDCap Database stores data for the Mobile Response and Stabilization Services program for youth. The data is managed by the OHSU DAETA team.
232. Oregon Health Authority. Children's Behavioral Health Continuum of Care. https://www.oregon.gov/oha/hsd/bh-child-family/pages/continuum.aspx. Accessed February 4, 2025.
This webpage by the Oregon Health Authority provides an overview of the integrated services available to support the mental and behavioral health of children and families. It outlines a comprehensive approach that spans from prevention and early intervention to intensive care, ensuring that children receive the appropriate level of support at different stages of their mental health journey.
233. Oregon Health Authority. Youth and Young Adult Substance Use Prevention, Treatment, and Recovery. https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/Youth-Young-Adult-SUD-Treatment-Recovery-Report-EN.pdf. Published August 2023. Accessed February 4, 2025.
This report from the Oregon Health Authority outlines strategies for preventing, treating, and supporting recovery from substance use disorders among youth and young adults. It emphasizes the need for prevention and early intervention, alongside a focus on recovery services that are age-appropriate and culturally competent.
234. Pate N. Oregon announces first three 'recovery' high schools to help students facing problems with substance abuse. OPB. https://www.opb.org/article/2024/10/23/oregon-addiction-recovery-high-schools-students-drugs-substance-abuse-mental-health/#:~:text=The%20schools%20are%20very%20small,it's%20a%20very%20important%20piece. Published October 23, 2024. Accessed February 4, 2025.
This article discusses Oregon's initiative to establish the state's first three "recovery" high schools aimed at supporting students facing substance abuse issues. The schools are designed to provide a safe, supportive environment for students recovering from addiction, offering both academic and therapeutic support to help them remain sober and succeed in school.
235. Oregon Health Authority. Approved Integrated Co-occurring Disorders (ICD) Programs by County. https://www.oregon.gov/oha/HSD/AMH/docs/ICD-Programs.pdf. Published January 24, 2025. Accessed February 4, 2025.
This document from the Oregon Health Authority provides a comprehensive list of approved Integrated Co-occurring Disorders (ICD) programs across Oregon, organized by county. It outlines programs designed to address both mental health and substance use disorders in a coordinated manner, offering integrated treatment options for individuals with co-occurring conditions.
236. Data, Evaluation, and Technical Assistance Team. Oregon Health & Science University. Oregon Intensive In-Home Behavioral Health Treatment. 2023 Annual Report. https://www.oregon.gov/oha/HSD/BH-

Child-Family/Documents/OHSU%20DAETA%202023%20Annual%20Report%20for%20Publication%20(IIBHT)%2010-22-24.pdf. Published March 15, 2023. Accessed December 31, 2024.
The 2023 Annual IIBHT report prepared by the OHSU DAETA provides outcome information for this program. The report also provides demographic data on youth served through this program.

237. Oregon Health Authority. Health Systems Division: Behavioral Health Services - Chapter 309. Outpatient Behavioral Health Services. https://secure.sos.state.or.us/oard/viewSingleRule.action;JSESSIONID_OARD=LKyvMeIIMfidVM2PpszyZn_8omxqb72ZjxV6EtVr_JACcVDBD6-E!-577805942?ruleVrsnRsn=242809. Accessed February 4, 2025.
This document outlines the regulations for outpatient behavioral health services within the Oregon Health Authority's Health Systems Division, Chapter 309. It provides guidelines and criteria for behavioral health service delivery, focusing on ensuring accessibility, quality, and integration of mental health and substance use disorder services in outpatient settings.

238. Charlie Health. Virtual Intensive Outpatient Program (IOP) at Charlie Health. https://www.charliehealth.com/intensive-outpatient-iop. Accessed February 4, 2025.
This webpage provides an overview of Charlie Health's Intensive Outpatient Program (IOP), designed for individuals struggling with mental health challenges, including anxiety, depression, trauma, and more. The IOP offers structured treatment sessions without requiring full-time hospitalization, making it suitable for individuals who need intensive care while maintaining their daily activities.

239. Discovery Mood & Anxiety Program. Partial Hospitalization Treatment Programs. https://discoverymood.com/treatment-programs/partial-hospitalization/. Accessed February 4, 2025.
This webpage details the Partial Hospitalization Program (PHP) offered by Discovery Mood & Anxiety Program, designed for individuals facing mental health issues such as anxiety, depression, and mood disorders. The PHP provides intensive therapy during the day while allowing patients to return home in the evening.

240. Kartini Clinic. Kartini Clinic Partial Hospitalization Program. https://kartiniclinic.com/eating-disorder-treatment/treatment-overview/partial-hospitalization/. Accessed February 4, 2025.
This webpage outlines the Partial Hospitalization Program (PHP) offered by Kartini Clinic, specifically designed for individuals with eating disorders. The PHP is an intensive, structured treatment program that provides patients with daily therapeutic services, including medical supervision, psychotherapy, and nutrition counseling, while allowing them to return home at the end of the day.

241. LifeWorks NW. Child & Family Services. https://www.lifeworksnw.org/child-family-services/. Accessed February 4, 2025.
This webpage provides an overview of the child and family services offered by LifeWorks NW, a nonprofit organization serving the Portland, Oregon area. The organization offers a range of programs designed to support children, youth, and families, with services including mental health treatment, substance use disorder support, and family therapy.

242. Providence St. Vincent Medical Center. Psychiatric Pathway Behavioral Health Adolescent Partial Hospital & Intensive Outpatient Program. https://www.providence.org/locations/or/st-vincent-medical-center/pathway-program. Accessed February 4, 2025.
The Adolescent Partial Hospital & Intensive Outpatient Program at Providence St. Vincent Medical Center offers specialized treatment for young individuals experiencing psychiatric and behavioral health challenges. This program is designed for adolescents who require more intensive care than traditional outpatient services but do not need the level of support provided by inpatient care.

243. Willamette Falls Medical Center. Providence. https://www.providence.org/locations/or/willamette-falls-medical-center/pathway-program. Accessed December 31, 2024.

The Pathway Behavioral Health Adolescent Program at Willamette Falls Medical Center offers intensive outpatient and partial hospitalization services for adolescents facing mental health and substance use issues. It combines therapy, family support, and skill-building to help stabilize youth and reduce the need for inpatient care.

244. Monte Nido. Effective Eating Disorder Day Treatment. https://www.montenido.com/programs/eating-disorder-day-treatment. Accessed February 4, 2025.
Monte Nido's Eating Disorder Day Treatment program offers a highly structured, outpatient treatment option for individuals dealing with eating disorders. This program combines therapeutic interventions, medical monitoring, and nutritional support in a comprehensive approach designed for those who do not need inpatient care but require more intensive treatment than weekly therapy sessions.

245. Riverview School. Day Treatment Classrooms. https://www.riverviewgrowth.org/programs-services/day-treatment-classrooms/. Accessed February 4, 2025.
Riverview School's Day Treatment Classrooms program is designed to support children and adolescents with emotional, behavioral, and learning challenges through a therapeutic and structured classroom environment.

246. Trillium Family Services. Psychiatric Day Treatment. https://www.trilliumfamily.org/feed/day-treatment. Accessed February 4, 2025.
Trillium Family Services offers a Psychiatric Day Treatment program designed for children and adolescents struggling with significant mental health challenges. The program provides comprehensive psychiatric care, including individual and group therapy, crisis intervention, and therapeutic activities.

247. Samaritan Health Services. Partial Hospitalization. https://samhealth.org/health-services/all-services/mental-and-behavioral-health/partial-hospitalization/. Accessed February 4, 2025.
Samaritan Health Services offers a Partial Hospitalization Program (PHP) for individuals facing mental health crises that require intensive treatment but do not necessitate inpatient care. The program provides a structured, outpatient setting where patients receive therapy, psychiatric evaluations, and other supportive services.

248. Madrone Mental Health. Adult Day Treatment Eating Disorder Program. https://www.madronementalhealth.com/adult-day-treatment-eating-disorder-program/. Accessed February 4, 2025.
Madrone Mental Health offers an Adult Day Treatment Eating Disorder Program that provides structured, intensive outpatient treatment for individuals struggling with eating disorders. The program integrates therapeutic support, nutritional counseling, and psychological services to help patients develop healthy eating patterns and coping strategies.

249. Odyssey Outpatient Network. Partial Hospitalization Program (PHP). https://odysseyoutpatient.com/levels-of-care/partial-hospitalization-program-php/. Accessed February 4, 2025.
Odyssey Outpatient Network offers a Partial Hospitalization Program (PHP) designed to provide intensive, structured treatment for individuals struggling with mental health disorders or addiction. PHP serves as a bridge between inpatient care and outpatient therapy, offering a highly supportive environment while allowing patients to return home in the evenings.

250. PeaceHealth. Intensive Outpatient and Partial Hospitalization Behavioral Health at PeaceHealth University District. https://www.peacehealth.org/locations/eugene/intensive-outpatient-and-partial-hospitalization-behavioral-health-peacehealth. Accessed February 4, 2025.
PeaceHealth offers Intensive Outpatient and Partial Hospitalization Behavioral Health programs, providing comprehensive mental health services for individuals in need of more intensive care than traditional outpatient treatment but less than inpatient hospitalization.

251. Salem Regional Medical Center. Behavioral Medicine/Mental Health. https://www.salemregional.com/outpatient-care/mental-health#:~:text=There%20are%20two%20types%20of,9%20a.m.%20%2D%201%3A30%20p.m.&text=Partial%20Hospitalization%20%2D%20Clients%20attend%20five,program%20day%20lasting%205%20hours.&text=Intensive%20Outpatient%20%2D%20Clients%20attend%20up,day%20ranging%20from%203%20hours. Accessed February 4, 2025.
Salem Regional Medical Center provides an overview of their Behavioral Medicine and Mental Health services, focusing on two outpatient treatment options: Partial Hospitalization and Intensive Outpatient Programs.
252. Sober Living Oregon Recovery Center. Primary Mental Health Treatment in Portland. https://www.slorecoverycenter.com/mental-health/. Accessed February 4, 2025.
The SLO Recovery Center offers a range of mental health services, including specialized care for individuals dealing with trauma, addiction, and mental health disorders. The center emphasizes a holistic approach to recovery, incorporating therapy, counseling, and support services to help individuals achieve long-term healing.
253. Cedar Hills Hospital. Understanding Partial Hospitalization Programs. https://cedarhillshospital.com/blog/understanding-partial-hospitalization-programs/. Published August 6, 2024. Accessed February 4, 2025.
This article provides an overview of Partial Hospitalization Programs (PHP), explaining their role in treating individuals with mental health and substance use disorders. It outlines the structure of PHP, which offers intensive treatment during the day, while allowing patients to return home at night.
254. Marshall R, Ribbers A, Sheridan D, Johnson KP. Mental health diagnoses and seasonal trends at a pediatric emergency department and hospital, 2015–2019. *Hospital Pediatrics*. 2021;11(3):199-206. doi:10.1542/hpeds.2020-000653.
This study examines the seasonal trends in mental health presentations among youth in a pediatric emergency department (ED) and hospital between 2015 and 2019.
255. Cushing AM, Nash KA, Foster AA, et al. Pediatric Inpatient Psychiatric Capacity in the US, 2017 to 2020. *JAMA Pediatr*. October 1, 2024;178(10):1080-1082. doi:10.1001/jamapediatrics.2024.2888
This study explores the growing pediatric mental health crisis, which has led to prolonged emergency department (ED) visits due to limited access to pediatric inpatient psychiatric beds.
256. Albertina Kerr. Crisis Psychiatric Care for Youth. https://www.albertinakerr.org/crisis/. Accessed February 4, 2025.
This webpage outlines the crisis services provided by Albertina Kerr, a nonprofit organization supporting individuals with mental health challenges. It details the resources available for individuals experiencing mental health crises, including 24/7 crisis intervention, a residential treatment center, and support for families.
257. Monte Nido. Clementine. Eating Disorder Treatment for Adolescent Girls. https://clementineprograms.com/program-locations/clementine-west-linn/?utm_medium=cpc&utm_source=google&utm_campaign=PMax%20-%20OR. Accessed February 4, 2025.
The source provides information about Clementine West Linn, a treatment center offering specialized care for adolescent girls with eating disorders. The center is part of the Monte Nido family of programs and focuses on delivering a range of therapeutic services tailored to the unique needs of young women struggling with disordered eating, including residential and outpatient options.
258. Embark Behavioral Health. A Residential Treatment Center for Youths in Oregon. https://www.embarkbh.com/location/embark-behavioral-health-in-bend-oregon/?utm_source=gmb&utm_medium=organic. Accessed February 4, 2025.

The source describes Embark Behavioral Health's Bend location, which offers specialized treatment for adolescents dealing with mental health challenges and substance use issues. This facility provides outpatient therapy and structured programs designed to support emotional growth, skill development, and recovery for youth in a compassionate and safe environment.

259. Jasper Mountain. How Is Jasper Mountain Unique? https://jaspermountain.org/jasper-mountain/. Accessed February 4, 2025.
This webpage highlights the unique qualities of Jasper Mountain, emphasizing its specialized treatment programs for children facing behavioral and emotional challenges. It outlines the therapeutic approach, including trauma-informed care, individualized treatment plans, and a focus on creating a supportive environment for healing.

260. Looking Glass. Regional Crisis Center. https://www.lookingglass.us/regional-crisis-center. Accessed February 4, 2025.
The webpage provides an overview of the Regional Crisis Center offered by Looking Glass, focusing on its role in delivering immediate mental health support to individuals in crisis. The center is designed to offer a safe space for individuals in acute mental distress, with services aimed at stabilization and support.

261. Madrona Recovery. https://www.madronarecovery.com/copy-of-intensive-out-patient. Accessed December 31, 2024.
Madrona Recovery is a rehabilitation center specializing in addiction treatment and mental health services. The facility provides a range of outpatient and residential services, offering individualized care plans to support long-term recovery. They focus on holistic and evidence-based treatment approaches, including cognitive-behavioral therapy (CBT) and trauma-informed care. The website offers comprehensive details about their services, treatment programs, and the team's approach to recovery.

262. Nexus Family Healing. Walden Crossing Psychiatric Residential Treatment Facility. https://www.nexusfamilyhealing.org/walden-crossing/walden. Accessed February 4, 2025.
The webpage outlines Walden Crossing, a program by Nexus Family Healing aimed at providing specialized care for adolescents dealing with mental health and emotional challenges. The program focuses on a therapeutic, family-centered approach to address issues such as trauma, emotional regulation, and behavioral difficulties.

263. Providence Health & Services. Child and Adolescent Psychiatry Inpatient Unit. Providence Willamette Falls Medical Center. https://www.providence.org/locations/or/willamette-falls-medical-center/child-and-adolescent-psychiatry-inpatient-unit. Accessed February 4, 2025.
The webpage details the Child and Adolescent Psychiatry Inpatient Unit at Willamette Falls Medical Center, offering specialized psychiatric care for children and adolescents in crisis. The unit provides a safe and structured environment with access to mental health professionals for intensive treatment.

264. Trillium Family Services. Psychiatric Residential. https://www.trilliumfamily.org/feed/psychiatric-residential. Accessed February 4, 2025.
This webpage provides information on the Psychiatric Residential Treatment program offered by Trillium Family Services. The program is designed for children and adolescents who require long-term, intensive mental health treatment in a residential setting.

265. Unity Health Center. A compassionate approach to mental health emergencies. https://unityhealthcenter.org/. Accessed February 4, 2025.
Unity Health Center offers a compassionate approach to mental health emergencies, focusing on delivering immediate and supportive care for individuals in crisis. The center provides a range of behavioral health services, including crisis intervention, psychiatric care, and treatment for substance use disorders.

266. Oregon Health Authority. (2022). *Intensive Behavioral Health Treatment Services for Children and Adolescents: Capacity and Demand.* https://www.oregon.gov/oha/ERD/SiteAssets/Pages/Government-Relations/HB%202086_Intensive%20Behavioral%20Health%20Treatment%20Services%20Report_OHA_December%202022.pdf. Accessed December 31, 2024.
This report from the Oregon Health Authority provides an overview of the implementation and status of the Intensive Behavioral Health Treatment Services program under HB 2086. It examines the need for expanded services in Oregon, identifying key barriers such as limited access to care, especially in rural areas, and the challenge of meeting the diverse needs of individuals with severe behavioral health conditions.
267. Oregon Health Authority. 2024. Update on children's Psychiatric Residential Treatment Facility (PRTF) capacity. https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/2023_OHA%20ODHS%20PRTF%20Capacity%20Memo.pdf. Accessed December 31, 2024.
This memo provides updates on Oregon's efforts to expand Psychiatric Residential Treatment Facility (PRTF) capacity for children. It highlights progress in reopening beds, expanding facilities, and launching new programs like the Residential Transformation Project. The document also addresses ongoing challenges, including workforce issues and the need for improved care coordination for children in foster care.
268. NAMI Multnomah. Improving Psychiatric Residential Treatment Services for BIPOC Youth in Oregon. https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/NAMI%20Multnomah%20Report.pdf. Published August 2022. Accessed February 4, 2025.
This report by NAMI Multnomah focuses on the disparities in psychiatric residential treatment services for BIPOC (Black, Indigenous, and People of Color) youth in Oregon. It outlines barriers to accessing these critical services, including cultural stigma, systemic inequalities, and a lack of resources tailored to the needs of BIPOC communities.
269. Neely W. Oregon State Hospital. Email Communication. Oregon Health Authority. January 23, 2025.
270. Adapt Integrated Health Care. Youth Residential: Addiction Services. https://adaptoregon.org/services/addiction-services/youth-residential/. Accessed February 4, 2025.
This webpage outlines the Youth Residential Addiction Services offered by ADAPT, a program dedicated to providing residential treatment for young people struggling with substance use. The services focus on a comprehensive, therapeutic approach that includes individualized counseling, educational support, life skills development, and family involvement.
271. Native American Rehabilitation Association (NARA). *NARA Youth Residential Treatment Center*. https://www.naranorthwest.org/projects/nara-youth-residential-treatment-center/. Accessed December 31, 2024.
The NARA Youth Residential Treatment Center offers inpatient care for Native American youth facing mental health and substance use challenges. This culturally grounded program integrates traditional Native practices with evidence-based therapies, focusing on emotional healing, trauma recovery, and life skills development. The center provides a structured and supportive environment for youth, emphasizing a holistic approach that nurtures both physical and emotional well-being.
272. Rimrock Trails. *Adolescent Rimrock Treatment*. https://www.rimrocktrails.org/adolescent-rimrock-treatment. Accessed December 31, 2024.
The Adolescent Rimrock Treatment program provides inpatient and outpatient services for youth facing substance use and mental health challenges. It offers individualized therapy, family involvement, and skill-building to support recovery and emotional well-being.
273. Fox SB. Oregon Department of Human Services. Email Communication. January 29, 2025.
274. Oregon Buys. Bid Solicitation. https://oregonbuys.gov/bso/external/bidDetail.sdo?docId=S-10000-00008917&external=true&parentUrl=close. Accessed February 4, 2024.

This webpage shows an example of bid solicitation from ODHS for an individual Residential care program bed. These bids are formal solicitations open to the public to increase bed capacity across the state.

275. Washington State Department of Children, Youth, and Families. Behavior Rehabilitation Services Semi-Annual Update. https://dcyf.wa.gov/sites/default/files/pdf/reports/BRS-SemiAnnual-Jan2023.pdf. Published January 2023. Accessed February 4, 2025.
This semi-annual update from the Washington State Department of Children, Youth, and Families provides detailed insights into the ongoing efforts, challenges, and improvements within the Behavior Rehabilitation Services (BRS) program.

276. Oregon Department of Human Services. BRS *Contracted Programs.* Oregon Department of Human Services. https://www.oregon.gov/odhs/providers-partners/child-welfare/Pages/contracted-programs.aspx. Accessed December 31, 2024.
This page from the Oregon Department of Human Services provides an overview of the contracted programs available under Oregon's Child Welfare services. It highlights the various partnerships and services aimed at supporting children and families, focusing on foster care, mental health services, and treatment programs.

277. Oregon Secretary of State. *Behavior Rehabilitation Services Program General Rules*. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=274928. Published December 27, 2020. Accessed February 4, 2025.
This document outlines the general rules for the Behavior Rehabilitation Services (BRS) program in Oregon. The rules focus on eligibility, services, program standards, and requirements to ensure consistency and quality in the care provided.

## Intellectual and Developmental Disabilities System

278. Oregon Department of Human Services. *I/DD Services and Eligibility*. https://www.oregon.gov/odhs/idd/Pages/eligibility.aspx. Accessed February 4, 2025.
The *I/DD Services and Eligibility* page provides information about the services available for individuals with intellectual and developmental disabilities (I/DD) in Oregon. It outlines the eligibility criteria for accessing these services, including assessments and requirements for enrollment.

279. Oregon Secretary of State. *Aging and People with Disabilities and Developmental Disabilities - Chapter 411*. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=300876. Accessed February 4, 2025.
The *webpage* outlines the rules and regulations related to services for individuals with disabilities and aging adults in Oregon. It provides guidance on eligibility, services, and care protocols for those who qualify for support through the state's programs.

280. National Core Indicators. *National Report 2022-23 Child Family Survey (CFS)*. Published June 2024. https://idd.nationalcoreindicators.org/wp-content/uploads/2024/06/NCI-IDD-CFS-National-Report-22-23-.pdf. Accessed February 4, 2025.
The *National Report 2022-23 Child Family Survey (CFS)* presents data and insights from families of youth with intellectual and developmental disabilities (I/DD) across the U.S. It provides an in-depth look at family experiences with services and supports, focusing on areas such as caregiving, access to resources, and quality of care.

281. Oregon Department of Human Services. Oregon Needs Assessment Manual. Published September 2023. https://www.oregon.gov/odhs/compass/Documents/ona-manual-case-managers.pdf. Accessed February 4, 2025.

The Oregon Needs Assessment Manual provides guidance for case managers working with individuals in need of services through the Oregon Department of Human Services. The manual details the processes for conducting assessments, identifying client needs, and ensuring appropriate services are provided.

282. Oregon Department of Human Services. Service Group Scoring. https://www.oregon.gov/odhs/compass/Documents/service-group-scoring.pdf. Published October 12, 2020. Accessed February 4, 2025.
The Service Group Scoring Guide provides detailed instructions and criteria for case managers to evaluate and score service groups for individuals receiving assistance from the Oregon Department of Human Services.

283. Oregon Department of Human Services. Service Groups. https://www.oregon.gov/odhs/compass/Pages/service-groups.aspx. Accessed February 4, 2025.
The Service Groups page on the Oregon Department of Human Services website outlines the various service groups available to individuals' receiving assistance. It provides information on how services are categorized and the criteria for determining eligibility for each group.

284. Oregon Department of Human Services. Individual Support Planning. https://www.oregon.gov/odhs/compass/pages/isp.aspx. Accessed February 4, 2025.
The Individual Support Planning page on the Oregon Department of Human Services website outlines the process and guidelines for creating personalized support plans for individuals receiving assistance. It focuses on assessing clients' specific needs and designing tailored plans to ensure they receive the appropriate services and resources.

285. University of Oregon. Adult Support Services, Hiring Service Providers. Center on Human Development. https://chd.uoregon.edu/transition-and-adulthood/adult-support-services. Accessed February 4, 2025.
This page from the University of Oregon's Center on Human Development outlines the support services available to individuals transitioning into adulthood. It provides resources aimed at enhancing life skills, community engagement, and opportunities for independence.

286. Berry S. Office of Developmental Disability Services. Email communication. February 12, 2025.

287. National Core Indicators. (2023). *2021-22 Oregon child and family survey state report*. National Core Indicators. https://idd.nationalcoreindicators.org/wp-content/uploads/2023/10/OR-Child-Family-Survey-21-22-State-Report.pdf.
The 2021-22 Oregon Child and Family Survey State Report provides an in-depth analysis of the experiences of children and families receiving services for developmental disabilities in Oregon. It highlights satisfaction levels, outcomes, and feedback regarding service quality and effectiveness. This data is critical for understanding how well Oregon's developmental services meet the needs of children and families, and it serves as a tool for improving policy and practice in the state.

288. Mirzaian CB, Deavenport-Saman A, Hudson SM, et al. Barriers to mental health care transition for youth and young adults with intellectual and developmental disabilities and co-occurring mental health conditions: stakeholders' perspectives. Community Mental Health Journal. Published April 15, 2024. doi:10.1007/s10597-024-01262-x. https://link.springer.com/article/10.1007/s10597-024-01262-x#citeas. Accessed February 4, 2025.
This article explores the challenges faced by youth and young adults with intellectual and developmental disabilities (I/DD) when transitioning to mental health care services, especially those with co-occurring mental health conditions. The study gathers insights from key stakeholders, including caregivers, service providers, and individuals with I/DD, to identify barriers such as system fragmentation, lack of accessible services, and gaps in support.

289. Oregon Legislative Assembly. Senate Bill 1557. https://olis.oregonlegislature.gov/liz/2024R1/Downloads/MeasureDocument/SB1557/Enrolled. Published March 7, 2024. Accessed February 4, 2025.

Senate Bill 1557, enrolled by the Oregon Legislative Assembly, focuses on improving services for individuals under 21 with complex needs, including mental health and developmental disabilities. It emphasizes individualized, family-centered care and promotes cross-agency collaboration to provide community-based support, prevent crises, and avoid institutional placements.

290. Oregon Health Authority. SB 5529 Report on Barriers to Access to Mental Health Services for People with IDD: Implementation Update. https://www.oregon.gov/oha/HSD/BH-Child-Family/SOCAC/SB%205529%20Report%20on%20Barriers%20to%20Access%20to%20MH%20for%20People%20with%20IDD_Implementation%20Update_SOCAC%2011.29.23_Final.pdf. Published November 29, 2023. Accessed February 4, 2025.

This report highlights ongoing challenges and progress in improving access to mental health services for individuals with intellectual and developmental disabilities (IDD). The report addresses barriers, outlines efforts to improve service delivery, and provides an update on the implementation of recommendations under Senate Bill 5529.

## Child Welfare System

291. Oregon Department of Human Services. Child Welfare Division. https://www.oregon.gov/odhs/agency/pages/cw.aspx. Accessed December 31, 2024.

The Child Welfare Division of the Oregon Department of Human Services oversees the state's Adoption and Guardianship, Child Safety, and Foster Care programs. The agency's website was used to gather general information about these programs, including program descriptions, services offered, youth served, etc.

292. Oregon Department of Human Services. Oregon Department of Human Services districts map. 2024. https://www.oregon.gov/odhs/providers-partners/Documents/workday-odhs-districts-map.pdf. Accessed December 31, 2024.

The districts map created by the Oregon Department of Human Services shows regional offices' service areas. This reference was used to describe how Oregon's Child Welfare system is set up as a series of independent districts.

293. ChildTrends. State-level data for understanding child welfare in the United States. https://www.childtrends.org/publications/state-level-data-for-understanding-child-welfare-in-the-united-states. Accessed December 31, 2024.

The ChildTrends Child Welfare data visualization page provides a dynamic, filterable view of trends across the nation. Users are able to compare individual state data to national data on child maltreatment, referrals, and investigations. Data from the National Data Archive on Child Abuse and Neglect are used to power visualizations.

294. Office of Reporting, Research, Analytics, and Implementation. 2023 Child Welfare Data Book. Oregon Department of Human Services. October 2024. https://www.oregon.gov/odhs/data/cwdata/cw-data-book-2023.pdf. Accessed December 31, 2024.

The Child Welfare Data Book is prepared annually by the Office of Reporting, Research, Analytics, and Implementation. The report includes Oregon data on child abuse and neglect and is cited numerous times throughout this report.

295. Office of Reporting, Research, Analytics, and Implementation. 2022 Child Welfare Data Book. Oregon Department of Human Services. December 2023. https://www.oregon.gov/odhs/data/cwdata/cw-data-book-2022.pdf. Accessed December 31, 2024.

The Child Welfare Data Book is prepared annually by the Office of Reporting, Research, Analytics, and Implementation. The report includes Oregon data on child abuse and neglect and is cited numerous times throughout this report.

296. Office of Reporting, Research and Analytics (ORRAI). Child Welfare Dashboard: Children in Foster Care Total Served. https://app.powerbigov.us/view?r=eyJrIjoiMWNhM2NjNDItMWYzNS00MDZmLTk5YzMtYWEwYmQzMzA4ZDI5IiwidCI6IjY1OGU2M2U4LThkMzktNDk5Yy04ZjQ4LTEzYWRjOTQ1MmY0YyJ9. Accessed December 31, 2024.

The Child Welfare dashboard is prepared by the Office of Reporting, Research, Analytics, and Implementation (ORRAI). The dashboard shows the counts of youth in foster care in Oregon. The data is reported by race/ethnicity, gender, age-group, and county location.

297. Borrud, H. Why a disproportionate number of Native American, Black children remain in Oregon foster care despite leaders' efforts at change. *The Oregonian*. 2022. https://www.oregonlive.com/data/2021/12/why-a-disproportionate-number-of-native-american-black-children-remain-in-oregon-foster-care-despite-leaders-efforts-at-change.html. Accessed December 31, 2024.

This news article looks at the racial disproportionality index for youth in Oregon's Child Welfare system. While other sources from the Oregon Department of Human Services provide annual data on this trend, the data in the news article is presented longitudinally to show the persistent issue of disproportionality in Oregon.

298. Child and Family Behavioral Health. Temporary lodging prevention for coordinated care organizations (CCOs). Oregon Health Authority. 2021. https://www.oregon.gov/oha/HSD/OHP/Announcements/CCO-TL-Prevention-Fact-Sheet.pdf. Accessed December 31, 2024.

This fact sheet discusses the role of various state partners in preventing temporary lodging. This source was used to describe what temporary lodging is and how the Oregon Health Authority is collaborating with Child Welfare on prevention efforts.

299. Public Knowledge. Oregon Child Welfare review assessment findings report. 2023. https://www.oregon.gov/odhs/data/cwdata/cw-assessment-findings-report-2023.pdf. Accessed December 31, 2024.

The Public Knowledge report was an independent investigation of the Child Welfare system in Oregon; it was commissioned by the Oregon Department of Human Services. The evaluation focused on 11 research questions related to Child Welfare policies, procedures, leadership, data, and improvement efforts.

300. Office of Reporting, Research, Analytics and Implementation. Child Welfare federal performance measures dashboard. Oregon Department of Human Services. https://www.oregon.gov/odhs/data/Pages/cw-dashboard-fpm.aspx. Accessed December 31, 2024.

This dashboard provides a dynamic, filterable view of Oregon's performance on numerous federal benchmarks related to Child Welfare. Data is presented by county, over time, and by race and ethnicity. Datapoints include maltreatment in foster care, re-entry to foster care, permanency, and placement stability.

301. Oregon Health Authority, Holding Hope-Children's Behavioral Health in Oregon. Newsletter. Published February 3, 2025. https://content.govdelivery.com/accounts/ORHA/bulletins/3cfa50e. Accessed February 4, 2025.

This newsletter from the Oregon Health Authority highlights several key initiatives and legislative actions for 2025, including the expansion of the Expedited Assessment Services for Youth (EASY) program, improvements in Oregon's behavioral health workforce, and the introduction of the Response and Support Network (RSN) to support resource and post-adoptive parents. The update also includes reflections on Black History Month and its connection to mental health, along with legislative discussions impacting youth and family behavioral health in Oregon. Additionally, it provides resources for engagement in these issues and calls for public input on youth suicide prevention efforts.

302. Oregon Department of Human Services. Adoption and guardianship. https://www.oregon.gov/odhs/adoption/Pages/default.aspx. Accessed December 31, 2024.
This webpage describes the Adoption and Guardianship programs in Oregon. Resources and answers to frequently asked questions are provided.

303. Oregon Department of Human Services. Child Welfare Public Data Reports. https://www.oregon.gov/odhs/data/Pages/cw-public-reports.aspx. Accessed February 4, 2025.
ODHS publishes data reports for children in the child welfare system. These reports include permanency reports such as permanency status, placement stability, re-entry into foster care. Also included are safety reports and Well-being reports.

304. Office of Reporting, Research, Analytics, and Implementation. 2021 Child Welfare Data Book. Oregon Department of Human Services. 2022. https://www.oregon.gov/odhs/data/cwdata/cw-data-book-2021.pdf.
The Child Welfare Data Book is prepared annually by the Office of Reporting, Research, Analytics, and Implementation. The report includes Oregon data on child abuse and neglect and is cited numerous times throughout this report.

305. Office of Reporting, Research, Analytics, and Implementation. 2020 Child Welfare Data Book. Oregon Department of Human Services. 2021. https://www.oregon.gov/odhs/data/cwdata/cw-data-book-2020.pdf.
The Child Welfare Data Book is prepared annually by the Office of Reporting, Research, Analytics, and Implementation. The report includes Oregon data on child abuse and neglect and is cited numerous times throughout this report.

306. Ofstedahl A. Oregon Department of Human Services: Child Welfare. Email Communication. January 21, 2024.

## Juvenile Justice System

307. Oregon youth Authority. How Oregon's Juvenile Justice System Works. https://www.oregon.gov/oya/publications/juvjusticesystem.pdf?utm_source=oya&utm_medium=egov_redirect&utm_campaign=%20%20%20%20https%3A%2F%2Fwww.oregon.gov%2Foya%2Fdocs%2Fjuv_justice_system.pdf. Accessed February 4, 2025.
This document from the Oregon Youth Authority (OYA) describes how the juvenile justice system works and how youth move through this system.

308. Office of Juvenile Justice and Delinquency Prevention (OJJDP). *Oregon Gender and Juvenile Justice*. U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. https://ojjdp.ojp.gov/sites/g/files/xyckuh176/files/pubs/gender/state-or.html#:~:text=In%20each%20of%20Oregon's%2036,brought%20before%20the%20juvenile%20court. Accessed December 31, 2024.
This resource from the Office of Juvenile Justice and Delinquency Prevention provides detailed information on gender and juvenile justice in Oregon. It highlights statistics and trends in how gender influences juvenile court cases, including data on arrests, court processing, and services for youth involved in the juvenile justice system. This page is a key reference for understanding gender-related issues in Oregon's juvenile justice processes.

309. Oregon Youth Authority (OYA). *At a Glance: Oregon Youth Authority*. Oregon Youth Authority. https://www.oregon.gov/oya/Publications/AtAGlance-OYA.pdf. Published September 2022. Accessed December 31, 2024.
This publication from the Oregon Youth Authority provides a concise summary of the agency's mission, services, and key programs. It highlights the agency's efforts in juvenile justice, including

youth detention, rehabilitation, and reentry support. It also includes important statistics about the population served, the goals of the agency, and the outcomes they aim to achieve, such as reducing recidivism and promoting positive youth development.

310. Juvenile Justice Information System (JJIS). 2023 Statewide Dispositions Report. https://www.oregon.gov/oya/jjis/Reports/2023StatewideDispositions.pdf. Published March 2024. Accessed December 31, 2024.
This report though the juvenile justice information system (JJIS) provides a comprehensive breakdown of the dispositions within the juvenile justice system for 2023. It includes data on youth demographics, referral categories, and the severity of offenses handled by the system.

311. Juvenile Justice Information System (JJIS). 2023 Statewide Detention, Admissions, and Releases Report. https://www.oregon.gov/oya/jjis/Reports/2023StatewideDetention.pdf. Published March 2024. Accessed December 31, 2024.
This report provides an overview of juvenile detention admissions and releases across Oregon, offering detailed demographic information, including age, sex, and race/ethnicity of youth. It presents data on detention length of stay, categorized by admission reasons.

312. Office of Juvenile Justice and Delinquency Prevention (OJJDP). *State Juvenile Arrest Data: Oregon, 2021*. U.S. Department of Justice. https://www.ojjdp.gov/ojstatbb/ezacjrp/asp/State_Adj.asp?state=59&topic=State_Adj&year=2021&percent=count&maps=no. Accessed December 31, 2024.
This data tool from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) provides state-level statistics on juvenile arrests in Oregon for the year 2021. The tool allows users to explore various categories of arrest data, including age, gender, race, and offense type. The data is presented in both numerical, percentage, and map formats, offering insight into trends in juvenile justice involvement in Oregon.

313. Oregon Youth Authority (OYA). *Quick Facts: January 2020*. Oregon Youth Authority, January 2020, https://www.oregon.gov/oya/Publications/QuickFacts-Jan2020.pdf.
The Oregon Youth Authority's *Quick Facts* report for January 2020 provides detailed data on the juvenile justice system in Oregon, focusing on youth demographics, placements, and services. It includes statistics on the number of youth in various types of facilities, recidivism rates, and the outcomes of rehabilitation programs.

314. Oregon Youth Authority (OYA). *Quick Facts: January 2021*. Oregon Youth Authority, January 2021, https://www.oregon.gov/oya/Publications/QuickFacts-Jan2021.pdf.
The Oregon Youth Authority's *Quick Facts* report for January 2021 provides detailed data on the juvenile justice system in Oregon, focusing on youth demographics, placements, and services. It includes statistics on the number of youth in various types of facilities, recidivism rates, and the outcomes of rehabilitation programs.

315. Oregon Youth Authority (OYA). *Quick Facts: January 2022*. Oregon Youth Authority, January 2022, https://www.oregon.gov/oya/Publications/QuickFacts-Jan2022.pdf.
The Oregon Youth Authority's *Quick Facts* report for January 2022 provides detailed data on the juvenile justice system in Oregon, focusing on youth demographics, placements, and services. It includes statistics on the number of youth in various types of facilities, recidivism rates, and the outcomes of rehabilitation programs.

316. Oregon Youth Authority (OYA). *Quick Facts: January 2023*. Oregon Youth Authority, January 2023, https://www.oregon.gov/oya/Publications/QuickFacts-Jan2023.pdf.
The Oregon Youth Authority's *Quick Facts* report for January 2023 provides detailed data on the juvenile justice system in Oregon, focusing on youth demographics, placements, and services. It includes statistics on the number of youth in various types of facilities, recidivism rates, and the outcomes of rehabilitation programs.

317. Office of Juvenile Justice and Delinquency Prevention (OJJDP). *Youth Residential Placement Rates by State*. U.S. Department of Justice. https://ojjdp.ojp.gov/statistical-briefing-book/corrections/faqs/qa08601?text. Accessed December 31, 2024.
This resource from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) offers detailed data on youth residential placement rates across U.S. states. It provides insights into how states utilize residential placements for youth in the juvenile justice system, highlighting trends in detention and correctional facility usage.
318. Oregon Child Integrated Dataset. *Class of 2020: Juvenile Justice Contact*. Oregon Child Integrated Dataset. https://www.ocid-cebp.org/class-of-2020-juvenile-justice-contact/. Accessed February 4, 2025.
The "Class of 2020: Juvenile Justice Contact" report from the Oregon Child Integrated Dataset (OCID) provides insights into the involvement of youth in Oregon's juvenile justice system during 2020. It presents detailed data on the demographic profiles of youth, the nature of their offenses, and the frequency of interactions with the justice system.
319. Office of Juvenile Justice and Delinquency Prevention (OJJDP). (2014). *Risk factors for delinquency: An overview*. U.S. Department of Justice. https://ojjdp.ojp.gov/model-programs-guide/literature-reviews/risk_factors_for_delinquency.pdf. Accessed December 31, 2024.
This report by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) provides an overview of the key risk factors that contribute to juvenile delinquency. It reviews research on the social, familial, and individual factors associated with higher rates of offending, such as poverty, substance abuse, peer influence, and family structure. The document serves as a resource for understanding the complex causes of delinquency and highlights the importance of addressing these factors through targeted interventions and preventive programs.
320. Oregon Health Authority. *Other treatment supports*. Oregon Health Authority. https://www.oregon.gov/oha/hsd/bh-child-family/pages/supports.aspx. Accessed December 31, 2024.
The Oregon Health Authority's webpage on "Other Treatment Supports" offers information on additional behavioral health resources for children and families in Oregon. It highlights various treatment options outside of traditional therapy, including community-based services, crisis intervention, and programs designed to support mental health and emotional well-being. This page also offers information on restorative services and “fitness to proceed.”
321. Oregon Psychiatric Security Review Board. *PSRB's mission*. Oregon.gov. https://www.oregon.gov/prb/Pages/Index.aspx. Accessed December 31, 2024.
This page outlines the mission of the Oregon Psychiatric Security Review Board (PSRB), which is to ensure public safety while facilitating the treatment and supervision of individuals found guilty except for insanity. It provides an overview of the PSRB's role in balancing mental health care and legal accountability. This resource will be useful for understanding the PSRB's objectives and its function within Oregon's legal and mental health systems.
322. Oregon Psychiatric Security Review Board. *PSRB plans & performance*. Oregon.gov. https://www.oregon.gov/prb/Pages/Agency-Documents.asp. Accessed December 31, 2024.
This page outlines the strategic plans and performance metrics for the Oregon Psychiatric Security Review Board (PSRB), detailing its goals for public safety, treatment outcomes, and operational efficiency. It is a key resource for understanding the PSRB’s progress and objectives in ensuring the proper management of individuals found guilty except for insanity.
323. Bort A. Psychiatric Security Review Board (PSRB). Email Communication. December 17, 2024.
324. Juvenile Justice Information System (JJIS). 2023 JJIS Annual Reports. https://www.oregon.gov/oya/jjis/pages/reports.aspx. Accessed December 31, 2024.
This webpage provides access to a series of annual reports published by the Oregon Youth Authority's Juvenile Justice Information System (JJIS). The data is used to inform the planning, development, and evaluation of programs aimed at reducing juvenile crime.

## System Workforce


325. Mental Health & Addiction Certification Board of Oregon. *Home*. MHACBO. https://mhacbo.org/en/ . Accessed December 31, 2024.
This website provides essential information for professionals seeking certification in mental health and addiction counseling in Oregon. It includes details on the application process, certification requirements, and ongoing professional development opportunities. It also provides information on how to become a QMHA and QMHP. The MHACBO Registry also allows users to search for MHACBO-certified providers.

326. Oregon Medical Board. *Licensing overview*. Oregon.gov. https://www.oregon.gov/omb/licensing/pages/default.aspx. Accessed December 31, 2024.
This webpage provides an overview of the licensing process for various healthcare professionals in Oregon, including Medical Doctors (MD), Doctor of Osteopathic Medicine (DO), Doctors of Podiatric Medicine (DPM), Physician Associates (PA), and Acupuncturists (LAc). It offers clear guidance on licensure requirements, application processes, and eligibility criteria for these professionals, making it a vital resource for those seeking to practice in Oregon's healthcare system.

327. Oregon Board of Licensed Social Workers. Licensing descriptions. Oregon.gov. https://www.oregon.gov/blsw/pages/licensedescriptions.aspx. Accessed December 31, 2024.
This webpage provides detailed descriptions of various social work licenses in Oregon, including requirements for licensure, scope of practice, and qualifications for each level of social work certification. It serves as a valuable resource for current and aspiring social workers in Oregon, offering clarity on licensing pathways and state-specific regulations for professional practice.

328. Oregon Board of Licensed Professional Counselors and Therapists. *Experience requirements*. Oregon.gov. https://www.oregon.gov/oblpct/pages/experience.aspx. Accessed December 31, 2024.
This webpage outlines the experience requirements for obtaining licensure as a professional counselor or therapist in Oregon. It provides guidance on the necessary supervised clinical hours, documentation, and other criteria needed to qualify for licensure. This resource is essential for individuals pursuing certification in counseling or therapy within Oregon, helping them understand the practical experience necessary to meet state standards.

329. Oregon State Board of Nursing. *Oregon State Board of Nursing*. Oregon.gov. https://www.oregon.gov/osbn/Pages/index.aspx. Accessed December 31, 2024.
This webpage provides essential information about the Oregon State Board of Nursing (OSBN), including licensing requirements, rules and regulations, continuing education, and other resources for nurses in Oregon. It serves as a comprehensive guide for current and prospective nurses seeking to understand the licensure process, renewal requirements, and professional standards within the state.

330. Oregon Board of Psychology. *Oregon Board of Psychology*. Oregon.gov. https://www.oregon.gov/psychology/Pages/index.aspx. Accessed December 31, 2024.
This webpage offers detailed information about the Oregon Board of Psychology, including licensing requirements, rules, regulations, and resources for psychologists in Oregon. It is a key resource for prospective and current psychologists, providing guidance on licensure, renewal processes, continuing education, and ethical standards within the state.

331. The Oregon Department of Education. Counseling Program Personnel and Licensing Requirements. https://www.oregon.gov/ode/educator-resources/standards/comprehensive_school_counseling/Pages/licensing.aspx. Accessed February 4, 2025.
This webpage outlines the qualifications and licensing requirements for school counselors in Oregon. It emphasizes the need for school counselors to have specialized training in

comprehensive school counseling programs that address academic, career, social/emotional development, and community involvement.

332. Options for Southern Oregon. Skills Training for Children and Families. https://www.optionsonline.org/skills-training-for-children-and-families. Accessed February 4, 2025.
This webpage outlines the Skills Training program provided by Options for Southern Oregon, aimed at helping children and families manage behavioral challenges. The program offers emotional regulation training for children and equips caregivers with effective parenting techniques to support children's development.

333. Oregon Health Authority. OHA Supported School-Based Mental Health Map. Updated December 2023. https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/SBMH-Map.pdf. Accessed February 4, 2025.
This map from the Oregon Health Authority provides an overview of school-based mental health (SBMH) services available across various schools in Oregon. It lists a range of school districts and educational institutions that partner with mental health providers to offer services to students.

334. American School Counselor Association. Student-to-School-Counselor Ratio 2022–2023. Published 2023. https://www.schoolcounselor.org/getmedia/a988972b-1faa-4b5f-8b9e-a73b5ac44476/ratios-22-23-alpha.pdf . Accessed February 4, 2025.
This document from the American School Counselor Association provides the student-to-school-counselor ratios for the 2022–2023 school year. The report compares the number of students per counselor across various states, highlighting the disparity in resources and the ongoing gap between the ideal counselor-to-student ratio of 250:1 and the current reality in many areas.

335. America's Health Rankings. Mental Health Providers in the United States. United Health Foundation. https://www.americashealthrankings.org/explore/measures/MHP . Accessed February 4, 2025.
This source provides a detailed analysis of the availability of mental health providers in the United States. It includes national and state-level data on the number of psychiatrists, psychologists, counselors, social workers, marriage and family therapists, and advanced practice nurses specializing in mental health care per 100,000 population.

336. Health Resources and Services Administration. Health Workforce Shortage Areas. U.S. Department of Health and Human Services. https://data.hrsa.gov/topics/health-workforce/shortage-areas. Accessed February 4, 2025.
This resource from the Health Resources and Services Administration (HRSA) offers data on Health Professional Shortage Areas (HPSA) across the United States. It provides a detailed overview of primary care, dental, and mental health shortages, allowing users to explore these areas by type, location, and specific attributes.

337. American Academy of Child and Adolescent Psychiatry. Practicing Child and Adolescent Psychiatrists. https://www.aacap.org/AACAP/Advocate/Policy_Resources/State_Workforce_Maps/AACAP/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx?hkey=56cd4ca3-d496-4e93-82a9-ff19376b5ac9. Accessed February 4, 2025.
This data dashboard shows where child and adolescent psychiatrists are practicing in the United States. This source also provides maps that show where there are shortages of these providers.

338. Oregon Health Authority. Oregon's Licensed Health Care Workforce. Data Dashboard. https://visual-data.dhsoha.state.or.us/t/OHA/views/Oregonslicensedhealthcareworkforce2022/Overview?%3Aembed=y&%3AisGuestRedirectFromVizportal=y. Published April 2023. Accessed February 4, 2025.
This data dashboard provides data on Oregon's licensed health care workforce. The Health Care Workforce Reporting program (HWRP) works with various licensing boards in Oregon to collect data on the workforce, which is presented in this dashboard. The data includes hours worked per week, specialty, and future plans.

339. Oregon State Board of Nursing. Number of NP Licenses by Specialty by County. https://osbnreports.osbn.oregon.gov/Main/LicenseBySpecialtyByCounty. Accessed February 4, 2025.

This source provides data on the number of Nurse Practitioner (NP) licenses by specialty and county in Oregon. It offers insights into the distribution of NP specialties across various counties, aiding in understanding healthcare workforce availability in different regions of the state.

340. Harrison H. Oregon Health Authority. Email communication. February 3, 2025.
341. Oregon Health Authority. About traditional health workers. Oregon.gov. https://www.oregon.gov/oha/ei/pages/about-traditional-health-workers.aspx. Accessed February 4, 2025.

This webpage provides an overview of the role and certification process for Traditional Health Workers (THWs) in Oregon. It outlines the different categories of THWs, such as community health workers, doulas, and peer support specialists, and offers information on certification requirements, training, and how these workers contribute to the state's healthcare system.

342. Oregon Health Authority. *How to become a traditional health worker*. Oregon.gov. https://www.oregon.gov/oha/EI/Pages/How-to-Become-a-THW.aspx. Accessed February 4, 2025.

This webpage provides detailed guidance on how to become a Traditional Health Worker (THW) in Oregon, including the certification process, required training, and eligibility criteria. It offers valuable information for individuals interested in pursuing a career as a community health worker, peer support specialist, or other types of THWs.

343. Oregon Health Authority. *Oregon Health Workforce Registry*. Oregon.gov. https://healthworkforceregistry.oregon.gov/. Accessed February 4, 2025.

This website provides access to the Oregon Health Workforce Registry, a platform for healthcare professionals to manage their certifications, training, and licensure information. It allows users to track and update their professional credentials and ensures compliance with state regulations.

344. Oregon Health Authority. Peer Wellness Specialist. https://www.oregon.gov/oha/ei/pages/thw-pws.aspx. Accessed February 4, 2025.

This page from the Oregon Health Authority details the certification and recertification requirements for Peer Wellness Specialists (PWS). The site offers guidelines on how to become certified, including completing an approved training program, applying through the legacy clause, or using reciprocity for those certified in other states.

345. Oregon Health Authority. (2021). *2021 survey of OHA registered traditional health workers*. Oregon.gov. https://visual-data.dhsoha.state.or.us/t/OHA/views/OHARegisteredTHWs/Overview?%3AisGuestRedirectFromVizportal=y&%3Aembed=y. Accessed February 4, 2025.

This webpage presents the findings from the 2021 survey of registered Traditional Health Workers (THWs) in Oregon. It includes key data on the workforce, such as demographic trends, areas of practice, and training levels of THWs. The survey results are a valuable resource for understanding the role and impact of THWs in Oregon's healthcare system, providing insight into their distribution and qualifications.

346. Oregon Health Authority. CCO Traditional Health Worker Deliverables. https://www.oregon.gov/oha/EI/Pages/CCO-Traditional-Health-Worker-Deliverables.aspx. Accessed February 4, 2025.

This source details the deliverables related to Traditional Health Workers (THWs) in Coordinated Care Organizations (CCOs) in Oregon, outlining essential objectives such as promoting health equity and sustaining the workforce.

347. Oregon Family Workforce Association. *Strengthening the Family Peer Support Workforce: Issue Brief*. Oregon Family Workforce Association. https://www.ohsu.edu/sites/default/files/2024-02/FSS%20Issue%20Brief_Updated%20Final%202-13-2024.pdf. Published February 13, 2024. Accessed February 4, 2025.

This issue brief discusses the challenges faced by Oregon's family peer support workforce, particularly in youth and family behavioral health systems. It highlights gaps in the infrastructure,

strain on the workforce, and the need for more robust support, including professional development and better understanding by employers and state leaders.

348. Oregon Health Authority. (2020). Oregon's licensed health care workforce supply based on data collected during 2009 through January 2020. Oregon.gov. https://www.oregon.gov/oha/HPA/ANALYTICS/HealthCareWorkforceReporting/2021-Workforce-Supply-for-web.pdf. Accessed February 4, 2025.
This report provides a comprehensive analysis of Oregon's licensed healthcare workforce, using data collected from 2009 to January 2020. It examines trends in the supply of healthcare professionals, workforce shortages, and demographic shifts within the state's healthcare sector. The findings offer valuable insights for workforce planning and policy development to address current and future healthcare needs in Oregon.

349. Oregon Health Authority. *Health Care Workforce Need Assessment 2025*. Oregon Health Authority. January 2025. https://www.oregon.gov/oha/HPA/HP-HCW/Documents/2025-Health-Care-Workforce-Need-Assessment-report-final.pdf. Accessed February 4, 2025.
This report, developed by the Oregon Health Authority, provides a comprehensive analysis of the state's health care workforce, highlighting trends, shortages, and the need for greater diversity and capacity.

350. Accreditation Council for Graduate Medical Education (ACGME). https://www.acgme.org/. Accessed February 4, 2025.
This webpage describes the Accreditation Council for Graduate Medical Education (ACGME), which is a non-profit organization responsible for accrediting medical education programs in the United States.

351. Accreditation Council for Graduate Medical Education (ACGME). ACGME Program Requirements for Graduate Medical Education in Pediatrics. https://www.acgme.org/globalassets/pfassets/programrequirements/2025-prs/320_pediatrics_2025_tcc.pdf. Published 2024. Accessed February 4, 2025.
This document presents program requirements for pediatrics residency, established by the Accreditation Council for Graduate Medical Education (ACGME). It outlines the expectations for residency programs, including required competencies, educational structure, clinical training experiences, and the goals for residents' development as pediatricians.

352. Accreditation Council for Graduate Medical Education International. Advanced Specialty Program Requirements for Graduate Medical Education in Family Medicine. https://www.acgme-i.org/globalassets/acgme-international/specialties/familymedicine/familymedicine.pdf. Published April 1, 2022. Accessed February 4, 2025.
This document outlines the specific requirements for advanced specialty programs in family medicine within graduate medical education. It details the competencies, curriculum, and training objectives necessary to prepare family medicine specialists.

353. Oregon Legislative Assembly. (2021). *House Bill 2315*. Oregon State Legislature. https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2315/Enrolled. Accessed February 4, 2025.
House Bill 2315, enacted in 2021, mandates continuing education for various healthcare professionals in Oregon related to suicide risk assessment, treatment, and management. It specifies the licensing boards affected, outlines the continuing education requirements, and establishes documentation and reporting procedures for professionals.

354. Oregon Pediatric Society. *Professional education*. Oregon Pediatric Society. https://oregonpediatricsociety.org/education/. Accessed February 4, 2025.
This webpage from the Oregon Pediatric Society provides a range of educational resources and training opportunities for pediatric healthcare providers. It includes information on upcoming events, continuing education courses, and resources aimed at improving pediatric care practices in

Oregon. The page is a valuable resource for healthcare professionals seeking to enhance their knowledge and skills in child healthcare and stay updated on relevant educational offerings within the pediatric field.

355. Oregon Council of Child and Adolescent Psychiatry (OCCAP). https://occap.org/. Accessed February 4, 2025.
This source describes the Oregon Council of Child and Adolescent Psychiatry (OCCAP), which is a professional organization dedicated to supporting mental health professionals who work with children and adolescents.

356. Oregon Health & Science University (OHSU). Continuing Professional Development. https://www.ohsu.edu/school-of-medicine/cpd/8th-annual-pediatric-mental-health-update. Accessed February 4, 2025.
Oregon Health & Science University's Continuing Professional Development (CPD) program offers ongoing education for healthcare professionals to maintain and enhance their clinical skills. The program is designed to provide the latest medical knowledge, focusing on both emerging healthcare topics and specialized fields, such as pediatric mental health.

357. Oregon Echo Network. Spring 2025 Programs. https://www.oregonechonetwork.org/programs. Accessed February 4, 2025.
The Oregon ECHO Network offers a variety of tele-education programs designed to connect healthcare professionals in underserved areas with specialists. Through this platform, healthcare providers can engage in real-time learning, share patient cases, and receive guidance on best practices for managing complex medical conditions.

358. Oregon Health Authority. Board of Behavior Analysis: Regulatory and License Information. Oregon Health Authority. https://www.oregon.gov/oha/ph/hlo/pages/board-behavior-analysis-regulatory-license.aspx. Accessed February 4, 2025.
This webpage provides information about the Oregon Board of Behavior Analysis, which oversees the licensing and regulation of behavior analysts in the state. It details the process for obtaining a behavior analysis license in Oregon, including the required qualifications, application procedures, and continuing education requirements.

359. Alternative Services Oregon Inc. The Oregon Intervention System. https://www.asioregon.org/oregon-intervention-system/. Accessed February 4, 2025.
The Oregon Intervention System (OIS) provides crisis prevention and intervention strategies for managing individuals with challenging behaviors. This resource is designed to help organizations implement evidence-based techniques for de-escalation, physical intervention, and long-term behavioral strategies.

360. Oregon Department of Human Services. Behavior Professionals. https://www.oregon.gov/odhs/providers-partners/idd/pages/behavior-professionals.aspx. Accessed February 4, 2025.
This page from the Oregon Department of Human Services provides information on behavior professionals working with individuals with intellectual and developmental disabilities (IDD). It includes resources for the training and certification required for professionals in this field, as well as information on best practices and guidelines for supporting individuals with IDD.

361. Oregon Community Brokerages. Brokerage Services. https://www.oregoncommunitybrokerages.org/brokerage-services. Accessed February 4, 2025.
This page from Oregon Community Brokerages outlines the services provided by community-based organizations that support individuals with intellectual and developmental disabilities (IDD). It highlights the brokerage model of care, which connects individuals with IDD to necessary resources and services tailored to their needs.

362. Oregon Department of Human Services, Office of Developmental Disabilities Services, & OHSU, University Center for Excellence in Developmental Disabilities. Stability of the Direct Support Professional

Workforce Providing Residential Supports to Adults with Intellectual and Developmental Disabilities in Oregon in 2022. https://www.oregon.gov/odhs/data/oddsdata/2024-dsp-workforce-report-en.pdf. Published 2024. Accessed February 4, 2025.

This report, produced collaboratively by the Oregon Department of Human Services and OHSU's University Center for Excellence in Developmental Disabilities, explores the stability of the Direct Support Professional (DSP) workforce in Oregon. It focuses on DSPs who provide residential care for adults with intellectual and developmental disabilities (IDD).

363. Keen Independent Research. (2022). *Oregon mental health regulatory agency diversity study*. https://www.oregon.gov/psychology/Documents/Diversity_Study_12-22.pdf. Accessed December 31, 2024.

The Oregon Mental Health Regulatory Agency Diversity Study by Keen Independent Research analyzes the racial, ethnic, and gender diversity of mental health professionals, specifically within the field of psychology in Oregon. The report identifies underrepresentation of certain demographic groups, addresses challenges to achieving a diverse workforce, and offers recommendations for increasing diversity and inclusion within Oregon's mental health services.

364. Occupational Safety and Health Administration. Regulations (standards - 29 CFR). U.S. Department of Labor. https://www.osha.gov/laws-regs/regulations/standardnumber/1910. Accessed December 31, 2024.

The Regulations (Standards - 29 CFR) page from the Occupational Safety and Health Administration (OSHA) provides comprehensive information on federal safety and health standards for general industry under 29 CFR 1910. These regulations cover various aspects of workplace safety, such as hazard communication, workplace environment standards, and employee protection measures.

365. Occupational Safety and Health Administration. Oregon state plan. U.S. Department of Labor. https://www.osha.gov/stateplans/or. Accessed December 31, 2024.

The Oregon State Plan page on the Occupational Safety and Health Administration (OSHA) website provides details about Oregon's state-specific occupational safety and health regulations. Oregon's plan is approved by OSHA and aims to provide workplace safety standards that meet or exceed federal guidelines.

366. Oregon Health Authority. (2022). *Behavioral health workforce report to the Oregon Health Authority and State Legislature* (Final Report, February 1, 2022). Center for Health Systems Effectiveness.. https://www.oregon.gov/oha/ERD/SiteAssets/Pages/Government-Relations/Behavioral%20Health%20Workforce%20Wage%20Study%20Report-Final%20020122.pdf. Accessed December 31, 2024

The *Behavioral Health Workforce Report to the Oregon Health Authority and State Legislature* outlines key findings from a study on the wages and compensation of behavioral health professionals in Oregon. The report addresses challenges such as wage disparities, workforce shortages, and the need for improved recruitment and retention strategies. It provides data-driven recommendations aimed at enhancing the effectiveness and stability of Oregon's behavioral health workforce.

367. Oregon Department of Human Services. OTIS Digital Data Book. https://www.oregon.gov/odhs/data/pages/otis-data.aspx?utm_source=ODHS&utm_medium=egov_redirect&utm_campaign=https%3A%2F%2Fwww.oregon.gov%2Fdhs%2Fpages%2Fotis.aspx. Accessed February 4, 2025.

The OTIS Digital Data Book from the Oregon Department of Human Services provides a comprehensive overview of data related to child welfare, including statistics on foster care, adoption, and other relevant services.

368. Oregon Legislative Assembly. SB 710: Relating to Children in Care; and Declaring an Emergency. Oregon Legislative Assembly. https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/SB710. Accessed February 4, 2025.

SB 710 focuses on improving services for children in foster care in Oregon. The bill aims to address the needs of children in care by enhancing support systems and ensuring better outcomes for these vulnerable youth.

369. Oregon Health Authority. CCO Quality Assurance. https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-QA.aspx?wp2008=se:%22adequacy%22. Accessed February 4, 2025.
The page from the Oregon Health Authority provides information on the quality assurance measures for Coordinated Care Organizations (CCOs) in Oregon, focusing specifically on the adequacy of services offered.

370. Oregon Health Authority. (2023). 2022 delivery system network evaluation of Oregon coordinated care organizations. Oregon Health Authority. https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/OR2022_CCO_Annual%20DSN%20Evaluation%20Report_F1.pdf. Accessed December 31, 2024.
The report focuses on the delivery of healthcare services to Medicaid recipients, assessing key areas such as access to care, quality of services, and network adequacy. It provides valuable data on the effectiveness of the system and offers recommendations for enhancing care delivery and improving member outcomes.

371. Oregon Health Authority. (2023). Ombuds program 2023 year-end report. https://www.oregon.gov/oha/ERD/OmbudsProgram/2023%20Ombuds%20Year%20End%20Report.pdf. Accessed December 31, 2024.
The Oregon Health Authority's 2023 Ombuds Program Year-End Report provides an overview of the program's activities and outcomes for the year. It details the number and types of cases handled, including issues related to Medicaid, healthcare access, and consumer rights. The report highlights trends in complaints, the resolution process, and the impact of the Ombuds program in improving the healthcare experience for Oregon residents.

372. U.S. Bureau of Labor Statistics. (2023). Occupational employment and wage statistics: Oregon (May 2023). U.S. Bureau of Labor Statistics. https://www.bls.gov/oes/2023/may/oes_or.htm#otherlinks. Accessed December 31, 2024.
The Occupational Employment and Wage Statistics: Oregon report from the U.S. Bureau of Labor Statistics provides detailed data on employment and wage levels across various occupations in Oregon as of May 2023.

373. Mental Health and Addiction Certification Board of Oregon. *MHACBO survey*. Mental Health and Addiction Certification Board of Oregon. https://mhacbo.org/media/filer_public/3b/44/3b44437d-d723-46b6-86c1-8d77a8cda5ef/mhacbo-survey.pdf. Accessed December 31, 2024.
The *MHACBO Survey* provides valuable insights into the mental health and addiction workforce in Oregon. This survey collects data on the certification and training of professionals in the field, offering a snapshot of trends, needs, and gaps in the mental health and addiction services sector. The findings are critical for informing policy, training, and resource allocation efforts to support the workforce in this field.

374. Chen, A. *Peer support specialist*. Published October 2017. U.S. Bureau of Labor Statistics. https://www.bls.gov/careeroutlook/2017/youre-a-what/peer-support-specialist.htm. Accessed December 31, 2024.
This article discusses the qualifications required, career opportunities, and the growing demand for peer support professionals as part of a holistic treatment approach. It offers valuable insights into the impact of peer support in recovery and its expanding role in healthcare.

375. Ramsey Solutions. Cost of Living in Oregon. Ramsey Solutions. https://www.ramseysolutions.com/real-estate/cost-of-living-in-oregon#:~:text=What's%20the%20Average%20Cost%20of,live%20than%20many%20other%20states. Accessed February 4, 2025.

This source provides a detailed breakdown of the cost of living in Oregon, offering insight into various factors such as housing, utilities, transportation, and healthcare costs.

376. Oregon Health Authority. *Oregon Behavioral Health Loan Repayment Program.* Oregon Health Authority. https://www.oregon.gov/oha/hsd/amh/pages/loan-repayment.aspx. Accessed December 31, 2024.
The Oregon Health Authority's Loan Repayment Program page provides information on financial assistance available to healthcare professionals working in underserved areas of Oregon. The program aims to reduce student loan debt in exchange for service in qualifying health settings, addressing healthcare access needs in the state.

377. Oregon Health Authority. *Behavioral Health Workforce Incentives*. Oregon Health Authority. https://www.oregon.gov/oha/HSD/AMH/Pages/Workforce-Initiative.aspx. Accessed December 31, 2024.
The Oregon Health Authority's Workforce Incentive page outlines efforts to strengthen the behavioral health workforce in Oregon. It provides information on various programs and strategies aimed at increasing the number of qualified professionals in the field, particularly in underserved areas.

378. Golden B. Oregon Behavioral Health Loan Repayment Program Email Communication. Oregon Health Authority. December 23, 2024

379. U.S. Department of Education. *Public service loan forgiveness*. Federal Student Aid. https://studentaid.gov/manage-loans/forgiveness-cancellation/public-service. Accessed December 31, 2024.
The U.S. Department of Education's Public Service Loan Forgiveness (PSLF) page provides detailed information about loan forgiveness options for individuals working in qualifying public service jobs. It explains the eligibility requirements, how to apply, and the steps necessary to have federal student loans forgiven after a set period of qualifying work.

380. Health Resources & Services Administration. *National Health Service Corps loan repayment program*. U.S. Department of Health and Human Services. https://nhsc.hrsa.gov/loan-repayment. Accessed December 31, 2024.
The National Health Service Corps (NHSC) Loan Repayment Program page provides information on how healthcare professionals can receive loan repayment assistance in exchange for working in underserved areas. It outlines eligibility requirements, application processes, and the benefits of the program, aimed at addressing healthcare provider shortages in rural and high-need communities across the United States.

381. U.S. Congressional Research Service. (2023). The National Health Service Corps *(R44970).* https://crsreports.congress.gov/product/pdf/R/R44970. Accessed December 31, 2024.
This Congressional Research Service report provides an in-depth analysis of the Public Service Loan Forgiveness (PSLF) program, its eligibility criteria, implementation challenges, and policy issues. The report discusses legislative changes, program requirements, and the impact on federal student loan borrowers working in public service jobs.

382. Health Resources & Services Administration. STAR loan repayment program. U.S. Department of Health and Human Services. https://bhw.hrsa.gov/funding/apply-loan-repayment/star-lrp. Accessed December 31, 2024.
The Health Resources and Services Administration's (HRSA) STAR Loan Repayment Program page outlines the opportunity for health professionals to receive loan repayment in exchange for serving in a State-Territory Area Recruitment (STAR) region. The program focuses on addressing healthcare workforce shortages by incentivizing professionals to work in underserved areas across the United States.

383. Health Resources & Services Administration. Pediatric specialty loan repayment program: Facility eligibility. U.S. Department of Health and Human Services. https://bhw.hrsa.gov/funding/apply-loan-repayment/pediatric-specialty-lrp/facility-eligibility. Accessed December 31, 2024.

The HRSA Pediatric Specialty Loan Repayment Program Facility Eligibility page provides essential information on which healthcare facilities are eligible to participate in the Pediatric Specialty Loan Repayment Program. This program offers loan repayment to pediatric specialists in exchange for their service at eligible facilities in underserved areas, aiming to improve access to pediatric care.

384. Oregon Goes to College. *Oregon Goes to College*. https://oregongoestocollege.org/. Accessed December 31, 2024.
Oregon Goes to College is a statewide initiative aimed at providing students with the information and resources necessary to pursue postsecondary education in Oregon. The website offers tools, guidance, and support for high school students, including scholarship opportunities, college application advice, and resources for navigating the transition to higher education.

385. Oregon Higher Education Coordinating Commission. Explore Oregon Community Colleges. Oregon.gov. https://www.oregon.gov/highered/access/pages/community-colleges.aspx#:~:text=Oregon%20has%2017%20community%20colleges,and%20centers%20throughout%20the%20state. Accessed February 4, 2025.
This webpage provides a detailed overview of Oregon's community colleges, outlining the 17 institutions and additional centers that serve the state's educational needs. It highlights the diverse opportunities offered, such as transfer pathways, workforce training, and adult education, emphasizing the vital role these colleges play in supporting both students and the broader Oregon economy.

386. Central Oregon Community College. *Peer support specialist (adult mental health) training*. Accessed https://www.cocc.edu/programs/public-health/peer-support-specialist-training.aspx. December 31, 2024.
This page from Central Oregon Community College outlines the Peer Support Specialist Training program, which is designed to prepare individuals to provide support for people experiencing mental health and substance use challenges. The training program emphasizes building skills to assist others in their recovery journey, while also promoting personal growth and community engagement in the behavioral health field.

387. University of Oregon. *About the Ballmer Institute*. https://childrensbehavioralhealth.uoregon.edu/about-ballmer-institute. Accessed December 31, 2024.
This page from the University of Oregon provides an overview of the Ballmer Institute for Children's Behavioral Health, which focuses on improving behavioral health services for children and families. The institute aims to expand the workforce of behavioral health professionals through training and educational initiatives, with a special emphasis on addressing the unique mental health needs of children in Oregon.

388. Oregon Health & Science University. Pediatric Fellowships. Doernbecher Children's Hospital. https://www.ohsu.edu/doernbecher/pediatric-fellowships. Accessed February 4, 2025.
This webpage from OHSU's Doernbecher Children's Hospital provides information about the pediatric fellowship programs available at the institution. It outlines the various specialized training opportunities for physicians in fields like pediatric cardiology, critical care, and oncology, among others.

389. Oregon Health & Science University. Child and Adolescent Psychiatry Fellowship. OHSU School of Medicine. https://www.ohsu.edu/school-of-medicine/psychiatry-education-and-training/child-and-adolescent-psychiatry-fellowship. Accessed February 4, 2025.
This webpage from OHSU's School of Medicine outlines the Child and Adolescent Psychiatry Fellowship program. It provides details about the program's structure, including the clinical and research opportunities available to fellows.

390. Samaritan Health Services. Child and Adolescent Psychiatry Fellowship. https://samhealth.org/careers-education/graduate-medical-education/our-programs/child-adolescent-psychiatry-fellowship/. Accessed February 4, 2025.

This webpage provides information about the Child and Adolescent Psychiatry Fellowship program at Samaritan Health Services. It outlines the structure of the fellowship, including training opportunities in clinical practice, research, and teaching, focusing on the mental health needs of children and adolescents.

391. George Fox University. Graduate School Programs. https://www.georgefox.edu/admission/graduate/programs.html. Accessed December 31, 2024.
This webpage from George Fox University provides an overview of the graduate programs offered at the university. It includes detailed descriptions of various academic fields, such as education, business, counseling, and psychology.

392. Lewis & Clark University. Counseling, Therapy, and School Psychology. https://graduate.lclark.edu/departments/counseling_psychology/. Accessed December 31, 2024.
The Counseling Psychology department at Lewis & Clark College offers advanced graduate programs in mental health and counseling. This webpage provides information on the master's and doctoral programs, including clinical mental health counseling, marriage and family therapy, and school counseling.

393. Oregon Health & Science University. Department of Psychiatry. https://www.ohsu.edu/school-of-medicine/psychiatry. Accessed December 31, 2024.
The Psychiatry department at OHSU School of Medicine offers comprehensive education and training for students interested in pursuing careers in psychiatry. This page provides an overview of their residency programs, fellowships, and research opportunities, emphasizing clinical exposure, research-driven approaches, and commitment to mental health care.

394. Oregon State University. Graduate Psychology. https://liberalarts.oregonstate.edu/sps/psychology/graduate-psychology. Accessed December 31, 2024.
Oregon State University's Graduate Psychology Programs page provides detailed information on advanced degrees in psychology, including master's and PhD programs. The page outlines the department's academic offerings, including specializations in clinical, experimental, and counseling psychology.

395. Pacific University. School of Graduate Psychology. https://www.pacificu.edu/directory/college-health-professions/school-graduate-psychology?gad_source=1. Accessed December 31, 2024.
Pacific University's School of Graduate Psychology offers a variety of graduate-level psychology programs, including master's and doctoral degrees. This page provides an overview of the school's academic programs, which include clinical psychology, counseling, and school psychology.

396. Portland State University. Graduate Psychology Programs. https://www.pdx.edu/academics/programs/graduate/psychology. Accessed February 4, 2025.
Portland State University's Graduate Psychology Programs webpage provides detailed information on the advanced degree opportunities available within the field of psychology, including master's and doctoral level programs. The site offers insights into program structures, specializations, and admission requirements, highlighting the university's commitment to training future professionals in various areas of psychological practice.

397. University of Oregon. Graduate Programs in Psychology. https://naturalsciences.uoregon.edu/psychology/graduate-programs. Accessed February 4, 2025.
The University of Oregon's Graduate Programs in Psychology webpage provides an overview of the graduate-level education opportunities within the psychology department, including details on the Ph.D. programs. It outlines specializations offered, such as clinical psychology, cognitive neuroscience, and developmental psychology.

398. Higher Education Coordinating Commission. Strategy, Research and Data. Oregon.gov. https://www.oregon.gov/highered/strategy-research/Pages/default.aspx. Accessed February 4, 2025.

The Oregon Higher Education Coordinating Commission's (HECC) Strategy, Research, and Data page provides key resources and reports related to higher education planning and research within Oregon. It includes data on state educational goals, trends, and outcomes, offering detailed reports and analysis that support decision-making for educators, policymakers, and stakeholders.

399. U.S. Census Bureau. Postsecondary Earnings Outcomes by Degree and Field. Data Dashboard. https://lehd.ces.census.gov/applications/pseo/?type=earnings&compare=postgrad&specificity=2&state=08&institution=08&degreelevel=05&gradcohort=0000-3&filter=50&program=52,45. Accessed February 4, 2025.

The U.S. Census Bureau's Longitudinal Employer-Household Dynamics (LEHD) application offers insights into postsecondary earnings outcomes based on degree, field of study, and state. This particular tool allows users to compare earnings for post-graduate degree holders across different institutions, with a focus on educational programs in various fields.

## System Funding

400. Henry I. Optimizing Oregon's Systems of Care; Fiscal Assessment. System of Care Advisory Council. Published September 2023. Accessed February 4, 2024.

This report assesses the fiscal structure of Oregon's care system, focusing on agencies like the Oregon Health Authority (OHA), the Oregon Department of Education (ODE), the Oregon Department of Human Services (ODHS), and the Oregon Youth Authority (OYA). It examines the allocation and utilization of resources across these sectors between 2019-2023, reviewing the biennial budget and service usage costs.

401. Oregon Department of Administrative Services. Oregon's Budget Process. https://www.oregon.gov/das/financial/pages/budgetprocess.aspx#:~:text=Oregon's%20budget%20is%20a%20tool,would%20be%20considered%20a%20biennium. Accessed February 4, 2025.

This webpage outlines Oregon's budget process, describing how the state develops, reviews, and approves its biennial budget. It highlights the fiscal framework, including key steps such as revenue forecasting, agency submissions, legislative review, and final budget adoption, emphasizing how state financial decisions are made to guide resource allocation for services.

402. Oregon Department of Education. 2023-2025 legislatively adopted budget. https://acrobat.adobe.com/id/urn:aaid:sc:VA6C2:ef2c4c09-0003-4b73-b79f-6cb27b24fb4a. Published 2023. Accessed December 31, 2024.

This report details the 2023-2025 Legislatively Adopted Budget for the Oregon Department of Education. It shows where funds are going in the education system, as well as places where there was a reduction of funds.

403. Oregon Health Authority. *2023-25 legislatively adopted budget*. https://www.oregon.gov/oha/Budget/2023-25%20Legislatively%20Adopted%20Budget.pdf. Published 2023. Accessed December 31, 2024.

The 2023-25 Legislatively Adopted Budget from the Oregon Health Authority outlines the state's budget allocations and financial plans for health services, including mental health, public health, and healthcare delivery.

404. Oregon Department of Human Services. 2023-2025 legislatively adopted budget: Section 3. https://www.oregon.gov/odhs/about/budget/2023-2025-lab-section-3.pdf. Published 2023. Accessed December 31, 2024.

The 2023-2025 Legislatively Adopted Budget (LAB) Section 3 from the Oregon Department of Human Services provides detailed financial information regarding the funding for various human services programs in Oregon. This includes allocations for services related to child welfare, aging,

and disability programs, with a focus on improving outcomes for vulnerable populations in the state.

405. Oregon Youth Authority. 2023-2025 legislatively adopted budget. Published 2023. https://www.oregon.gov/oya/Reports/2023-25-OYA-LAB.pdf. Accessed December 31, 2024.
The 2023-2025 Legislatively Adopted Budget (LAB) for the Oregon Youth Authority (OYA) outlines the financial allocations and priorities for the agency's programs. The document details the funding for youth rehabilitation services, juvenile justice programs, and initiatives aimed at improving the outcomes for young people involved in the justice system over 2023-2025.

406. Oregon Legislative Fiscal Office. 2023-2025 legislatively adopted budget: Detailed. https://www.oregonlegislature.gov/lfo/Documents/2023-25%20LAB%20Detailed.pdf. Published 2023. Accessed December 31, 2024.
The 2023-2025 Legislatively Adopted Budget (LAB) Detailed document from the Oregon Legislative Fiscal Office provides a comprehensive breakdown of Oregon's state budget. It includes detailed financial data for various state agencies, programs, and services, offering insights into spending priorities, funding allocations, and fiscal strategies to support state government operations and services.

407. Oregon Legislative Fiscal Office. 2023-2025 budget highlights. https://www.oregonlegislature.gov/lfo/Documents/2023-25%20Budget%20Highlights.pdf. Published 2023 . Accessed December 31, 2024.
The 2023-2025 Budget Highlights document from the Oregon Legislative Fiscal Office summarizes the key components of the state's budget. It outlines major funding decisions, policy changes, and priority areas for state spending, providing an overview of the financial plan and strategic goals for the period.

408. State of Oregon. State Revenue. https://www.oregon.gov/transparency/pages/revenue.aspx#:~:text=General%20Funds%20come%20almost%20entirely,Governor%20and%20Legislature%20may%20spend. Accessed December 31, 2024.
This page from the Oregon government website provides information on the state's budgeted revenue reporting, public finance, fund sources, and revenue forecasts.

409. Oregon Legislative Fiscal Office. 2021-23 Budget Highlights Update. https://www.oregonlegislature.gov/lfo/Documents/2021-23%20Budget%20Highlights%20Update.pdf. Published 2021. Accessed December 31, 2024.
This document provides an update on the budget highlights for Oregon's 2021-23 biennium, offering an overview of the state's financial decisions, allocations, and fiscal priorities. It covers key areas such as public services, healthcare, education, and public safety, highlighting changes in budget allocations and the financial strategies used to address the state's needs.

410. Oregon Secretary of State Audits Division. Search State Audits and Reviews. Available at: https://sos.oregon.gov/audits/Pages/stateaudits.aspx. Accessed December 31, 2024.
The Oregon Secretary of State Audits Division website provides access to a variety of state audits and reviews, offering detailed reports on state government programs, operations, and financial activities. These audits are intended to assess efficiency, accountability, and transparency within state agencies.

411. Oregon Secretary of State. ODE and PPS Must Do More to Monitor Spending and Address Systemic Obstacles to Student Performance, Particularly at Struggling Schools. Published January 2019. https://records.sos.state.or.us/ORSOSWebDrawer/Recordhtml/6687804. Accessed December 31, 2024.
The Oregon Secretary of State's January 2019 report highlights the need for the Oregon Department of Education (ODE) and Portland Public Schools (PPS) to improve spending oversight and address systemic barriers to student performance, particularly in struggling schools.

412. Oregon Secretary of State. Chronic and Systemic Issues in Oregon's Mental Health Treatment System Leave Children and Their Families in Crisis.

https://records.sos.state.or.us/ORSOSWebDrawer/Recordhtml/7555866. Published September 2020. Accessed December 31, 2024.

This report by the Oregon Health Authority examines persistent challenges in Oregon's mental health treatment system, highlighting how chronic and systemic issues are leaving children and families in crisis. The findings emphasize the need for reforms to address gaps in services and improve outcomes for those affected by mental health issues.

413. Oregon Secretary of State. Developmental Disabilities Leadership is Proactively Addressing Program Challenges to Ensure Optimal Service Delivery. https://records.sos.state.or.us/ORSOSWebDrawer/Recordhtml/8214465. Published August 2021. Accessed December 31, 2024.

This report discusses the proactive efforts of leadership in Oregon's developmental disabilities programs to address challenges and improve service delivery for individuals with developmental disabilities.

414. Oregon Department of Human Services. Foster Care in Oregon: Chronic Management Failures and High Caseloads Jeopardize the Safety of Some of the State's Most Vulnerable Children. https://records.sos.state.or.us/ORSOSWebDrawer/Recordhtml/5849909. Published January 2018. Accessed December 31, 2024.

This report from the Oregon Department of Human Services investigates significant issues within the state's foster care system, specifically chronic management failures and overwhelming caseloads. It underscores how these problems compromise the safety of vulnerable children, stressing the urgent need for systemic reforms to improve the welfare and protection of children in care. The report calls for more effective oversight and resource allocation to address these challenges.

415. Oregon Secretary of State. Oregon Youth Authority juvenile justice system review. https://records.sos.state.or.us/ORSOSWebDrawer/Recordhtml/6710557. Published March 10, 1999. Accessed December 31, 2024.

This review by the Oregon Secretary of State evaluates the juvenile justice system under the Oregon Youth Authority, assessing its effectiveness, practices, and the challenges faced in rehabilitating juvenile offenders. The report highlights key areas for improvement and offers recommendations for strengthening the system to better serve youth and public safety.

416. Hanson M. Public education spending statistics: Oregon. EducationData.org. https://educationdata.org/public-education-spending-statistics#oregon. Published July 14, 2024. Accessed December 31, 2024.

This article provides an analysis of public education spending in Oregon, offering key statistics and insights into how state funds are allocated to K-12 education. It covers various aspects of spending, including per-student expenditure, funding sources, and comparisons with other states, providing a comprehensive view of Oregon's educational funding landscape.

417. McCann A. States with the Best & Worst School Systems (2025). WalletHub. https://wallethub.com/edu/e/states-with-the-best-schools/5335. Published July 22, 2024. Accessed December 31, 2024.

This article from WalletHub ranks U.S. states based on the quality of their school systems for 2025, evaluating factors such as academic performance, funding, safety, and student-to-teacher ratios. It provides a comparative analysis of the best and worst states for education, offering insights into how various states perform in key educational metrics. The report helps identify strengths and challenges in school systems across the nation.

418. National Resources Institute (NRI). FY 2019 state mental health agency revenues and expenditures. National Resources Institute. Available at: https://www.nri-inc.org/media/rmrd2s5e/nri-2020-profiles-trends-in-smha-expenditures-and-funding-for-mental-health-services-fy-2001-to-fy-2019.pdf. Published January 2022. Accessed December 31, 2024.

This report by the National Resources Institute provides an overview of the revenues and expenditures of state mental health agencies (SMHAs) for fiscal year 2019. It includes trends in funding and spending for mental health services from 2001 to 2019, highlighting changes in state-level investment in mental health care. The report offers valuable data on how states allocate resources for mental health services and the impact of funding on service delivery.

419. The University of Kansas. State of the States in Intellectual and Developmental Disabilities. https://stateofthestates.ku.edu/. Accessed December 31, 2024.

This website from the University of Kansas provides comprehensive data and analysis on the state of services and supports for individuals with intellectual and developmental disabilities across the United States. It offers a detailed report on trends, funding, and policy in each state, helping to assess the effectiveness of various programs and inform future improvements in care and services for this population.

420. Rosinsky K, Fischer M, Haas M. Child welfare financing survey, SFY 2020. Child Trends. https://www.childtrends.org/publications/child-welfare-financing-survey-sfy2020#new_ta. Published May 22, 2023. Accessed December 31, 2024.

This report from Child Trends presents the results of the Child Welfare Financing Survey for State Fiscal Year 2020, analyzing the financial resources allocated to child welfare services across the United States. The study examines funding trends, state investments, and financial disparities within child welfare systems, providing important insights into how resources are distributed and the impact on service delivery for children and families.

421. Justice Policy Institute. Calculating the full price tag for youth incarceration. https://justicepolicy.org/wp-content/uploads/2022/02/sticker_shock_final_v2.pdf. Published December 2014. Accessed December 31, 2024.

This report from the Justice Policy Institute examines the financial costs of youth incarceration, providing a detailed analysis of the direct and indirect expenses associated with confining young people in detention facilities. The study highlights the long-term financial burden of youth incarceration on state and federal budgets, while also emphasizing the economic and social impacts on communities.

422. Justice Policy Institute. Sticker shock 2020: The cost of youth incarceration. https://justicepolicy.org/research/policy-brief-2020-sticker-shock-the-cost-of-youth-incarceration/. Published July 30, 2020. Accessed December 31, 2024.

This policy brief by the Justice Policy Institute explores the high financial costs of youth incarceration, highlighting the significant expenses for taxpayers associated with confining young people in detention facilities. The report provides updated data on the economic impact of youth incarceration, urging policymakers to reconsider the financial sustainability of this approach and invest in more cost-effective, rehabilitative alternatives for youth involved in the justice system.

## Youth & Family Experience of the System

423. The Oregon Department of Education. Student Educational Equity Development Survey (SEED). https://www.oregon.gov/ode/educator-resources/assessment/pages/student_educational_equity_development_survey.aspx. Accessed December 31, 2024.

This webpage outlines the SEED survey designed to assess and promote educational equity across the state's schools. The page explains the survey's role in understanding student experiences related to educational access and outcomes, aiming to support equity-focused policies and practices.

424. Oregon Department of Education. Feedback. https://www.oregon.gov/ode/about-us/pages/feedback.aspx Accessed December 31, 2024.
This webpage provides information on how individuals can submit feedback to the Oregon Department of Education. It offers a platform for parents, students, educators, and community members to share their thoughts, suggestions, or concerns regarding educational programs and policies in Oregon. This resource is important for fostering community engagement and ensuring that the Department of Education hears from diverse stakeholders.

425. Oregon Department of Education. Complaints and Appeals. https://www.oregon.gov/ode/about-us/pages/complaints.aspx. Accessed December 31, 2024.
This webpage outlines the process for filing complaints with the Oregon Department of Education, providing guidance on how individuals can report issues related to education programs or services. It details the types of complaints that can be addressed and the steps for submitting them, ensuring transparency and accountability in Oregon's educational system.

426. Oregon Health Authority. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Banner Books. https://www.oregon.gov/oha/hpa/analytics/pages/cahps.aspx. Accessed February 4, 2025.
This website provides an overview of the CAHPS survey, which is designed to assess patient experiences and satisfaction with healthcare services. It details how the data gathered from the survey is used to improve healthcare quality, enhance patient-provider communication, and guide healthcare policies.

427. Oregon Health Authority. Comagine Health. 2022 Youth Mental Health Survey Report. Published January 2023. https://www.oregon.gov/oha/HPA/ANALYTICS/MHSIPSurveyDocs/2022%20MHSIP%20Youth%20Survey%20Report.pdf. Accessed February 4, 2025.
The 2022 Youth Mental Health Survey Report by the Oregon Health Authority offers an in-depth evaluation of youth mental health services across Oregon, focusing on aspects such as service access, satisfaction, and overall care quality.

428. Oregon Health Authority. *Ombuds program*. https://www.oregon.gov/oha/erd/pages/ombuds-program.aspx. Accessed December 31, 2024.
The Oregon Health Authority's Ombuds Program provides an independent resource for resolving concerns or disputes between healthcare consumers and the state's Medicaid and health services programs. The program offers assistance in addressing issues related to healthcare access, quality of care, and Medicaid benefits, ensuring that individuals' rights are protected and that they receive fair treatment within the healthcare system.

429. Oregon Secretary of State. Developmental Disabilities Leadership is Proactively Addressing Program Challenges to Ensure Optimal Service Delivery. Oregon Audits Division. https://sos.oregon.gov/audits/Documents/2021-24-e-reader.pdf. Published August 2021. Accessed February 4, 2025.
This audit report from the Oregon Secretary of State examines the actions taken by the Developmental Disabilities Leadership to address challenges within the program. The report outlines efforts to improve the quality and accessibility of services, such as implementing more efficient coordination and reallocating resources.

430. Performance Based Standards (PBS). *Why PBS*. Public Broadcasting Service. https://pbswebsite.azurewebsites.net/why-pbs/. Accessed December 31, 2024.
Performance Based Standards (PbS) outline the organization's data-driven approach to improving conditions and quality of life in juvenile justice facilities and community programs. It emphasizes research-based standards and performance measures aimed at enhancing safety, improving rehabilitation, and supporting the reintegration of youth. PbS focuses on continuous improvement through regular data collection and analysis to drive better outcomes in juvenile justice settings.

431. University of Connecticut. School of Social Work. Oregon System of Care Barriers Report. Published January-June 2023.
The Oregon System of Care (SOC) Barriers Report analyzes barriers to mental health services for children and families in Oregon, focusing on submissions from January to June 2023. Using thematic coding, the report identifies key barriers such as service gaps, child health needs, and administrative issues. The most frequent barrier was service gaps (32.7% of comments), followed by health needs and facilitative administration. The findings aim to guide improvements in the SOC's strategic plan to reduce barriers and enhance service access for young people in Oregon.
432. System of Care Advisory Council. Citizens for safe Schools Mini Grant Report. Published September 1, 2023.
This source describes a meeting with parents, community members, and students from diverse backgrounds, including the indigenous Klamath Tribes and Latinx communities, as well as individuals from the LGBTQ+ community, all living in rural Klamath County.
433. Jackson Street Youth Services. System of Care Advisory Council Mini Grant Report. Published September 1, 2023.
This source describes the Mentoring Program for youth who are homeless or at risk of homelessness in Linn and Benton counties. The program, developed by Jackson Street, distributed a survey to 25 families with youth participating in mentoring. The survey aimed to assess engagement with Oregon's System of Care (SOC), identifying barriers and gathering feedback on what families and youth would like to see more of from local agencies.
434. System of Care Advisory Council. Mini Grant Report #179591. Published September 1, 2023.
The focus group session for Grant #179591 involved 9 adults and 2 youths, exploring key themes related to the System of Care (SOC). Participants discussed their current knowledge of the SOC, how they wish to engage with it, and the resources or support needed to facilitate their participation. The session aimed to gather insights on community members' awareness, preferences, and needs for effective involvement in the SOC.
435. Community Healing Initiative. POIC and RAHS Mini Grant Report. September 4, 2023.
This source describes four focus group meetings in 2023 with families from Multnomah County, mostly unaware of the Oregon System of Care (SOC). Participants, primarily Black with some mixed-ancestry children, expressed frustration over the lack of support until justice involvement, school communication issues, and a lack of culturally relevant services.
436. System of Care Advisory Council. Somali Empowerment Circle Mini Grant Report. Published September 1, 2023.
This source describes two focus groups held in July 2023 with 8 Somali youth and 8 mothers, where participants discussed how the Somali Empowerment Circle (SEC) can better support ongoing engagement and provide access to resources. Feedback highlighted the need for continuous involvement and resource accessibility. A fiscal report details project expenditures.
437. System of Care Advisory Council. Adelante Mujeres Mini Grants Final Report. Published 2023.
This mini grant report describes Adelante Mujeres' Esperanza program, which hosted six listening sessions in summer 2023, engaging Latino and Latina youth and adults, including LGBTQ+ individuals. The sessions addressed mental health barriers, focusing on cultural stigma and, more significantly, structural issues like cost and access. A fiscal report details project expenditure.
438. System of Care Advisory Council, Oregon School-Based Health Alliance. Youth Experience of the System of Care Survey. 2024.
The System of Care Advisory Council and the Oregon School-Based Health Alliance surveyed youth to understand their experiences within the system of care.
439. Oregon Department of Education. Culturally specific afterschool learning programs. https://www.oregon.gov/ode/students-and-family/equity/CulturallySpecificAfterSchoolLearning/Pages/default.aspx. Accessed December 31, 2024.

This Oregon Department of Education webpage details culturally specific. afterschool programs designed to support underserved students. It emphasizes the importance of culturally responsive programs for academic success and engagement, and provides resources, funding opportunities, and benefits for educators, community organizations, and policymakers focused on educational equity.

440. Oregon Department of Education. Multilingual and migrant education. https://www.oregon.gov/ode/about-us/pages/multilingual_and_migrant_education_team.aspx. Accessed December 31, 2024.
This webpage provides information about Oregon's Multilingual and Migrant Education Team, which works to support students from diverse linguistic and migrant backgrounds. It highlights resources, programs, and initiatives aimed at improving educational outcomes for multilingual and migrant students, making it a useful resource for educators and policymakers focused on equity and inclusion.

441. Oregon Migrant Education Program. Service Delivery Plan. The Oregon Department of Education. https://www.oregon.gov/ode/schools-and-districts/grants/ESEA/Migrant/Documents/Oregon_SDP_Final_Report_8-2021.pdf. Published July 2021. Accessed December 31, 2024.
The report provides insights into program implementation, services provided, and challenges faced, with an emphasis on improving educational equity and access for migrant youth.

442. Oregon Department of Education. Cultural Toolkits. https://www.oregon.gov/ode/students-and-family/childnutrition/f2s/pages/oregonharvestforschoolsculturaltoolkits.aspx#:~:text=Created%20by%20Food%20Hero%2C%20these,in%20increased%20attention%20to%20equity. Accessed December 31, 2024.
This webpage introduces Cultural Toolkits, which provide resources for incorporating culturally relevant food education into school programs. The toolkits aim to promote healthy eating while highlighting cultural diversity, with an emphasis on equity and inclusion in school nutrition.

443. Oregon Department of Education. Education Equity. https://www.oregon.gov/ode/students-and-family/equity/Pages/default.aspx. Accessed February 4, 2025.
The Oregon Department of Education's Equity webpage focuses on the state's efforts to ensure equitable access to education for all students. It highlights initiatives aimed at addressing disparities in educational outcomes related to race, ethnicity, disability, and socio-economic status.

444. U.S. Department of Health and Human Services. National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf. Accessed February 4, 2025.
The Enhanced National CLAS Standards, published by the U.S. Department of Health and Human Services, provide a comprehensive framework for advancing health equity, improving quality, and reducing healthcare disparities.

445. U.S. Department of Health and Human Services. Improving Quality of Care & Eliminating Health Disparities. Think Cultural Health. https://thinkculturalhealth.hhs.gov. Accessed February 4, 2025.
This website focuses on strategies to enhance healthcare quality while addressing health disparities. This initiative emphasizes the importance of culturally and linguistically appropriate services (CLAS) to ensure all individuals, regardless of background, receive effective and equitable care.

446. Culturally and Linguistically Specific Services. Oregon Health Authority. https://www.oregon.gov/oha/hsd/ohp/pages/clss.aspx. Accessed December 31, 2024.
The Oregon Health Authority's page on Culturally and Linguistically Specific Services (CLSS) provides information on initiatives designed to enhance the accessibility of healthcare for diverse

populations in Oregon. It outlines the CLSS framework, which focuses on addressing health disparities by providing services that are tailored to the cultural and linguistic needs of individuals.

447. Oregon Department of Human Services. Certification training for resource and adoptive families. https://www.oregon.gov/odhs/providers-partners/foster-care/Pages/training-certification.aspx. Accessed December 31, 2024.
This webpage outlines the training curriculum for foster care certification. Session descriptions were used to understand what trauma-informed and culturally responsive topics were included in the curriculum.

448. State of Oregon Judicial Department. Interpreter Services. Union County Oregon Courts. https://www.courts.oregon.gov/courts/union/programs-services/pages/interpreters.aspx. Accessed February 4, 2025.
This page outlines the process for requesting an interpreter, for assistance in legal proceedings. The service ensures equitable access to justice by providing non-English speakers with necessary language support during court proceedings, helping bridge communication barriers in the legal system.

449. Oregon Youth Development Division. Oregon Juvenile Detention Facility Guidelines. Oregon.gov. Published 2020. https://www.oregon.gov/youthdevelopmentdivision/Juvenile-Justice/Documents/Facility%20Monitoring%20Resources/2020%20Juvenile%20Detention%20Guidelines.pdf. Accessed February 4, 2025.
The *Oregon Juvenile Detention Facility Guidelines* document outlines the operational standards and expectations for juvenile detention facilities in Oregon. It provides detailed criteria for the care, custody, and treatment of detained youth.

450. Oregon Youth Authority. (2022). *2022 statewide programs and services report*. Oregon Youth Authority. https://www.oregon.gov/oya/jjis/Reports/2022StatewideProgramsServices.pdf. Accessed December 31, 2024.
The 2022 Statewide Programs and Services Report by the Oregon Youth Authority provides an overview of the agency's juvenile justice programs, focusing on outcomes, challenges, and future recommendations. It includes data on rehabilitation, education, and community-based services aimed at reducing recidivism among youth offenders.

451. Oregon Youth Authority. Office of Inclusion and Intercultural Relations. https://www.oregon.gov/oya/oiir/pages/default.aspx. Accessed February 4, 2025.
This webpage provides information about the initiatives and programs designed to address issues related to inclusion, equity, and reconciliation within the youth justice system in Oregon.

452. Oregon Legislature. House Concurrent Resolution 33. Published 2017. https://www.oregonlegislature.gov/bills_laws/lawsstatutes/2017hcr0033.pdf. Accessed February 4, 2025.
The *House Concurrent Resolution 33* outlines the Oregon Legislature's commitment to addressing youth mental health issues. It highlights the importance of increasing support for mental health services for children and adolescents in the state, with an emphasis on improving access to care, early intervention, and prevention programs.

453. Oregon Department of Education. *Trauma-informed practices in schools*. https://www.oregon.gov/ode/students-and-family/GraduationImprovement/Documents/Trauma-Informed%20Practices%20in%20Schools.pdf. Accessed December 31, 2024.
This document provides guidelines for integrating trauma-informed practices in schools, focusing on strategies to support students who have experienced trauma. It emphasizes creating a safe, responsive environment and offers practical approaches for educators to address trauma-related challenges in the classroom.

454. The Oregon Department of Education. The Use of Implementation Science to study Trauma-Informed Practices: A Closer Look at Implementation in Two Oregon Schools.

https://www.oregon.gov/ode/reports-and-data/LegReports/Documents/TIP Pilot Report Rev Final Oct 2019.docx. Published October 2019. Accessed February 4, 2025.
This report provides an overview of a trauma-informed pilot study initiated in two Oregon high schools as part of House Bill 4002. It discusses the methods employed, such as hiring trauma-informed school coordinators, engaging staff in specialized training, and blending trauma-informed approaches into existing school initiatives like PBIS.

455. Oregon Department of Education, House Education Committee. HB 2368 & -1 Amendment - Trauma Informed Pilot Program. https://olis.oregonlegislature.gov/liz/2021R1/Downloads/PublicTestimonyDocument/13231. Published March 9, 2021. Accessed February 4, 2025.
This document discusses House Bill 2368 which seeks to implement a Trauma-Informed Pilot Program in Oregon schools to address the needs of students affected by trauma. The document includes public testimony, outlining the potential benefits and challenges of introducing trauma-informed practices in educational environments to foster better emotional, psychological, and academic outcomes for students impacted by trauma.

456. Oregon Health Authority. *Trauma-Informed Approaches.* https://www.oregon.gov/oha/hsd/bh-child-family/pages/tia.aspx. Accessed December 31, 2024.
This webpage from the Oregon Health Authority provides an overview of trauma-informed practices in child and family services. It outlines the principles and strategies for integrating trauma-informed care into service delivery to improve outcomes for children and families affected by trauma.

457. Trauma Informed Oregon. https://traumainformedoregon.org/. Accessed December 31, 2024.
Trauma-Informed Oregon is a statewide initiative aimed at promoting trauma-informed care across Oregon's systems and communities. The website offers resources, training, and best practices for individuals and organizations working to integrate trauma-sensitive approaches in various settings, including healthcare, education, and social services.

458. Oregon Department of Human Services. Trauma-Informed Organization Policy. https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/de010-022.pdf. Published December 2, 2019. Accessed February 4, 2025.
The Trauma-Informed Organization Policy by the Oregon Department of Human Services (DHS) outlines the agency's commitment to adopting a trauma-informed approach to its operations, staff interactions, and services.

459. Oregon Legislative Assembly. HB 2575 (2021). Oregon Legislative Assembly. https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2575/Introduced. Accessed February 4, 2025
House Bill 2575 (2021) directs the Oregon Department of Justice (DOJ) to fund training programs focused on trauma-informed practices for law enforcement agencies and local governments. The bill aims to enhance the ability of law enforcement and local officials to understand and respond effectively to individuals affected by trauma, promoting better interactions and outcomes within the community.

460. Oregon Department of Justice. Trauma Informed Response Training. Oregon Department of Justice, https://www.doj.state.or.us/crime-victims/grant-funds-programs/trauma-informed-response-education-grant/. Accessed February 4, 2025.
The *Trauma Informed Response Training* initiative, administered by the Oregon Department of Justice, focuses on equipping professionals with the knowledge and skills to respond to victims of crime in a manner that is sensitive to the effects of trauma. This training emphasizes understanding the psychological and emotional impacts of trauma and the importance of creating a safe, supportive environment for victims.

461. Oregon Youth Authority. Developmental approach to parole and probation. Oregon Youth Authority. https://www.oregon.gov/oya/Publications/DAPPpracticeguide.pdf. Accessed December 31, 2024.
The *Developmental Approach to Parole and Probation* guide by the Oregon Youth Authority provides strategies for tailoring parole and probation practices to the developmental needs of youth. It emphasizes age-appropriate interventions that recognize the potential for growth in young offenders, aiming to reduce recidivism and support rehabilitation through developmentally informed approaches.

## System Readiness for Change

462. University of Connecticut. School of Social Work. System Reform Support Instrument (SRSI). Accessed February 4, 2025.
This report describes the System Reform Support Instrument (SRSI) which is a tool designed to help system leaders assess readiness and prioritize indicators that enhance system design and outcomes, particularly in behavioral health. It promotes a comprehensive approach to system transformation, focusing on policy, management, practice, and community.

463. Ramos C, Beriault J. Oregon System of Care Advisory Council (SOCAC) Marketing & Communication Report: Evaluating Communication, Engagement, and Outreach Effectiveness Phase I. Portland State University. School of Business Administration. December 31, 2024.
This evaluation provides an overview of the Oregon System of Care Advisory Council (SOCAC), focusing on its efforts to enhance support systems for children, youth, and families with complex needs. Based on 15 qualitative interviews and an analysis of SOCAC's practices, the report assesses how effectively SOCAC communicates its mission, engages diverse stakeholders, and addresses systemic challenges.