Improving Behavioral Health Care in Oregon

The Oregon Health Authority's ten-year strategic goal is to eliminate health inequities. This means people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identify, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

Oregon's health care transformation has changed how health care is conceptualized, managed, delivered and financed in Oregon. There has been a significant increase in the number of people eligible for Medicaid funded health services with about 300,000 new members enrolled. Oregon's Health System Division administers state and federal funds to deliver and pay for health care services to over 1 million people in Oregon, primarily through the Oregon Health Plan (OHP) with 43 percent of them being children. Enrollment in OHP contributes to Oregon achieving one of the lowest uninsured rates in the nation. Prevention, treatment, and recovery services have a solid evidence base on which to build a system that promises better outcomes for people who have been diagnosed with or who are at risk for mental illness, substance use, gambling disorders and cooccurring disorders. Preventing the need for behavioral health services through evidence based primary prevention and environmental interventions at the population level are also critically needed. Oregon's Behavioral Health System

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

Medicaid/Oregon Health Plan – The Centers for Medicare & Medicaid Services (CMS) approved Oregon's Substance Use Disorder 1115 Demonstration waiver, effective April 8, 2021, through March 31, 2026. A central part of the waiver focuses on enhancing residential treatment services as a crucial component in the continuum of substance use addiction benefits. It accomplishes this by permitting Oregon to receive federal funding for Medicaid services for individuals with a substance use disorder in residential treatment facilities with more than 16 beds.

This new federal funding, added to the resources provided in the Governor's Budget for 2021-23, allows for greater investment in Oregon's vision to prevent, identify, and treat people with substance use disorder and help them sustain long-term recovery. The other major component of this waiver increases the service array for Oregon Health Plan (OHP) members with substance use disorders, including Community

Integration services composed of housing and employment support. At the guidance of CMS, the proposed Recovery Support Services were separated out from this waiver. This means peer delivered services outside of a treatment episode will be considered for further conversation and development in the future.
The current OHP waiver makes Oregon the first state to keep children on OHP covered from birth to age six. Starting January 1, 2023, this means families do not need to renew OHP benefits to keep children covered and can get the health care their child needs in their most formative years.
The 2022-2027 waiver also allows Oregon to:

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

Health-related Social Needs and Health Equity

Where we are born, live, learn, work, play, and age can affect our health and quality of life. Access to health care, healthy foods, and safe housing is important to our health. By supporting these social needs through OHP coverage, the 2022-2027 waiver helps Oregon:

- Better coordinate services for people when they most need stability.
- Dismantle policies that discriminate against people of color, Tribal communities, people with low income, people with disabilities, people who identify as LGBTQIA2S+ and other groups.
- Align with other health policy initiatives in our state to achieve health equity.

Achieving health equity will help Oregon to:

- Improve the lives of individuals who face historic and contemporary injustices;
- Increase individual, family and community resilience; and
- Reduce health disparities for groups most affected by injustice and discrimination.

Who will qualify for services that address health-related social needs?

Determinations about eligibility requirements are currently in process. In 2024, OHA plans to first cover these benefits for OHP members in life transitions. This includes:

- Youth ages 19 to 26 with special health care needs.
- Youth involved with child welfare, including youth leaving foster care at age 18.
- People experiencing homelessness or at risk of homelessness.
- People who are transitioning from Medicaid-only to both Medicaid and Medicare coverage.
- People released from settings such as jail, residential facilities, and Oregon State Hospital.
- People who experience weather-related emergencies. The Governor or federal government declares weather emergencies.

Local mental health authorities (LMHA) are typically comprised of the County Board of Commissioners, who are responsible for the management and oversight of the public system of care for mental illness, intellectual/developmental disabilities, and substance use disorders at the community level. LMHA's must plan, develop, implement, and monitor services within the area served by the local mental health authority to ensure expected outcomes for consumers of services, within available resources. Community mental health programs (CMHP) provide care coordination and treatment for people with mental illness, intellectual/developmental disabilities, and substance use disorders. Core services include screening, assessment, and referral to providers and community organizations, as well as emergency or crisis services. All members of a community can access core services from community mental health programs, subject to the availability of funds. These safety net and crisis services play a key role in the overall behavioral health system.

Oregon State Hospital (OSH):

provides an essential service to Oregonians who need longer term hospital level care for behavioral health issues, which cannot be provided in the community. For adults needing intensive psychiatric treatment for severe and persistent mental illness, hospital level care provides twenty-four-hour on-site nursing and psychiatric care, treatment planning, pharmacy, laboratory, food and nutritional services, and vocational and educational services provided by credentialed professional and medical staff. The role of the hospital is to restore patients to a level of functioning that allows a successful transition back to the community. OSH provides services to 3 primary groups of individuals: Civil Commitment, Guilty Except for Insanity (GEI), and those found unfit to stand trial, often called "Aid and Assist" Oregon. Individuals placed at OSH under any of the 3 jurisdictions must be found to have a either a mental disorder (Civil Commitment) or a qualifying mental disorder (GEI and Aid and Assist). All are only placed at OSH after some form of court process to ensure that the individual's rights are upheld. OHA is working to increase the utilization of community-based competency restoration while decreasing the use of hospital-based restoration. Some of the initiatives being worked on to accomplish this are increasing the availability of licensed residential housing, increasing community-based treatment resources, and reviewing the relevant Oregon Revised Statutes. This work is being done through increases in funding, RFP's and ongoing legislative workgroups.

Patient-Centered Primary Care Home Program

Oregon's Patient-Centered Primary Care Home (PCPCH) program was established in 2009 as part of the state's broader transformation efforts to achieve better health, better care, and lower costs within the health system. The intent was to improve Oregon's primary care system by developing a set of standards for primary care practices. After the legislation was passed, Oregon convened a volunteer advisory committee to develop the PCPCH standards. The committee has reconvened several times over the years to refine the standards. The PCPCH recognition criteria is defined by six core attributes, each with specific standards under each attribute, and measures that indicate the extent to which a clinic is meeting that standard. Behavioral Health Services is standard 3.C in the PCPCH model. There are three measures for the behavioral health services standard; one is required and two are optional.

1. 3.C.0 - PCPCH has a screening strategy for mental health, substance use, and developmental conditions and documents on-site and local referral resources and processes (required)

2. 3.C.2 - PCPCH has a cooperative referral process with specialty mental health, substance abuse, and developmental providers including a mechanism for co- management as needed or is co-located with specialty mental health, substance abuse, and developmental providers.
3. 3.C.3 - PCPCH provides integrated behavioral health services, including population-based, same-day consultations by behavioral health providers.

More than 600 primary care clinics are recognized as PCPCHs in Oregon - about 2/3 of all primary care clinics in the state. There are recognized PCPCHs in 35 out of 36 counties in Oregon and approximately ¾ of all Oregonians get their care at a PCPCH.
PCPCH recognition is attestation based, so the program conducts on-site visits to a select number of PCPCHs each year. The PCPCH program has conducted more than 320 site visits to date, over 1/3 of those in last 18 months. Each clinic will receive a site visit at least once every five years, per Oregon Administrative Rule.

Certified Community Behavioral Health Clinics

In 2016, SAMHSA awarded Oregon the CCBHC Planning Grant . Twenty-five million dollars in planning grants were available to states to develop applications to participate in a two-year CCBHC demonstration program. Only states awarded a planning grant are eligible to apply for the demonstration program grant. Oregon applied for, and was awarded a planning grant, as the program aligns with the state's broader health care transformation efforts, enabling Oregon to further advance behavioral health care for Oregonians. The Oregon Health Authority subsequently submitted an application to SAMSHA to be considered for participation in the 2017-2019 CCBHC Demonstration Program. In December 2016, Oregon was selected as one of eight demonstration states. Currently Oregon has 12 CCBHC organization, with 21 sites across the state.

The 2017-2019 Demonstration Program Advisory Group, comprised of diverse stakeholders from across Oregon, representing providers, consumers, policy makers, health plans and professional associations, meets quarterly to advise the Oregon Health Authority on a variety of programmatic issues throughout the demonstration period.CCBHCs are supposed to report on asset of measures as per SAMHSA standards to demonstrate integration of behavioral health with physical health, especially among population with Serious Persistent Mental Illness and Substance Use Disorder. In addition, Oregon has introduced 12 more standards for CCBHCs to meet in order to stay certified, which are in alignment with Oregon's Patient centered Primary Care Home standards.

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Prevention Services within Public Health Division

PREVENTION AND HEALTH PROMOTION THROUGH THE OREGON HEALTH AUTHORITY

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

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

Tribal Behavioral Health Services

TRIBAL PREVENTION INITIATIVES

Five of the total 13 portions of the Tribal Behavioral Health Plan in HSD focus on prevention.

Tribal Alcohol and Other Drugs Prevention Program (TAD 352) – Program Goal: Implement and evaluate strategies that prevent substance use by reducing risk factors and increasing protective factors associated with alcohol, tobacco, and other drugs in Oregon Tribal Communities. Tribes/Urban Indian Health Programs (UIHPs) can develop goals and strategies based on community priorities and needs.

Problem Gambling Prevention integrated with ATOD Prevention (TAD 352) - Program Goal: Integrate problem gambling education and awareness into alcohol and other drug prevention efforts. Develop sustainable resources and partnerships that integrate the commonalities of risk factors for problem gambling and substances like alcohol, cannabis, opioids, and other drugs.

Tribal Tobacco Prevention Program (TAD 353) - Program Goals: 1) Address commercial tobacco and nicotine use (including inhalant delivery systems (IDS) and electronic cigarette use) in Oregon Tribal Communities through prevention and cessation efforts; and 2) Reduce tobacco-related health inequities through the prevention and management of chronic disease related to commercial tobacco and nicotine.

Tribal State Opioid Response Grant (SOR) (TAD 357) - Program Goal: Address the opioid overdose crisis by providing resources for increasing access to FDA-approved medications for opioid use disorder (MOUD), and supporting the continuum of prevention, harm reduction, treatment, and recovery support services for OUD and other concurrent substance use disorders. The SOR program also supports the continuum of care for stimulant misuse and use disorders, including for cocaine and methamphetamine. The SOR program aims to help reduce unmet treatment needs and reduce opioid-related overdose deaths across America.

Tribal Youth Suicide Prevention, Intervention, and Postvention (TMH 306) - Program Goal: Create wellness for Oregonian young people (ages 0-24) ensuring that young people can build connectedness, to cope well when life is hard, and to access help when needed.

Suicide Prevention

With strong partnerships across OHA divisions and with local partners, Oregon is a leader in statewide suicide prevention. OHA has 5 dedicated FTEs devoted to suicide prevention efforts. The five positions are spread across two departments (HSD and PHD) and three units (Injury and Violence Prevention Program, Child and Family Behavioral Health, and Adult Mental Health). The five positions include an Adult Suicide Prevention Coordinator, Zero Suicide in Health Systems Coordinator, a Public Health Suicide Prevention Coordinator, and two Youth Suicide Prevention Coordinators. Despite being spread across two divisions and several units the team functions as one cohesive unit communicating daily and meeting weekly. Although each position has a different focus, all five Suicide Prevention Coordinators share many responsibilities and lend support to one another.

The Adult Suicide Prevention Coordinator and the Youth Suicide Prevention Coordinator positions are in HSD. The Adult Suicide Prevention position, located in the Adult Mental Health Unit, was charged with developing and implementing the first statewide Adult Suicide Intervention and Prevention Plan which was published in April of 2023. In addition to those efforts the Adult Suicide Prevention Coordinator is the project director on the CDC Comprehensive Suicide Prevention grant, which focuses on suicide prevention for populations that are disproportionately affected by suicide-- including veterans and older adults living in rural and frontier/remote geographic areas. This 5-year grant ends September 2027. The grant has enabled a host of suicide prevention activities in rural Oregon including firearm safety awareness and training, Program to Encourage Active, Rewarding Lives (PEARLS) trainings, Applied Suicide Intervention Skills Training (ASIST) trainings, alcohol prevention, and community mini-grant opportunities.

The two remaining suicide prevention positions in HSD are focused on youth ages 5-24 and are in the Child and Family Behavioral Health Unit. The positions focus on different aspects of suicide prevention—one on policy and one on program. The second edition of the Youth Suicide Intervention and Prevention Plan (YSIPP), a five-year state plan, was published in 2021 by the youth coordinators.

To support implementation of the YSIPP, the **Oregon Alliance to Prevent Suicide** (the Alliance) was created in 2016 and is charged with overseeing statewide integration and coordination of suicide prevention, intervention, and postvention activities. With more than 50 members, the Alliance represents a diverse group of organizations, advocates, youth

and survivors working to reduce suicide rates in Oregon and is a key collaborator in suicide prevention. The Alliance is charged by OHA to oversee implementation of the YSIPP. Committees of the Alliance include Executive, Transitions of Care, Workforce, Outreach and Awareness, Research and Evaluation and Schools. Workgroups consist of Firearm

Safety - Lethal Means and Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and others (LGBTQIA+).

The Alliance operates under the administration of the **Association of Oregon Community Mental Health Programs** (AOCMHP), a non-profit whose mission is to support and advocate for Local Mental Health Authorities (county mental health programs) in their planning and management of mental health, addictions, and developmental disabilities programs to ensure an effective local system of care.

In 2019, OHA began offering a menu of evidence-based, locally energized programs that have already been successful and effective in Oregon. These programs are stably funded, are coordinated statewide, and are available widely: Sources of Strength (for grades K through college), Mental Health First Aid, Question, Persuade, Refer (QPR), Youth Suicide Assessment in Various Environments (YouthSAVE), ASIST, and Connect Postvention. The suicide prevention team also sponsors various advanced skills training options and has developed a three-hour training for Traditional Health Workers and Qualified Mental Health Associates in suicide prevention. Additionally, OHA has worked with the Oregon Department of Education to provide technical assistance to schools as they develop suicide prevention plans for their districts and buildings.

The OHA COVID response Suicide Prevention, Intervention, and Postvention (S-PIP) team was created in 2020 as an inter-departmental effort to address the impact of COVID-19 on mental health and suicide behaviors, to track data, and to be responsive to emerging issues. The team has expanded its focus beyond youth suicide prevention, to include lifespan. There are now four subgroups of this team that meet at least quarterly.

The SAMHSA Zero Suicide in Health Systems grant has provided OHA the ability to formalize a Zero Suicide in Health Systems Program including hiring dedicated staff. Grant activities have included facilitating a Zero Suicide Advisory Committee composed of partners implementing Zero Suicide and individuals with lived experience either as consumers of the behavioral health system, experiencing suicidality or as a suicide loss survivor. As part of grant activities OHA has contracted with the Zero Suicide Institute to provide technical assistance and training to Oregon health systems. OHA hosted a Zero Suicide Academy in March 2022, a Zero Suicide Booster focused on addressing barriers to implementation in June 2023 and is planning a Zero Suicide Summit featuring Oregon Zero Suicide Implementers and national Zero Suicide faculty in September 2023. OHA has also released a Request for Proposal to provide 1-year mini grants (ranging from $15,000 - $35,000) to health systems implementing Zero Suicide to support their efforts. Mini grants are anticipated to start on August 28, 2023.

OHA has contracted with one health system, a rural Community Mental Health Program serving multiple counties, to directly support their Zero Suicide implementation efforts and to gather lessons learned and best practices to share with other implementers in the state. Additionally, OHA is supporting systems through Zero Suicide evaluation support. OHA has contracted with Portland State University's Human Services Implementation Lab to modify the national Zero Suicide Organizational Assessment Tool, with Zero Suicide Institute feedback, to build in tracking of key Zero Suicide elements including just culture/philosophy of care, workforce wellness, postvention for staff and community members, and commitment to diversity, equity and inclusion.

Health systems that complete the Oregon Zero Suicide Implementation Assessment Tool are provided with a report on progress across elements, and if completed multiple times, can see progress over time to help gauge success, identify gaps, and use as a tool to solicit continued leadership support for Zero Suicide. OHA is also able to develop a de-identified state assessment report to help target funding to areas of Zero Suicide implementation which health systems have overall lower scores in.

The other suicide prevention position in IVPP manages the SAMHSA Garrett Lee Smith Memorial Youth Suicide Prevention award (GLS), which focuses on a public health approach to youth suicide prevention. OHA has been awarded three GLS awards since 2006. The current award is in its fifth and final year with a focus on capacity-building grants to select Oregon counties, supporting suicide prevention training (gatekeeper training) in communities and youth-serving organizations, convening the annual Oregon Suicide Prevention Conference, managing the Oregon Suicide Prevention website and supporting clinician training. Highlights of recent grant work include:

- GLS is currently funding three counties (Deschutes, Lane, and Multnomah) to build capacity in their suicide prevention programs. All counties have dedicated staffing toward suicide prevention, have established youth or lifespan focused suicide prevention coalitions, and are implementing gatekeeper training in addition to other grant activities.
- Since June 2019, a total of 18,566 individuals have received gatekeeper training through the grant.
- GLS is supporting gatekeeper training with the Oregon Department of Human Services (ODHS), including Child Welfare personnel, community partners and resource parents. In April 2021 ODHS made Question, Persuade and Refer (QPR) computer-based training required for all employees. Since launch of the program, 9195 ODHS employees and community partners had completed the training.
- Clinical training has provided training to over 650 individuals utilizing the Assessing and Managing Suicide Risk (AMSR) and Collaborative Assessment & Management of Suicidality (CAMS) trainings.
- The October 2022 conference was held in Ashland, OR and had approximately 230 attendees. The 2023 conference is being facilitated by Lines for Life and will take place in Hood River, OR this November.

PUBLIC HEALTH PREVENTION INITIATIVES

The Oregon Health Authority's Public Health Division (OHA-PHD) works with internal and external partners across the state to prevent and reduce substance use and overdose across the lifespan. These efforts advance primary prevention, population health strategies outlined in the State Health Improvement Plan, Healthier Together Oregon, and the Alcohol Drug Policy Commission's Strategic Plan.

TOBACCO, ALCHOL AND OVERDOSE PREVENTION

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

Tobacco Control and Prevention

In 1996, Oregon voters passed Measure 44 which raised the price of tobacco and dedicated funding to OHA PHD's comprehensive **Tobacco Prevention and Education Program (TPEP).** In 2020, Oregon voters passed Ballot Measure 108 which again raised the price of tobacco products, including cigarettes, by $2.00 per pack ($1.33 to $3.33). Increasing the price of tobacco is an evidence-based strategy shown to be highly effective in reducing consumption of tobacco products, particularly for youth. Recent 2022 data per capita sales of cigarette packet down by nearly 14% over the previous year.

TPEP implements community and state level, evidence-based interventions, surveillance and evaluation, communications, screening interventions, and state administration and management to prevent tobacco use and associated effects across the lifespan. Currently, OHA-PHD directly funds Oregon's 36 counties, 94 geographic and culturally specific organizations, and six Regional Health Equity Coalitions (RHECs) to advance an equity centered, comprehensive tobacco prevention system in Oregon. Nationally and in Oregon, tobacco use among adults has dropped to an all-time historical low.

Since 2012, OHA has enforced the minimum legal sales age for purchasing tobacco and vaping products through numerous measures, including:

- Increasing the minimum legal sales age from 18 to 21
- Expanding the types of products requested during compliance checks (cigarettes, little cigars, e-cigarettes)
- Funding local public health authorities to work on tobacco prevention and control policies
- Implementing a comprehensive database that combines Synar, state enforcement and FDA inspections data to map retail locations
- Implementing legislation to develop and implement a Statewide Tobacco Retail License Program to enforce tobacco related sales laws

In 2016, OHA began publicly posting results from both Synar and state enforcement inspections which include individual retailers' inspection results. Oregon's retailer violation rate subsequently dropped from 22.5% in 2012 to 15.5% in 2019. OHA did not conduct Synar inspections from 2020 or 2021 due to coronavirus pandemic, limitations on agency staff capacity, and restrictions on indoor gatherings.

During the 2021 Legislative Session, Senate Bill 587 created a **Tobacco Retail License (TRL) Program** to increase retailer knowledge and compliance of federal and state laws regulating the retail sale of tobacco and vaping products. As of January 1, 2022, any business selling tobacco, nicotine or vaping products in Oregon is required to get a license from the Department of Revenue. OHA-PHD conducts minimum legal sales age inspections and tobacco retail sales law compliance inspections for all retailers. In other states and internationally, TRL has reduced youth access to tobacco products in their communities. Since program implementation, OHA-PHD has completed over 2,700 inspections. In the first year, 26% of licensed tobacco retailers sold tobacco products illegally to young adult inspectors. This increase can be attributed to expanding inspections to include places that are restricted to persons 21 and over.

Alcohol Policy & Prevention

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

Over the last seven years, OHA-PHD has worked towards the goal of building a comprehensive prevention program addressing alcohol and other drug use that parallels the more robust infrastructure of tobacco prevention and cessation. This work occurs in collaboration with Oregon's local public health

authorities (LPHAs), culturally specific organizations, nine federally recognized Tribes, and five Regional Health Equity Coalitions (RHECs). OHA-PHD also coordinates closely with OHA-HSD's Child and Family Behavioral Health Program; Addiction Treatment, Recovery and Prevention Unit; Medicaid Policy and Partnerships Team; Health Policy & Analytics and Medicaid Programs to align efforts across the substance use continuum of prevention, harm reduction, treatment, and recovery**.**

Primary prevention strategies include raising the price of alcohol; increasing access to comprehensive alcohol screening, referral, and treatment; maintaining state control for distilled spirits; increasing regulation of alcohol outlet density and retail environments; and limiting exposure to and access to alcohol. Community or tribal based ADPEP prevention strategies include Tribal Based Practices, coalition building, school-based prevention programs and supports or environmental prevention and community mobilization.

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

OHA-PHD's **Alcohol Density Work Group** includes representation from across OHA and Oregon's Transportation Growth Management Program. A technical sub-workgroup of analysts supports the technical aspects of methodology and mapping. The workgroup is currently classifying alcohol outlet license types into categories appropriate for mapping retail and non-retail and on- and off-premises. These categories may evolve as the mapping work moves forward. OHA-PHD's Rape Prevention and Education (RPE) grant also supports environmental strategies to reduce alcohol outlet density.

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

- Over 90 news stories, including the New York Times, have highlighted Rethink the Drink
- Campaign messaging reached millions of people and had one of the highest recall rates recorded by evaluators compared to other health campaigns in Oregon
- Over 42,000 *unique* visitors accessed the campaign website
- The toolkits have been downloaded over 140 times

More information is available at www.rethinkthedrink.co with evaluation results from the initial campaign to be released in Fall 2023.

OHA's new CDC **Comprehensive Suicide Prevention Grant** provides 5 years of funding to prevent and reduce the impacts of suicide among adults in Oregon. Priority populations include rural and remote geographical areas, older adults, and veterans. Funding supports strategies across three tiers, including community based, health care systems, and protective environments that reduce excessive alcohol through

increasing the price of alcohol, reducing outlet density, raising awareness of the link between excessive alcohol use and suicide, and disseminating data for program and policy development.

OHA also works with communities directly funded by the Substance Abuse Mental Health Services Administration (SAMHSA) to implement eight **Drug Free Communities (DFC)** and three **Strategic Prevention Framework (SPF) grants** in Oregon**.**

Overdose Prevention

Since 2020, OHA has funded 11 **Regional Overdose Prevention Programs** to increase local capacity for multisector coordination, community outreach, prevention messaging, and harm reduction across 23 counties in Oregon. To date, OHA's Health Systems Division (OHA-HSD) and Public Health Division (OHA-PHD) have braided funding from SAMHSA and the CDC to implement this initiative, which supports counties or regions with a high burden of overdose deaths and hospitalizations. In the future, SUPTRS BG funds will support these efforts beginning in October 2023.

Local Public Health Authorities (LPHAs) leverage overdose prevention programs to complement other prevention initiatives to reduce overdose deaths, hospitalizations, and harms associated with substance misuse. Regional Overdose Prevention Coordinators collaborate with pharmacies, law enforcement and first responder agencies, schools, harm reduction organizations, judicial systems, and others to address community challenges related to drug overdoses using the following strategies:

- Establishing Linkages to Care
- Supporting Providers and Health Systems
- Partnering with Public Safety and First Responders
- Empowering Individuals to Make Safer Choices
- Implementing Prevention Innovation Projects

Required work consists of:

- Engaging a regional multisector stakeholder group to coordinate local/regional overdose prevention activities
- Consulting with stakeholders to develop, implement, and iteratively refine overdose emergency response protocols
- Developing and implementing prevention project(s) that address one or more of the above strategies and targets populations experiencing a disproportionate overdose burden and/or individuals at high risk of accidental overdose
- Collaborating with harm reductions partners and community stakeholders to expand naloxone distribution
- Reviewing, coordinating, and disseminating local data to promote public awareness and harm reduction

LPHAs also implement community-level interventions that address stigma and inequities to ensure that people who use drugs are treated respectfully and can access resources. Priority populations include but are not limited to American Indian/Alaska Native communities, Black/African American communities, people who use drugs, youth and young adults, individuals who have experienced previous accidental overdose, individuals with substance use and/or alcohol use issues, individuals who have been involved with the carceral system, and individuals with inequitable access to resources that impact quality of life.

In January 2023, OHA-PHD and OHA-HSD braided CDC and SAMHSA funds to support LPHAs in implementing localized, community-specific **fentanyl education and awareness campaigns** across 26 counties in Oregon. Campaigns in 15 of these 26 counties specifically target youth, young adults and/or parents and educators. Additional priority populations include rural communities, Latinx communities, Slavic communities, LGBTQ communities, first responders, and the general public. LPHAs have shared

localized fentanyl messaging via billboards, community events, social media campaigns, radio advertisements, print materials, and LPHA websites.

Since 2011, CDC and SAMHSA funds have supported an **annual conference on Opioids, Pain, and Addictions Treatment** (OPAT) to educate the medical community, social service agencies, public health agencies and others throughout the state about evidence-based pain management and addictions treatment. From 2018-2022, CDC and SAMHSA funds have supported an annual **Tribal Opioid Training academy**, in partnership with the NW Portland Area Indian Health Board. The NW Portland Area Indian Health Board opted to use these funds to host a **National Tribal Opioid Summit** in 2023.

Oregon established the **Prescription Drug Monitoring Program** (PDMP) in 2011 as a healthcare tool to enhance providers access to patient's comprehensive prescription histories. This allows providers to determine what medications are appropriate and improve patient outcomes. Patient data is secure and can be only accessed by individuals using the proper authentication, for the purpose of treatment planning and the healthcare needs of their individual patients. Oregon providers access the PDMP through a secure web browser or through their electronic medical records.

Oregon retail pharmacies contribute data on specific prescription drugs dispensed to patients, including, schedule II, III and IV controlled substances, and drugs of interest naloxone and gabapentin. These medications place patients at risk for overdose, side effects, and increased effect when combined with alcohol and/or other drugs, risk for physical dependence, and risk for developing patterns of drug abuse. The PDMP provides practitioners and pharmacists a means to identify and address these problems. Over 29,000 practitioners and pharmacists have authorized access to the PDMP in Oregon

In 2023, OHA-PHD launched the **Overdose Prevention Dashboard** which displays mortality, emergency department discharge, and hospital discharge data and annual, statewide, county- level, and demographic trends for 11 drug categories, including fentanyl, heroin, and stimulants. IVPP publishes the **Opioid Overdose Public Health Surveillance Update**, a quarterly public report that compiles overdose information from two state-based surveillance systems: the State Unintentional Drug Overdose Reporting System (SUDORS) and the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE). IVPP also provides LPHAs and tribal health authorities quarterly reports that summarize overdose and suicide death and hospitalization data, by county.

IVPP is developing an agency-level **State Overdose Emergency Response Protocol** that, when completed, will define a process for monitoring and responding to overdose events. The Emergency Response Protocol will delineate OHA, LPHAs, and behavioral health agencies' roles and responsibilities in the event of multi-county and statewide overdose spikes. The Overdose Response & Fatality Review Coordinator is also providing technical assistance and support to LPHAs to **build local systems to initiate overdose fatality reviews at the county level**.

OHA-PHD's Injury & Violence Prevention Program (IVPP) partners with Oregon Department of Human Services - Child Welfare Program to **incorporate overdose prevention and harm reduction into child welfare practices, policies, and procedures** as well as foster opportunities for cross-sector collaboration. OHA-PHD's Overdose Response & Fatality Review Coordinator is now participating in child fatality reviews involving overdose to identify system gaps and opportunities for improvement to prevent youth overdoses.

PREVENTION IN SCHOOLS/EDUCATION

OHA is building a comprehensive approach to substance use prevention programs and policies that support youth and families, school practices, media interventions, and neighborhood and community-wide efforts. OHA works closely with the Oregon Department of Education, school districts, community and Tribal alcohol and drug prevention education programs to implement evidence-based prevention education, policies, and practices in schools.

Oregon's **Student Health Survey (SHS)** is a collaborative effort with the Oregon Department of Education to improve the health and well-being of all Oregon students to help them succeed. The SHS is a comprehensive, school-based, anonymous, and voluntary health survey of 6th, 8th and 11th graders conducted in even-numbered years. Students are asked about substance use and perceptions of substance use, as well as upstream indicators such as perceptions of student health and safety, student mental health, school climate and culture, and access to resources.

In 2021, OHA collaborated with the Oregon Department of Education (ODE) to **survey health education teachers** across the state to learn about health education gaps, specifically alcohol & other drugs, including opioids. Survey results supported **professional development for health educators** and the **development of learning modules** accessible via ODE's Oregon Open Learning Hub. This effort was funded from the State Opioid Response (SOR-2) grant. OHA staff participate in ODE's 2022-23 Health Education Content Advisory Panel and continue collaborating to refine the draft standards, support ODE and the upcoming Board of Education approval process, and the implementation of K-12 health education standards and performance indicators.

In May 2022, OHA and ODE created the **Fentanyl & Opioid Response Toolkit for Schools** to support educators, administrators, school nurses, students, and families in response to the public health crisis related to rising youth and adult opioid overdoses and deaths in Oregon. The toolkit provides guidance on developing school policies and protocols to access, store and administer naloxone; includes middle and high school opioid prevention curricula; and provides information for parents on how to talk to kids about fentanyl and counterfeit pills.
https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Documents/FentanylOpioidResponseToolkit.pdf.

OTHER OHA-PHD PREVENTION INITIATIVES

Maternal and Child Health

OHA-PHD's Maternal and Child Health (MCH) Program works across systems and in communities to foster safe, supportive environments; resilient and connected communities and families; nutrition and

healthy childhood development; and oral health. This work addresses both universal and targeted approaches that promote protective factors and resilience in the early years.

MCH works closely with the Health Systems Division, Children and Family Behavioral Health Unit, to address substance use issues impacting families, collaborating widely to reach pregnant and postpartum people, as well as other parents, with mental health needs and substance use disorders (SUD). The **Oregon MothersCare Program** (OMC) assists pregnant people to access a variety of prenatal services including mental health and substance use disorder treatment services. OMC screens, provides health education, and facilitates referrals for behavioral health, alcohol and other SUD services.

MCH initiatives in Oregon are primarily funded through HRSA's **MCH Title V Block Grant Program**. Title V addresses specific priorities, including Toxic Stress/Trauma/Adverse Childhood Experiences (ACEs) and Resilience. Activities include promotion of family friendly policies, parenting supports, outreach and education, ACE's and trauma assessment and surveillance, and trauma-informed workforce and workplace development. Title V also partially funds **Oregon's 211 Info Resources and Referral Line**

Two MCH Specialists provide resources to pregnant people and families, including mental health and alcohol and other drug treatment referrals.

Home Visiting Programs are evidence based, effective strategies for strengthening families and improving the health status of women and children. Programs are voluntary and serve families with diverse social and economic needs, including mental health and substance use disorders. In 2019, the Oregon Legislature passed legislation making Oregon the first state in the nation mandated to provide universally offered home visiting to all families of newborns regardless of insurance coverage and insurance status through the Family Connects model. This service is currently available in eight Oregon counties with plans to expand statewide.

Oregon's **Pregnancy Risk Assessment Monitoring System (PRAMS)** collects monthly data on maternal attitudes and experiences prior to, during, and immediately after pregnancy from a representative sample of Oregon people giving birth. The survey also asks people about their mental health and substance use. The **Oregon Early Childhood Experiences (ECHO) survey** interviews respondents when their child is 3 years old. Both the PRAMS and ECHO survey include questions that assess mental health and substance use. OHA-PHD-MCBH also funds the Adverse Childhood Experiences (ACEs) module of the BRFSS, to collect data regarding adverse childhood experiences of adults, which can then be analyzed for its association with adult mental and behavioral health issues. Both PRAMS and BRFSS ACEs data inform public health policy and program efforts.

Through the Oregon Department of Human Services (ODHS), Oregon receives a federal grant from the U.S. Department of Health and Human Services, Administration on Children, Youth and Families under the **Child Abuse Prevention and Treatment Act (CAPTA).** States receiving a CAPTA grant must ensure that a Plan of Care for substance exposed infants be collaboratively developed to address the needs of both the infant and the affected family or caregiver. OHA (Public Health Division and Health Systems Division) is partnering with ODHS to implement a culturally responsive and trauma informed approach to implementing Infant Plans of Care with the objectives of eliminating or reducing Child Welfare involvement and implementing a family centered, equitable system of care.

Other prevention initiatives

Since April 2022, OHA-PHD's **Community Based Organization (CBO) Equity Funding Collaborative** has funded over 170 CBOs to center health equity and community priorities by implementing community-driven, culturally, and linguistically responsive projects. Eight programs collaborated to braid funding towards advancing OHA's strategic goal of eliminating health inequities by 2030. Twenty CBOs are implementing school-based prevention, resource navigation, and social-emotional well-being services. Seven CBOs are conducting overdose prevention projects. 94 CBOs, including 15 specifically supporting youth, address the social determinants of tobacco use (through funding from the "Tobacco and E-Cigarette Tax Increase for Health Programs" (Ballot Measure 108).

OHA-PHD strives to support **youth, family, and community voice across all prevention programs** through outreach and community engagement infrastructure for long-term strategy and decision making. Informed by a youth working group, the PHD Adolescent and School Health Unit is drafting youth engagement guidance for all prevention programs working with youth.

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

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

OHA's 2021-2025 Oregon **Youth Suicide Intervention and Prevention Plan** describes current and emerging needs and strengthens linkages with mental and behavioral health supports, with active engagement from Oregon youth. The Oregon Suicide Prevention Framework ensures the voices of people with lived experience and youth meaningfully inform plan implementation.

OHA-PHD's Environmental Public Health Program (EPH) is engaging youth in climate health and mental wellness & resiliency projects and sponsored a "**Youth Mental Health & Climate Workshop -** Collaborating across Sectors to better support Youth during an Accelerating Environmental Crisis" in June 2023. The EPH Program has expanded work to address climate change and wildfires in recent years to focus on mental health promotion and community resiliency, including how climate change affects youth depression and mental health.

HIV/STD/TB

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

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

authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

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

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

HIV and other sexually transmitted infections, such as syphilis and gonorrhea, are reportable diseases. In Oregon, local county health departments are responsible for HIV/STI Partner Services. This includes case investigation and follow up, such as eliciting partner information, assisting with notifications around exposure, and linking people to testing and treatment as needed. A key component of HIV/STI Partner Services also includes referrals to services such as mental health, substance use treatment, and harm reduction (e.g. syringe access) programs. Additionally, as part of the interview that takes place with individuals diagnosed with HIV or an STI, questions are posed concerning substance use which allows epidemiologists at the state and local level to track data regarding use of illicit substances as a behavioral factor for HIV/STIs. Given nearly all HIV positive persons in Oregon are insured, or are insurable with the assistance of CAREAssist, most financial barriers to mental health and substance use treatment are removable. The bigger barriers related to access are systematic in nature, for example provider shortages and access to culturally competent providers, particularly in rural areas of the state. HST has prioritized several projects that focus on ameliorating health disparities. We currently have a statewide contract with Familias en Accion, to promote HIV/STI education, testing and other sexual health resources to Latino/x/e communities in Oregon and support the African-American AIDS Awareness Action Alliance, which promotes HIV/STI and mental health awareness to African-Americans in the Portland metro area. Additionally, HST contracts with other community-based agencies to promote or provide community-based, HIV/STI testing, as well as support with service navigation using a status neutral approach. HST works closely with OHA's Saves Lives Oregon team fill gaps related to harm reduction supplies and services, as allowable. HST uses a combination of funding, such as state general funds and some federal funding, to support HIV/STI and harm reduction programming, including use of staff time and reimbursement for the purchase of syringes and biohazard/disposal containers not otherwise available through the State's Harm Reduction Clearinghouse. Harm reduction programming in Oregon is generally offered in three ways, a fixed location (e.g., a community-based or health department location/office), a mobile van which visits multiple locations at fixed days/times each week, and/or through home or

community-based delivery. HST also provides mini grants, as well as capacity building and technical support to entities who want to begin providing harm reduction programming or services in the State.

TB services:

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

The OHA Tuberculosis Program engages in essential activities, which include:

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

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

Early Learning Council (ELC) is now an independent state agency called the Department of Early Learning and Care

July 1, 2023, the Department of Early Learning and Care (DELC) became the official agency for early learning and childcare policy and program administration throughout Oregon. That means Oregon's families and childcare professionals will now have one state agency dedicated to ensuring high-quality, family-centered and culturally appropriate early learning and care opportunities for families and childcare professionals. They now have a new name, look, email addresses, and website: oregon.gov/DELC.

The Oregon Legislature passed House Bill 3073 in 2021, heralding the transition towards the launch of DELC. The agency brings together the Early Learning Division (ELD) and Employment Related Day Care (ERDC) program. ELD was a division of the Oregon Department of Education (ODE), and Employment Related Day Care (ERDC) was a program of the Oregon Department of Human Services (ODHS).

The launch of DELC is only the beginning of the benefits providers and families can expect. DELC staff will continue to listen to and learn from Oregon families and childcare professionals on how to best support them and meet their needs. Over the next few years, unifying these agencies and programs under DELC will help:

- Enable greater alignment across major early learning and childcare programs
- Maximize state and federal funding for early learning programs

- Create a more efficient and effective billing and licensing system for providers
- Support and strengthen the early learning and care workforce
- Promote culturally specific and family-centered resources, services and programs for families and childcare professionals

Treatment Services Section

Ballot Measure 110

Measure 110 is a health-based approach to addiction and overdose. Established by Oregon Voters in November 2020 and subsequently codified into law through Senate Bill 755 in 2021, Measure 110 established Behavioral Health Resource Networks (BHRNs) – a network of comprehensive, community-based services and supports to people with substance use disorders or harmful substance use. Each Oregon County has at least one BHRN. Funding was also established for each of the nine Federally recognized Tribes of Oregon through a set aside. Each BHRN must provide trauma-informed, culturally specific and linguistically responsive services to all who want or need them, free of charge. Services include, but are not limited to:

i. Screening for health and social service needs
ii. Screening and referral for substance use disorder and appropriate outside services
iii. Low-barrier substance use disorder treatment
iv. Harm reduction services
v. Peer support services
vi. Housing supports
vii. Supported Employment

State Opioid Response (SOR 3) Overview

In September 2022, Oregon received the two-year SOR 3 grant administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), totaling $30.9 million. The Oregon State Opioid Response (SOR 3) grant focuses on regions and populations with high rates of opioid use disorder (OUD) or stimulant use disorder (StimUD), high overdose rates, and low substance use disorder (SUD) treatment participation. Activities aim to (1) Expand the statewide structure for prevention messaging, school-based prevention programs, and outreach to underserved and diverse populations; (2) Expand and strengthen the statewide overdose prevention infrastructure and increase access to harm reduction services; (3) Expand the statewide SUD treatment system to increase treatment access for individuals with OUD and StimUD; (4) Expand the statewide recovery support services framework for individuals with OUD and StimUD; and (5) Expand and enhance the statewide substance use workforce.

Addressing System Gaps and Unmet Needs

The Oregon SOR 3 grant focuses on regions and populations with limited access to SUD treatment and high rates of OUD, StimUD, and overdose. Geographic areas of focus include (1) Southwest and Southwest Coast; (2) Portland Tri-County; (3) Eastern; and (4) Northwest Rural. Based on an analysis of 2020-2021 Oregon Medicaid data, the Portland Tri-County and Southwest regions have a particularly high prevalence of people with OUD or StimUD who are not receiving treatment. Efforts to increase access to treatment and recovery services will occur in these regions, including expansion of medications for opioid use disorder (MOUD) and contingency management (CM) for StimUD. All four of the high-

impact regions have high and growing fatal and nonfatal overdose rates and will be areas of focus for overdose prevention and harm reduction efforts.

Additionally, Oregon's SOR 3 activities aim to address disparities in treatment access and overdose among tribal communities and communities of color. The SOR 3 grant will also support prevention and recovery services for LGBTQIA2S+ and young adult populations. Oregon's SOR 3 needs assessment highlights disparities in treatment participation for communities of color. SOR 3 provides funding for culturally specific services, including peer recovery supports, MOUD, and CM for StimUD. Services include community-based naloxone distribution to people at high risk of overdose such as people experiencing homelessness; recovery support service program expansion for communities of color, LGBTQIA2S+, and young adult populations; and statewide youth/young adult overdose prevention messaging and outreach.

PCIT Opioids: Access to Services and Treatment

Oregon currently has 26 opioid treatment programs (OTP) within the state; these facilities are comprehensive treatment facilities which offer counseling and other psychosocial supports, including wraparound service referrals to assist patients with mental health needs and other services. These facilities all dispense full agonist (methadone) and partial agonist (buprenorphine) medications, for the treatment of opioid use disorder (OUD). For over 70 years, this modality of treatment has been considered the "gold standard" of OUD treatment, due to its empirically proven ability to reduce harms associated with OUD, including infectious disease, illicit drug usage, overdose, and death; in addition, patients engaged in treatment through the OTP system generally show improved quality of life, reduced involvement in the criminal justice system compared to those with OUD in other care settings. Oregon has a total of 26 OTPs, and 25 of these 26 have certifications with OHA to provide "outpatient synthetic opioid replacement therapy" (one OTP in Oregon is operated by United States Veteran's Administration, in the city of Portland, at the Portland VA Medical Center). All have certifications from the US Drug Enforcement Administration (DEA) and SAMHSA/CSAT Division of Pharmacologic Therapies (DPT) to dispense narcotic medication for the treatment of OUD as well as provide comprehensive therapeutic services to their clients. In addition, Oregon has two "mobile" OTP units; one operates in western Washington County near the city of Hillsboro, and the other, Oregon's first Tribally owned and operated mobile OTP, operates both on the Confederated Tribes of Grande Ronde's tribal lands and surrounding communities in Marion, Yamhill and Polk counties). These programs are regulated by the State Opioid Treatment Authority (SOTA), who approves these programs to operate on behalf of SAMHSA DPT and serves as a liaison between the State and federal governments in terms of their management and operation, as well as the OHA HSD Licensing and Certification unit, who is responsible for issuing a State certification to operate an outpatient OTP. Currently, OTPs now operate in all counties along the I-5 corridor, with OTPs opening in Douglas, Josephine and Linn counties over the last 6 years. While a majority of Oregon's OTPs are located in the Willamette Valley and 1-5 corridor (home to approximately 80% of Oregon's population) several new facilities have opened in underserved rural and frontier areas of Oregon, including the Oregon Coast, and Eastern and Central Oregon. Several of these newer facilities have been supported through expansion efforts funded by Federal opioid related grant dollars.

Demographically, Oregon's OTPs have differing patient populations; while several located in Portland do have relatively significant populations of people of color, and the Tribally owned and operated mobile and "brick and mortar" OTPs serve significant populations of Tribal members and other Native Oregonians, the majority of the OTPs in the state mirror's Oregon's overall demographic landscape, with a vast majority of the patients self-identifying as "white".

Regulatory Requirements

OTP programs must comply with both Federal and state regulations. A federally recognized accreditation body must approve all programs. In Oregon, the Commission on Accreditation of Rehabilitation Facilities accredits 18 OTP programs, and 8 programs are accredited by the Joint Commission on Accreditation of Healthcare Organizations. Agencies are reviewed by their accreditation agencies at least once every three years.

OHA approves OTPs in Oregon, with the exception of the Federally run program, and no OTP with a OHA certificate of approval can operate in Oregon without the permission of the SOTA. Each program is reviewed at least once every three years. In addition, current state statutes prohibit methadone programs from operating within 1,000 feet of a school, a licensed childcare facility, or a career school attended primarily by minors. In 2018, SB 910 modified some of these regulatory barriers by removing the requirement of a client to obtain prior approval from a probation or parole officer to be admitted and inducted on methadone or buprenorphine at an OTP. The bill also outlines a process for a waiver of the aforementioned "1000 foot rule", through permission from a county's Local Public Health Authority (LPHA); in Oregon, statute dictates in a majority of cases that this authority lies directly with each county's Board of Commissioners.

Admission Requirements

The program's Medical Director approves all admissions. Individuals being considered for methadone treatment must have a one-year history, immediately prior to admission, of a continuous physical dependence on narcotics or opiates as documented by medical records, records of arrests for possession of narcotics, or records from drug treatment programs. The program must have evidence of an individual's current physical dependence on narcotics or opiates as determined by the program physician or medical director. The agency may also admit individuals where there is documentation demonstrating that medically supervised withdrawal or medically supervised withdrawal with acupuncture and counseling has proven ineffective, that a physician licensed by the Oregon State Board of Medical Examiners has documented in the patient record a medical need to administer opioid agonist medications, or if the patient is currently pregnant and opioid dependent. Additional flexibilities were added to the OTP Oregon Administrative Rules in fall of 2022, allowing for a medical director to admit patients who are at high risk of overdose or death due to their usage of opioids, including those who have a history of opioid overdose. These rule flexibilities have been added to account for the unprecedented rise in overdose death due to synthetic opioid analogues in Oregon, primarily fentanyl.

Daily Operations

Clinics in Oregon are required to be open Monday through Saturday, except for federal holidays. Multiple clinics have made requests to alter hours on Sunday or close entirely, mainly due to unprecedented workforce shortages; these requests are routinely granted by the SOTA, in consult with SAMHSA DPT officials. Clinics are open early morning through early afternoon and provide dosing, counseling, and urinalysis testing. Upon admission, individuals are required to pick up their medication at the clinic six days a week. Over time and with documented progress, individuals are eligible for "take home" privileges that enable them to come to the clinic less frequently. The criteria and time frame for these privileges are described in federal and state regulations.

Since the onset of the COVID 19 pandemic in Spring of 2020, many new flexibilities in Federal rule for take home medications have been implemented nationwide. Oregon is in formal concurrence with these ongoing flexibilities, originally implemented to prevent COVID 19 spread in the OTP system, but

maintained after evidence surfaced of their safety, overall efficacy in terms of clinical care, and lack of significant increase in overdose or death as a result of opioid use in the population under care at OTPs nationwide. For example, as of Spring 2023, OTPs may give up to a week of take home medications to an incoming client, if a medical director deems the client is not at increased health or safety.

Prescription Drug Monitoring Program

The Oregon Prescription Drug Monitoring Program (PDMP) assists health care providers and pharmacists to provide patients better care in managing their prescriptions. The PDMP was started in 2011 to help individuals collaborate with their health care providers and pharmacists to determine what medications are best for them. The system allows healthcare practitioners to be able to access a database, which makes them aware of the specific medications prescribed to their individual patient, in order to provide oversight in medication management, as well as protect the overall health and welfare of their patient. The patient data is secure and can be only accessed by individuals using the proper

authentication, for the purpose of treatment planning and the healthcare needs of their individual patients. Pharmacies contribute data to the program on specific prescription drugs, Schedule II, III and IV controlled substances, dispensed to patients. These medications place patients at risk for overdose, side effects, and increased effect when combined with alcohol and/or other drugs, risk for physical dependence, and risk for developing patterns of drug abuse. The PDMP provides practitioners and pharmacists a means to identify and address these problems.

• More than 14,900 practitioners and pharmacists have PDMP accounts in Oregon.

• In 2016, more than 1.2 million queries were made by practitioners and pharmacists.

• Approximately 7 million prescription records are uploaded into the system annually.

Services for Individuals Charged with Driving Under the Influence of Intoxicants (DUII)
Oregon law (ORS Chapter 813) requires anyone charged with driving under the influence of intoxicants (DUII) – whether they are under a diversion agreement or have been convicted – to complete both a screening interview and a treatment program approved by the Oregon Health Authority (OHA).

OHA certifies Alcohol and Other Drug Screening Specialists (ADSS) throughout the state to provide screening and referral services. In addition, ADSS monitor treatment engagement and report the individuals' successful completion or failure to complete to the court. Between 11,000 and 12,000 people each year are screened by an ADSS and referred to a DUII Services Program certified by OHA.

DUII Services Programs use the screening information provided by the ADSS to inform their diagnostic assessment and determine the appropriate programming for each person referred for services – either DUII Education or DUII Rehabilitation.

DUII Education
DUII Education is for people who do not meet diagnostic criteria for a substance use disorder and have not had a previous DUII. Services consist of a minimum of 12 hours of psychoeducational services aimed at preventing DUII recidivism and reducing substance use. Approximately 10 percent of people served are eligible for DUII Education.

DUII Rehabilitation

DUII Rehabilitation is for people who meet diagnostic criteria for a substance use disorder or have had a previous DUII. DUII Rehabilitation includes the education component discussed above, in addition to individualized substance use disorder treatment services. Participants in DUII Rehabilitation services are also required to demonstrate a minimum of 90 days abstinence in order to complete services successfully. Approximately 90 percent of people referred to DUII Services Programs are required to complete DUII Rehabilitation.

DUII Modernization

OHA has undertaken a modernization project. This is a multi-year process that began with extensive engagement with stakeholders – including treatment providers, ADSS, law enforcement, the Department of Motor Vehicles, and consumers of services. The aims of modernization for the system are to increase equity, reduce recidivism, and improve access to quality treatment.

Problem Gambling Services

Oregon has a long history of addressing the risks associated with gambling through research, prevention and education, responsible gambling guidelines, treatment, strong partnerships, and collaborations. Oregon uses the public health approach that combines prevention, harm reduction and multiple levels of treatment focusing on quality-of-life issues for individuals with problems with gambling, their families and communities.

In Oregon, it is estimated 2.6 percent of the adult population experience moderate or serious problems with gambling. It is estimated that 88,000 Oregon adults and adolescents meet the clinical diagnosis for gambling disorder, with another 180,000 at risk of developing a problem with gambling. For each person with a serious problem, many others are affected (e.g., spouse, children).

One percent of Oregon Lottery revenues fund problem gambling services. The Oregon Health Authority administers the funds that provides approximately $7.5 million annually for prevention and treatment programs and services within each county.

Oregon is a national leader in preventing and treating gambling related problems, promoting informed and balanced attitudes and protecting vulnerable groups. These goals are accomplished by promoting healthy public policy, developing collaborative relationships among various stakeholder groups and providing local governments with funds to develop strategies like those used in other behavioral health systems.

Oregon provides prevention, outreach, early intervention, treatment and recovery services across the continuum of care at NO COST to the individual with a problem with gambling, and family members or concerned other impacted by the gambling. The following is a list of the type of services OHA funds provide:

- Prevention and outreach efforts, stand alone and infused into other prevention efforts such as suicide, alcohol, tobacco and other drug; 24- hour Helpline staffed by professional certified problem gambling specialists.
- A minimal intervention program involving phone counseling with a workbook.

• Outpatient treatment services in every county.
• 1 centers providing Crisis Respite care.
• 1 Residential treatment center; and
• Culturally specific and prison-based treatment programs

In fiscal year 2022-23, 451 individuals received problem gambling treatment services, along with 46 family members or concerned others impacted by the negative consequences of gambling. 498 calls for assistance or information were made to the Helpline with 442 referrals directly to a treatment organization.

Oregon's problem gambling services, along with the behavioral health system, is still bouncing back from the implications of the COVID-19 pandemic and the workforce crisis that ensued. This is reflected in enrollment numbers being half of what they were prior to COVID and our residential facility just starting to operate after being temporarily shut down during the pandemic. The system has endured a lot of turn over and vacancies among treatment and prevention professionals, however, we are hopeful for the future and rebuilding and much of this has already started.

Strengths of Program:
• Ensuring a prevention system that is guided by the Centers for Substance Abuse Prevention (CSAP) six core prevention strategies, the Social Ecological Model, and SAMHSA's Strategic Prevention Framework.
• Ensuring culturally relevant treatment services for Latinos, African Americans, Native Americans, and Asian Americans.
• Ensuring treatment or psychoeducation for incarcerated persons and other high-risk populations.
• Implementing a program evaluation system that allows the program to gather demographic data on the individuals served, along with feedback on the services, as both help to inform decisions.
• Ensuring prevention providers conduct community readiness assessments to obtain metrics to guide future planning.
• Providing, in partnership with Oregon Lottery, access to information, help and hope through the Oregon Problem Gambling Resource web page.
• Strengthening our connections to and partnership with the emerging problem gambling recovering community.

Recovery Services Section

Recovery Support Services

OHA promotes the belief that recovery must be the common outcome of treatment and support services and an approach that promotes resiliency and develops and supports policies consistent with that outcome. This guiding principle follows the recovery model: "People get better! People Recover!" Oregon's recovery support services include supports through the key components of health, home, purpose and community; and recognize that recovery is a lifelong experience. In the past, resources have been used largely for acute treatment needs rather than ongoing recovery support. Health system transformation in Oregon has allowed resource investment in recovery support services throughout the behavioral health system, supporting an active consumer, family, and youth voice in the planning of services throughout the system.

OHA has made significant investments in recovery support services. In 2014, the Office of Consumer Activities (OCA) was created to work in collaboration with OHA leadership to improve behavioral health services for the state. OCA is staffed by people who self identify as having lived experience with a mental health or addictions condition.

OCA addresses issues important to individuals who receive behavioral health services and provides a designated, consumer voice.

A chief goal of the office is to be a cornerstone for systemic change in reshaping policies and service delivery toward more recovery-oriented system of care. The office strives for services to be more welcoming and to more fully honor each individual's dignity. The primary initiatives of the OCA include:

• Build a statewide network of peer-run programs to facilitate the sharing of promising ideas, policies, practices and procedures.
• Providing technical assistance to peer-run programs.
• Help OHA behavioral health increase peer involvement in evaluating the state's policies, planning, and programs.
• Increase representation of consumers, survivors, and former patients-including ethnic and racial groups-in local and state mental health planning activities.
• Conduct a stigma and discrimination reduction initiative.
• Reduce racial and ethnic groups' barriers to mental health and addiction services by promoting culturally competent services for peers in these groups.
• Ensure that peers have a strong voice in state mental health and substance use disorder treatment policy development, planning and practice; and,
• Coordinate an annual statewide peer conference.

Honoring the voice of consumers and survivors in mental health and addictions policy is what will give them equal footing in service delivery. The long-term goal of OCA is to promote policies and services that:

• Support mental health and substance use disorder recovery.

• Respect individuals' choices and acknowledge their self-determination.
• More fully honor individuals' dignity and ability to experience recovery.
• Promote higher levels of community inclusion, employment, and education; and
• Encourage traditional providers to partner with peers and adopt practices that help people heal and recover their lives to the fullest, as they define for themselves.

Peer Delivered Services

The Center for Medicaid and Medicare Services (CMS) recognizes Peer Delivered Services (PDS) as an evidence-based practice for supporting recovery from behavioral health and addictions disorders. Peer delivered services is an array of agency or community-based services provided by peers to individuals with similar lived experience. There are four types of peer delivered services:

• An adult who has either received mental health services or self-identifies as a person in recovery, recovering or recovered from a mental health condition may provide services to an adult who is receiving mental health services.
• An adult who has either received additions services or self-identifies as a person in recovery, recovering or recovered from addictions may provide services to an adult who is receiving addictions services.
• A young adult with behavioral health concerns or challenges who has either received or self-identifies with behavioral health concerns may provide services to another young adult who has behavioral health concerns; and
• A family member who has patented a child or young adult with behavioral health concerns may provide services to another family member addressing children's behavioral health concerns.

The services are provided at all levels of mental health service delivery including health promotion, outreach, crisis intervention, recovery support, advocacy skills, supported housing, SRT, SRTF, acute, and respite care. As a part of Oregon's health transformation efforts, Peer Support and Peer Wellness Specialists (PSS/PWS) are now organized under the as Traditional Health Workers (THW). OHA supports the use of PDS and plans to continue to increase the availability of PDS statewide.
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Behavioral Health Promotion

Behavioral health promotion is integral to the promotion of health, which in turn is an important component in assurance of public health, or the health of the population. Emotional health promotion is one of the keys to maintaining physical and mental wellness by increasing the individual's ability to cope with normal stresses of life and their positive connectivity with family and community. Emotional health

is protective against the development of mental illness, pathological gambling and substance abuse disorders. It is also protective against the development of physical illness and the impact of trauma and stigma.

Mental Illness Prevention

Each Community Mental Health Program (CMHP), subject to the availability of funds, is required to provide or ensure the provision of the following services to persons with mental disorders:

1. Prevention of mental disorders and promotion of mental health.
2. Preventive mental health services for children and adolescents, including primary prevention efforts, early identification, and early intervention services. These services should be patterned after service models that have demonstrated effectiveness in reducing the incidence of emotional, behavioral, and cognitive disorders, and suicide attempts in children; and
3. Preventive mental health services for older adults, including primary prevention efforts, early identification, and early intervention services. These services should be patterned after service models that have demonstrated effectiveness in reducing the incidence of emotional and behavioral disorders and suicide attempts in older adults.

Mental Health Promotion and Prevention Programs

In 2019-2021, the Legislative allocated more than 6 million dollars for youth suicide prevention work for 2019-2021 biennium. These funds allowed OHA, its contractors, and the Alliance to Prevent Suicide to stand up seven sustainable statewide programs for suicide prevention, intervention and postvention. The funding also allowed for increased data collection and evaluation to better inform suicide prevention partners. Strategic partnerships flourished between the Oregon Department of Education, OHA, and local stakeholders. Finally, more funds were crucial for OHA's Suicide Prevention staff to be responsive to the unique circumstances that occurred in 2020 due to COVID-19.

Behavioral Health Promotion, Prevention and Early Intervention Services and Supports OHA supports a continuum of care based on the Institutes of Medicine model1, which incorporates behavioral health promotion, prevention, treatment, recovery, and maintenance. Behavioral health promotion is a broad concept with specific strategies, supporting wellness, early intervention, and prevention of mental and substance use disorders.

The Adverse Childhood Experiences (ACE) Study is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and wellbeing. The study is a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego.

The ACE Study arose from more than seventeen thousand Health Maintenance Organization (HMO) members undergoing a comprehensive physical examination who chose to provide detailed information about their childhood experience of abuse, neglect, and family dysfunction. To date, more than 50 scientific articles have been published and more than 100 conference and workshop presentations have been made.

The ACE Study findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. It is critical to understand how some of the worst

health and social problems in our nation can arise as a consequence of adverse childhood experiences. Realizing these connections is likely to improve efforts towards prevention and recovery.

Oregon has created Trauma Informed Oregon (www.traumainformedoregon.org) as a centralized resource for providers, families, adult consumers, and other stakeholders statewide, to have a reliable source of information on trauma and Adverse Childhood Experiences. Trauma Informed Oregon is also training nurses to incorporate Trauma Informed Care into their workforce training and culture as a standard in Oregon.

Children's Behavioral Health

The array of services and supports

Children youth and families need an array of services and supports to meet their individual needs. This graphic illustrates the full continuum as defined in the 2021 The Evolution of the System of Care Approach. Oregon has most of these services and supports and is working to develop the others.

Centering Health Equity

Health equity is a critical need in Oregon, and a leading initiative at the Oregon Health Authority. OHA has heard unequivocally that we are not reaching disproportionally impacted populations, nor are we addressing those in populations experiencing health inequity with a robust enough response to adequately meet their needs.

We have developed a framework to center our OHA health equity goal by 2030 in all our work, inclusive of trauma informed principles and practices. We commit to center youth and families to build a system that will work for all.

OHA is committed to meaningfully integrate the voices of youth and families with lived experience Tribes and communities of color into the work, to addressing gaps in equity, creating access to culturally responsive programming and treatment options, addressing workforce issues, and finding better, trauma informed ways to work together

Parent-Child Interaction Therapy (PCIT)
PCIT is an empirically supported treatment for young children with emotional and behavioral disorders. Research from around the world shows that it is effective for families from diverse cultures and communities. PCIT provides live practice for parents through coaching with a wireless communication device by the therapist who views the parent and child (ages two-seven) through a one-way mirror. It teaches parents to develop a warm, responsive relationship with their children, to selectively reinforce pro- social and adaptive behavior while also learning to safely and consistently provide developmentally appropriate consequences to change children's negative behaviors. An adaptation of PCIT for toddlers (ages 12-24 months) teaches parents to become more attuned and responsive to their young child while helping toddlers develop emotional and behavioral self-regulation. National research indicates PCIT can also be adapted for children with anxiety disorders, developmental delays, children on the autism spectrum, children who have experienced chronic trauma, families who are involved with child welfare because of harsh physical discipline, and mother-child dyads following episode(s) of domestic violence. The average length of treatment is 16 to 20 weeks. The use of standardized instruments for data collection demonstrates improved functioning during treatment.

In 2008, four Oregon agencies began to implement PCIT with funding support from OHA to provide PCIT to Medicaid eligible families. As of January 2019, there were high fidelity PCIT programs serving Medicaid

eligible families at 59 locations, in 21 Oregon counties. Two additional behavioral health clinics which were providing PCIT in 2019, have had to pause their PCIT programs due to loss of staff during the COVID-19 health emergency in Oregon. Most other Oregon PCIT programs successfully switched to providing PCIT via telehealth services. Currently there are approximately 130 trained staff on PCIT treatment teams, including certified Master's Level PCIT Trained therapists, Bachelor's level skills trainers, PCIT Within Agency Trainers, and 2 certified Regional Trainers authorized by PCIT International, Inc. to train across Oregon. Training to meet PCIT certification requirements takes a year or more to complete. All OHA funded PCIT sites receive on- going consultation, training and fidelity monitoring by OHA contracted certified Regional PCIT trainers. This has been provided virtually during the COVID-19 pandemic.

There will be statewide training in September 2023 that will train 8 new clinicians. There will also be a session specifically for supervisors to provide support sustainability in the provision of fidelity PCIT.

PCIT demonstrates large effect sizes in reducing child problem behavior despite high treatment attrition rates in community-based clinics. A recent study done by the Department of Psychology at West Virginia University, in cooperation with OHA, was published, titled *Reconceptualizing attrition in Parent–Child Interaction Therapy*

in Psychology Research and Behavior Management[1]. This study employed one of the largest PCIT community research samples ever conducted (2,787 children and their families across Oregon, 1,318 with usable data) to determine how PCIT impacts both who complete treatment and those who leave treatment early. The purpose of the study was to examine the impact of PCIT on child behavior problems for families who received at least a small dose of PCIT but not enough to meet the strict mastery criteria required for PCIT treatment graduation in the fidelity model. While families who graduated from PCIT demonstrated a very large effect size in problem behavior intensity improvements (d=1.65), families who terminated treatment early, but after attending at least four treatment sessions, still showed significant improvements in behavior problems with a medium-to-large effect size (d=0.70).

Child-Parent Psychotherapy (CPP) is an intervention for children from birth through six years who have experienced at least one traumatic event (e.g., maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, or exposure to domestic violence) and are consequently experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD). The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent or caregiver to restore the child's sense of safety, attachment, and appropriate affect and to improve the child's cognitive, behavioral, and social functioning. CPP is recognized by the National Child Traumatic Stress Network and the SAMHSA National Registry of Evidence-Based Programs and Practices.

OHA has been providing funding since 2014 for CPP training annually, including 18 months of reflective supervision/consultation. To date, 150 clinicians have started CPP training and approximately 35 clinicians have dropped out of the training and on-going supervision before completing training.

The current goals of this project are to:

1. Implement CPP with fidelity through provision of mental health promotion and intervention services, behavioral health clinics, and Oregon Relief Nurseries to at-risk families.

2. Utilize the CPP Fidelity Tools.
3. Utilize the Devereaux Infant Toddler Assessment to measure outcomes starting in September 2019.
4. Continue ongoing consultation, supervision, and networking between CPP- trained therapists to maintain fidelity to the model over time.

Generation PMTO (Parent Management Training- Oregon) is a family-based, trauma informed intervention with over 50 years of research from across the USA and several other countries demonstrating its effectiveness[2]. Generation PMTO can be used as a preventive program and as a treatment program. It be delivered through individual family treatment, group parent training in agencies or home-based and via telephone/video conference delivery. Generation PMTO providers are encouraged to tailor the services to meet the needs of diverse populations, family circumstances and service provider type.

Generation PMTO is effective for families with children ages 2-17 years experiencing significant social emotional or behavioral problems such as depression, hyperactivity, non-compliance, substance use, lying and stealing, or other maladaptive behaviors. Research shows that Generation PMTO also improves positive parent skills, family communication style, standard of living and marital satisfaction while decreasing coercive parenting patters parental depression and arrest rates.

OHA began a five year roll out of Generation PMTO in 2019 with a pilot project of one program. The goal of this project is to increase access to this effective family intervention across Oregon, especially in rural areas where master's level behavioral health staff are in limited supply. During the COVID-19 health emergency began in 2020, Generation PMTO providers were quick to successfully switch to providing this service via telehealth. Currently there are programs providing Generation PMTO in 11 counties and 14 locations.

The planned expansions in 2021 did not happen due to workforce hiring and retention challenges. There is active planning with the GenPMTO Leadership Committee and Oregon Health Authority for sustaining current service levels while continuing to provide training and certification for therapists. There are also continued efforts to train and certify therapists to become coaches. A budget outline for planning GenPMTO Infrastructure in Oregon has been developed by Oregon Health Authority for use by the Generation PMTO Leadership Committee.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

In 2020-2021 the Oregon Health Authority contracted with a Nationally certified TF-CBT Trainer to provide all training and consultation to qualify for certification for 115 outpatient mental health therapists statewide who serve Medicaid eligible clients. An additional 120 training slots were offered in 2021-2023. Oregon Health Authority continues to provide training and consultation with this trainer.

Training will be offered in October 2023 and Spring 2024.TF-CBT is a well-supported evidence-based treatment[3] for children and adolescents impacted by trauma, and their parents or caregivers. TF-CBT has been evaluated and refined during the past 25 years to help children and adolescents across many cultures[2] after trauma. TF-CBT is for children 3-18 years of age, and their parent or other caregiver. Average treatment is 12-14 sessions provided in an outpatient setting and it can be provided via telehealth.

Research shows that TF-CBT successfully resolves a broad array of emotional and behavioral difficulties associated with single, multiple and complex trauma experiences such as physical or sexual abuse[4], domestic violence, and community violence, an unexpected death of a loved one, natural disasters and war.

[1] Retrieved from Psychology Research and Behavior Management July 2019 Volume 12: 543-555
[2] https://www.cebc4cw.org/program/the-oregon-model-parent-management-training-pmto/ and https://www.generationpmto.org/pubs
[3] https://www.nctsn.org/sites/default/files/interventions/tfcbt_culture_specific_fact_sheet.pdf
[4] https://tfcbt.org/wp-content/uploads/2019/02/TF-CBT-Child-Welfare-Information- Gateway-Fact-Sheet.pdf

Early Assessment and Support Alliance (EASA)

EASA serves youth and young adults, ages 12-27, and their families, using a Coordinated Specialty Care (CSC) model, which is an intensive multidisciplinary approach during what is known as the "critical period," where intervention is most effective and may prevent the long-term negative life consequences associated with chronic psychotic illness. Early intervention and treatment of psychosis assists individuals in becoming independent, healthy and safe. The restoration of normal functioning helps individuals maintain employment and support themselves and their families.

EASA's current structure offers a robust and efficient model of care while mirroring many public health strategies through integration of physical and mental health care. Utilization of this model has resulted in dramatic outcomes such as decreased hospitalization rates. The model is cost-effective in the short term and results in cost savings in the long term.

Impact and Data

Since its first investment in 2008, EASA has provided services to 3,833 young adults and their families. With the addition of federal dollars, 29 Oregon counties are funded to provide EASA services . In calendar year 2020, EASA received 828 referrals and served 779. The ongoing current caseload is around 400 individuals throughout the state of Oregon. In EASA, young people maintain or enter school or work (59.1% at intake, 59.4% at discharge). Hospitalizations in the three months prior to entry have dropped from 37% to 6% in the final quarter of being in the program. Community education, outreach and quality improvement efforts are focused on improving these numbers. Each EASA team conducts extensive and ongoing community education. During this 2019-2021 biennium EASA conducted 802 community education events reaching approximately 16,800 people.

EASA Center for Excellence

Oregon is the first state in the U.S. to commit to universal access to early psychosis intervention and is an established national leader. EASA has a Center for Excellence (CfE) housed at OHSU/PSU (Oregon Health and Science University) School of Public Health. The EASA CfE maintains collaborative partnerships with Portland State University and OHSU Child Psychiatry and is part of the Technical Assistance Network for Children's Mental Health, has a strong affiliation with the federal initiative Reclaiming Futures and Pathways to Positive Future federal grant projects, and has become increasingly involved in national technical assistance activities. EASA Center for

Excellence has a robust series of ongoing trainings, consultation, and technical assistance and the fall 2019 conference attended by 190 individuals is a good example of the level of energy and buy-in across the state. The development of online options has provided additional opportunities for new staff to receive rapid information and to make training more accessible. Advanced training in areas such as texting and CBT for psychosis has been developed. Regional and statewide consultation is provided routinely.

The EASA Center for Excellence is also investing in two "train the trainer" series to then train all EASA staff in Cognitive Behavioral Therapy for psychosis and Dually Diagnosing Individuals with Intellectual and Developmental Disabilities (IDD) and First Episode Psychosis. Furthermore, the EASA Center for Excellence is working with EASA Sites and the Oregon Health Authority to integrate the use of alternative models for rural and frontier counties as well as adaptation for different cultural groups. This work will be done through workgroups and consumer feedback session.
The EASA Center for Excellence is maintaining a centralized registry of credentialing status for all EASA clinicians through a databased established at PSU.

Young Adult Leadership

A very dynamic and engaged Young Adult Leadership Council has been established, made up of EASA graduates who want to help guide and support EASA's evolution. The council meets monthly, and their vision statement speaks to their focus and enthusiasm: "The vision of the Young Adult Leadership Council is to unite the voices and strengths of young adults and their allies to build a thriving community and a revolution of hope."

The EASA Young Adult Leadership Council is actively involved in advising and developing programming for EASA and national audiences. Leadership Council members have presented at Peerpocalypse and numerous conferences including NAMI national and a research conference in Florida. The Leadership Council developed a national policy statement and an article for Focal Point magazine, and met with Paolo Del Vecchio, the director of the Center for Mental Health Services. The Young Adult Leadership Council has taken the lead on working through a social media strategy for reaching young adults. Ongoing outreach to high schools and colleges continues to occur.

EASA developed shared decision-making materials in collaboration with members of the Young Adult Leadership Council. In addition, a young adult design team funded through Pathways and the Young Adult Leadership Council developed a comprehensive website, videos and written handouts which are written from the perspective of individuals who have graduated from EASA.

Adult Mental Health Services

Each CMHP provides or ensures the provision of a continuum of care for adults with serious mental illness, subject to the availability of funds. These services include, but are not limited to:

1. Screening and evaluation to determine the individual's service needs.
2. Individual, family, and group counseling and therapy.
3. Medication monitoring.

4. Residential services.
5. Psychiatric care in state and community hospitals; and
6. Crisis stabilization to meet the needs of people experiencing acute mental or emotional disorders, including the costs of investigations and prehearing detention in community hospitals or other facilities approved by OHA for people involved in involuntary commitment procedures.

Within the limits of available funds, CMHPs provide the above services to individuals in the following order of priority:

1. Individuals who, in accordance with the assessment of a mental health professional, are:
    a. At immediate risk of hospitalization for the treatment of mental or emotional disorders, or
    b. In need of continuing services to avoid hospitalization, or
    c. Pose a hazard to the health and safety of themselves, including the potential for suicide, or others
    d. And those persons under 18 years of age who are at immediate risk of removal from their homes for treatment of mental or emotional disorders or exhibit behavior indicating high risk of developing disorders of a severe or persistent nature.
2. Individuals who, because of the nature of their mental illness, their geographic location, or their family income, are least capable of obtaining assistance from the private sector; and
3. Individuals who are experiencing mental or emotional disorders but will not require hospitalization in the foreseeable future.

Individuals participating in mental health services assist their service providers to develop a comprehensive service plan, which specifies services and supports provided or coordinated for an individual and his or her family. The plan should be reflective of the assessment and the intended outcomes of service. The plan documents the specific services and supports to be provided, arranged, or coordinated to assist the individual and his or her family, if applicable, to achieve intended outcomes. At a minimum, each plan must include:

1. Measurable or observable intended outcomes.
2. Specific services and supports to be provided; and
3. Applicable service and support delivery details.

Mental Health Services for Older Adults

Mental health services provided to older adults through the CMHP and their contractor are limited. This is primarily due to the fact that the majority of older adults are only on Medicare. Several CMHP use multidisciplinary teams (MDT) to address the gap in mental health services. These teams vary from county to county and not all counties have a MDT. These teams often have representatives from Aging and People with Disabilities, law- enforcement, adult protective services with the primary focus to link vulnerable older adults with necessary mental health and social services in a seamless manner. Some CMHP use their indigent funds underinsurance for Medicare recipients with serious mental illness.

Some CMHP or their subcontractors have developed and maintained age specific services. In our most populous county one subcontractor has developed a substance use disorder program specifically for older adults called Young at Heart using the SAMHSA curriculum called Substance Abuse and Relapse Prevention for Older Adults.. Some counties have older adult peer delivered services. 9 CMHP or their sub- contractors

(in 9 counties) in Oregon have developed specific older adult behavioral health programs. OHA has convened an Older Adult & People with Disabilities Advisory Council.

Pre-Admission Screening and Resident Review (PASRR)

PASRR is a federally mandated, statutory program that requires all states to develop a comprehensive process to prescreen for serious mental illness all individuals applying for admission to a Medicaid certified nursing facility. The mandate requires a personalized assessment and recommendations for the mental health services and a determination that nursing home level of care is appropriate for the person.

Oregon Health Authority, as the State Mental Health Authority, maintains a PASRR Level II program that follows federal regulations. In the majority of counties, CMHP are contracted to provide PASRR level II services and are expected to link individuals with a serious mental illness with the appropriate outpatient mental health services.

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

Programs emphasize person-centered rehabilitative mental health treatment while continuing to work towards transitioning individuals into the most integrated community setting possible. OHA is responsible for collaborating with APD on managing program referrals, and for working with local providers regarding program administration and strengthening coordination between systems. There are 9 Enhanced Care Facilities that are either APD licensed residential care facilities or units within intermediate care facilities dedicated to serving individuals who qualify for this service. These programs have higher staffing ratios than traditional APD licensed settings, and mental health staff on-site 7 days a week. Mental health staff work closely with APD in developing strategies to support individuals in meeting their goals. Enhanced Care Outreach Services provides intensive mental health services to individuals living in standard APD licensed settings.

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

Complex Case Consultation and Care Transitions

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

Older Adult Behavioral Health Initiative (OABHI)

Oregon invests in the Older Adult Behavioral Health Initiative . The goal of this Initiative is to serve older adults and people with physical disabilities by improving timely access to care from qualified providers (workforce) who work together to provide coordinated, quality and culturally responsive behavioral health and health and wellness promotion. We do this by funding staff positions – older adult behavioral health specialists – who cover all 36 counties in Oregon. These Specialists provide the

following deliverables : enhance multi agency and multi sector collaboration and coordination, provide workforce development trainings, promote emotional health and wellness activities, and provide complex care consultations by bringing community partners and key state partners together to find solutions for older adults with complex care needs. Focus areas are scaling depression care, building resilient communities through mitigating social isolation and loneliness, end of life planning, busting ageism and moving the needle on equity , suicide prevention, health and wellness promotion , dementia education and awareness; developing geriatric behavioral health core competencies in the workforce; providing multidisciplinary teams to coordinate care for older adults with complex care needs.

Oregon has invested in a statewide Senior Loneliness Line (SLL) . This is a warm line where seniors and their caregivers or family members can call for support and connection to resources. This line averages about 1400/month. We are piloting a small program where frequent callers to the SLL will be offered a three session CBT Skill building course called Connections Planning . This pilot is underway.

We implemented a nationally recognized program by USAging called OPAL (Options to Address Alternatives to Loneliness) in two rural counties using community health workers as depression coaches: one in a FQHC and the other in a food bank. This program is a combination of PEARLS plus resource connection.

Through a CDC multi-year comprehensive suicide prevention grant one of the priority populations is Older Adults. Through this grant we have trained 24 of the older adult BH specialists in PEARLS (Program to Encourage Active, Rewarding Lives) a treatment program designed to reduce symptoms of depression from the University of Washington – as PEARLS Coaches. These 24 specialists have just started to deliver this 6-week program to older adults in community setting such as senior centers, churches and public housing – low barrier, easy access to evidence based depression program. The first two cohorts of PEARLS groups will be completed by September 2023.

We have developed to ECHO projects that target older adults: Geriatric Behavioral Health ECHO for Nursing Facilities which was first started in 2018 and continues today. The second one Substance Use Disorder ECHO for Licensed Community Based Care settings.

Choice Model Services

Choice Model Services, previously known as Adult Mental Health Initiative, is designed to promote more effective utilization of current capacity in facility-based treatment settings, increase care coordination and increase accountability at a local and state level. Choice Model will promote the availability and quality of individualized community-based services and supports so that adults with mental illness are served in the most independent environment possible and use of long-term institutional care is minimized. The initiative re-allocated a portion of resources historically used to develop community based licensed residential care facilities. These resources were directed to nontraditional person- centered supports in care management, a broad range of treatment services, discharge planning, and community-based supports such as rental assistance.

The target population is individuals who, because of mental illness: (a) Currently reside at an institution listed in ORS 179.321 and includes patients residing within a Neuro/Gero ward at OSH in Salem, Oregon; or (b) Currently reside in a licensed community based setting listed in ORS 443.400 and includes licensed programs designated specifically for young adults in transition; or (c) Are under a civil commitment pursuant to ORS 426; or

(d) Were under a civil commitment that expired in the past 12 calendar months; or (e) Would deteriorate to meeting one of the above criteria without treatment and community supports; and (f) Does not include individuals who are under the jurisdiction of the Psychiatric Security Review Board (PSRB).

Choice has improved local accountability for positive treatment outcomes through performance-based contracting. Increased local control and accountability help OHA's community partners provide high quality care at the right time, for the right duration, and at lower cost. Providers are required to stay involved with their members throughout the full-service continuum, and work with the individual to develop a care plan that meets the individual's needs and choices.

Choice collaborates with local partners to enhance client self-determination by developing an Individualized Recovery Plan (IRP) for each member served. This enhanced emphasis on recovery and self-determination is expected to help lessen transition times to more independent and integrated living environments. For individuals experiencing mental illness, residential treatment helps promote and enhance skills needed to lead independent healthy lives. Many coordinated care organizations (CCO) members receive this kind of treatment on a temporary basis, outside their home community. After many thoughtful discussions with CCO and behavioral health stakeholders, the Oregon Health Authority updated CCO enrollment rules to support keeping individuals in their "home"

CCO when in out-of-area treatment. (The "home" CCO is the CCO the individual had prior to being placed in temporary residential treatment.)

Residential Mental Health Adult Mental Health Residential Treatment Programs Adult Mental Health Residential Treatment is defined as a 24-hour level of care that provides a range of rehabilitative and habilitative services which cannot be provided in an outpatient setting. Placement in residential treatment is appropriate if the member is not in need of a higher level of physical security and frequency of psychiatric or nursing intervention that is available on an inpatient unit. The overall goal is to provide a therapeutic environment that is both safe and least restrictive to the individual. Adult Residential Treatment includes Residential Treatment Facility (RTF); Residential Treatment Home (RTH); Secure Residential Treatment Facility (SRTF); Adult Foster Home (AFH). Residential Treatment Homes (RTH), Residential Treatment Facilities (RTF), and Secure Residential Treatment Facilities (SRTF) provide housing and treatment services to adults diagnosed with a qualifying mental illness and are staffed 24 hours a day. The capacity of an AFH and RTH is up to five residents and the capacity of an RTF and SRTF is 6-16 residents, though there are few contracted facilities that provide services for 16 or more residents. Most placements into these residential programs come from state hospitals and acute care facilities. An assessment and determination for admission is usually conducted by a local Community Mental Health Provider (CMHP).

HSD monitors and consults with licensed and contracted community providers to ensure appropriate services are being delivered to individuals in the least restrictive environment. Facilities are required to be licensed or accredited for the level and type of care provided and is practicing within the scope of its license.

Three levels of community-based residential treatment services are offered for adults with serious mental illness:

1. Residential Treatment Homes (RTHs) provide services on a 24-hour basis for five or fewer residents.
2. Residential Treatment Facilities (RTFs) provide services on a 24-hour basis for six to 16 residents: and
3. Secure Residential Treatment Facilities (SRTFs) restrict a resident's exit from the facility or its grounds through the use of approved locking devices on resident exit doors, gates or other closures. SRTFs provide services on a 24-hour basis for 16 or fewer residents.

Type of Housing	Capacity
Adult Foster Home	590
Residential Treatment Home	290
Residential Treatment Facility	498
Secure Residential Treatment Facility	539
TOTAL	1,917

Psychiatric Security Review Board (Ryan Stafford)

The Psychiatric Security Review Board (PSRB) is a Governor appointed, ten-member multi-disciplinary board made up of two, 5-member panels: Adult Panel and Juvenile Panel. Each panel includes a psychiatrist, a psychologist, an attorney experienced in criminal practice, a parole/probation officer and a member of the general public.

The Psychiatric Security Review Board's mission is to protect the public by working with partnering agencies to ensure persons under its jurisdiction receive the necessary services and support to reduce the risk of future dangerous behavior using recognized principles of risk assessment, victims' interest, and person-centered care.

The Board has jurisdiction over five different programs:

- GEI: Adults who have successfully pled Guilty Except for Insanity (GEI) through the court system (ORS 161.295)
- Civil Commitment: Adults committed through the court system as "extremely dangerous" person with mental illness (ORS 426.701).
- REI: Youth adjudicated Responsible Except for Insanity (REI)(419C.529).
- Gun Relief Program: Restoration of firearm rights for those persons previously barred from purchasing or possessing a firearm due to a mental health determination and who have petitioned to have that right restored.
- Sex Offender Classification & Relief Program: Classification or reclassification, or relief from registration requirements for those persons who have successfully asserted the GEI defense for a sex offense that resulted in assigning a risk designation.

As of June 2021, 620 individuals are under the supervision of the board as GEI; 24 individuals a committed as an "extremely dangerous" person with mental illness; and six youth adjudicated as REI. All three of these populations have the right to be considered for conditional release to the community. Presently, about 62% reside in the community across the continuum of care and under the direct supervision and treatment supports offered by Community Mental Health Programs (CMHP). These individuals are required to observe the requirements outlined in their individual conditional release plans but could be returned to the Oregon State Hospital under circumstances that are deemed to be a threat to public safety.

The PSRB reports to the Governor and the Legislature through its annual key performance measures. The primary way the Board conducts its business and meets its mission is through conducting timely, contested hearings and monitoring and supervising individuals who are under its jurisdiction and conditionally released

to the community through its orders and partnership with community treatment providers. OHA is statutorily responsible for providing mental health services to these individuals. CMHPs provide evaluations for the PSRB or the court, to determine if treatment in the community is appropriate and to secure resources in the community. Determination of supervision requirements and treatment for persons conditionally released into the community is also

provided by CMHPs. Residential services are provided in varying levels of care including: Secure Residential Treatment Facilities, Residential Treatment Facilities and Homes, Adult Foster Care, Supported Housing, Intensive Case Management and Independent Living. Individualized community placements include, but are not limited to, the following services:

4. Community risk evaluation.
5. Monitoring, security and supervision.
6. Case management.
7. Psychotherapy.
8. Residential supports.
9. Supported employment and education services.
10. Substance use disorder treatment services; and
11. Medication management

The PSRB and OHA continue to work with OSH Treatment Teams and CMHPs to assure that individuals are placed in the appropriate level of care and receive the services needed to live as independently as possible while maintaining public safety.

Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) is an Evidence-Based Practice (EBP) designed to provide comprehensive treatment and support services to individuals who are diagnosed with severe and persistent mental illness.. ACT services are provided by a multidisciplinary team which includes psychiatrists, therapists, substance abuse treatment specialists, certified peer specialists, employment specialists and nursing. These services are designed to be provided in the most integrated setting possible to maximize independence and community integration. The Oregon Center of Excellence for Assertive Community Treatment (OCEACT) was created to promote and implement Assertive Community Treatment (ACT) as an evidence-based practice (EBP) throughout Oregon.

The Oregon Center of Excellence for Assertive Community Treatment (OCEACT) is funded through a contract between the Oregon Health Authority Health Systems Division (HSD) and Josephine County, who subcontracts the program to Options of Southern Oregon. OCEACT is operated in partnership with the Oregon Supported Employment Center for Excellence (OSECE), both working as programs of Options for Southern Oregon.

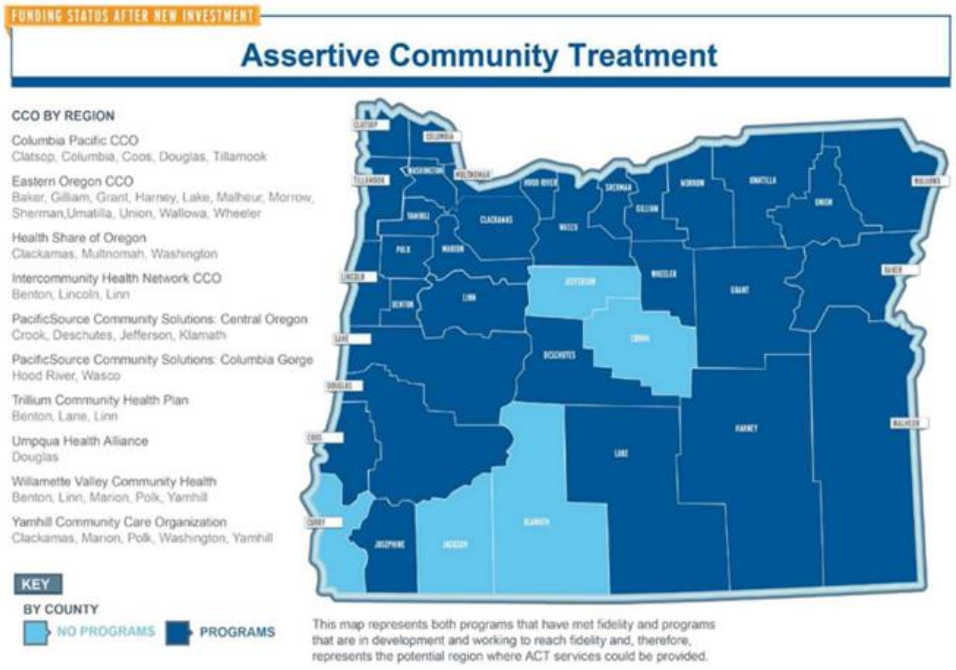
The primary goals of OCEACT are to:

- Provide training and technical assistance. OCEACT provides training and technical assistance to educate mental health service providers about the Assertive Community Treatment model. OCEACT statewide trainers provide expert consultation to established and developing ACT teams.
- Help programs achieve high fidelity to the ACT model and improve quality. The OCEACT staff conducts annual fidelity reviews of ACT programs statewide. Programs must meet a fidelity

benchmark in order to be certified by OHA as ACT providers and to bill Medicaid for ACT services. OCEACT is a resource for current and future ACT teams interested in learning more about the ACT model and improving adherence to ACT principles.

- Provide an annual ACT conference, statewide trainings for ACT programs, trainings for individual programs, provide ongoing technical assistance.
- Measure and report statewide ACT program outcomes on a quarterly basis. High fidelity ACT programs have been shown to reduce psychiatric hospitalization and utilization of acute care, improve housing stability, and improve quality of life for participants. ACT programs report on a core set of participant outcomes to measure the impact of the ACT program across Oregon.

- Educate and advise state and local policy makers. OCEACT staff meet regularly with representatives from the Oregon Health Authority and other stakeholders to share success stories, discuss implementation issues, program outcomes, and ways to best support high fidelity ACT model service delivery.



Veterans Behavioral Health

OHA's Veteran & Military Behavioral Health (VBH) Program is founded on a commitment to engage federal, state, community, and Tribal partners to inform programming. The Oregon Veterans' Behavioral Health Services Improvement Study: Needs Assessment & Recommendations Report (2019), associated community forums, and ongoing community engagement, allow OHA's VBH program to amplify voices of lived experience while developing culturally specific programming and policy recommendations.

Informed by Veterans, Service Members, and their Families (SMVF), healthcare providers, and other military connected community members, OHA has disbursed approximately 4.7 million dollars of funding dedicated to veteran behavioral health in Oregon since 2019. Between October 2018 and March 2023, OHA's VBH program was supported by one Full Time Employee (FTE). As of March 2023, staffing has increased to 1.5 FTE. Work is cross-matrixed within the agency, with regular collaboration with OHA's Adult Behavioral Health Unit, Youth and Family Behavioral Health Unit, and Office of Recovery and Resilience. The VBH program also works closely with OHA Tribal Affairs, and OHA's Public Health Division Injury and Violence Prevention Program, and other state agencies such as Oregon Department of Veterans' Affairs, Oregon Housing and Community Development, and Oregon Judicial Department. Both of OHA's VBH program staff bring lived experience to the work, identifying as SMVF and consumers of the behavioral health system for themselves and/or on behalf of loved ones.

Between 2019-2021 OHA's VBH program prioritized work in the following areas:

- Peer Delivered Services
- Community engagement
- Addressing community and workforce needs

This was accomplished by the development and support of approximately 14 different initiatives such as:

- Development and rollout of an Oregon specific Military Culture and Suicide Prevention Training (MCASPT)
- Supporting a military specific track at the 2021 Oregon Suicide Prevention Conference
- Development and rollout of a veteran and military behavioral health ECHO training program
- Rollout of veteran specific Mental Health First Aid (MHFA) to veteran and military training cohorts
- Development and launch of Oregon's first state funded Veteran Behavioral Health Peer Support Specialist Program (VBHPSS)
- Needs assessment of military brain injury resources in Oregon and development of a military specific brain injury screening tool modified, with permission, from the standardized Ohio State TBI Identification Method.
- Support of veteran and military behavioral health services and culturally specific workforce supports in clinical settings
- Tribal set aside of 20% of legislatively allocated VBH program budget to support first Tribal Veteran behavioral health grants in Oregon.

Between 2021-2023 OHA's VBH program prioritized work in the following areas:

- Peer Delivered Services
- Workforce training and development
- Access to care

This was accomplished by the development and support of approximately 30 different initiatives such as:

- Expansion of the VBHPSS (Peer) program launched in 2019
- Expansion of funding to support veteran and military behavioral health services in clinical settings, emphasizing rural and underserved communities
- Continuation of military culture trainings launched in 2020 and development of new training opportunities to SMVF in rural locations, inclusive of QPR (Question, Persuade, Refer) firearm training, OHA approved Peer Support Specialist 40-hour training, OHA approved Peer Wellness Specialist 80-hour training
- Addressing barriers to DUII screening and DUII education for veterans and service members
- Support of the United States Department of Veterans Affairs/Rocky Mountain MIRECC Together with Veterans Suicide Prevention Program in Northwest Oregon
- Increased collaboration with other state agencies such as Oregon Department of Veterans' Affairs to support LGBTQ+ Veterans Villages at community Pride events; Oregon Judicial Department to represent veteran and military behavioral health in strategic planning sessions specific to Veteran Treatment Courts (VTC) in Oregon.