2020-2025

OREGON STATEWIDE STRATEGIC PLAN

Alcohol and Drug Policy Commission

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LETTER FROM THE ALCOHOL AND DRUG POLICY COMMISSION

Dear Oregonian,

The increasing number of individuals with substance use conditions has enormous health, fiscal, and human costs. Substance misuse affects people from all walks of life and age groups. These chronic illnesses are common, recurrent, and often serious, but they are treatable, and many people recover. However, without an effective, accountable, and sustainable system, jails, prisons, and the streets become the proxy treatment delivery system. We must create a system that diverts individuals who struggle with substance use conditions away from jails and prisons and toward more appropriate and culturally competent, community-based treatment and recovery programs. Prevention, early intervention, treatment, and recovery supports must be essential components of our state's strategy to provide people the supports they need and eliminate unnecessary involvement in non-recovery settings.

Oregon, like much of the rest of country, needs system transformation. Under the leadership of Governor Kate Brown, the Alcohol and Drug Policy Commission (ADPC) is working to improve of the effectiveness and efficiency of state and local alcohol and drug misuse prevention and treatment services. In part to achieve these goals, the ADPC, along with our state agency partners, adopted a comprehensive strategic plan, pursuant to ORS 430.242. The plan seeks to identify:

1. *Processes and resources to create, track, fund, and report on strategies for systems integration, innovation, and policy development*
2. *Strategies to reduce Oregon's substance use disorder (SUD) rate, including preventing SUD and promoting recovery*
3. *Strategies to reduce morbidity and mortality related to SUD*

When fully implemented, the plan will sustain system transformation. This strategic plan will be the state's blueprint for saving lives. System transformation is not an inexpensive or easy undertaking; it requires the commitment and will to accomplish the greatness that is Oregon.

Sincerely,

Reginald C. Richardson, PhD, ACSW, LCSW
Executive Director

Judge Eric J. Bloch
Chair

State Strategic Planning Subcommittee Members

Anthony Jordan, Chair; Alcohol and Drug Policy (ADP) Commissioner

Dr. Brad Anderson, ADP Commissioner

Anthony Biglan, Ex-Officio ADP Commissioner

Brent Canode, ADP Commissioner

Dr. James Davis, Oregon Disabilities Commission; Older Adult-People with Disabilities Behavioral Health Advisory Council

Nate Gaoiran, ADP Commissioner

Karen Girard, Oregon Health Authority

Heather Jefferis, Oregon Council for Behavioral Health

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Jackie Mercer, Native American Rehabilitation Association of the Northwest

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Oregon Department of Corrections: Dawnell Meyer

Oregon Department of Business and Consumer Services: Lou Savage, Richard Blackwell

Oregon Department of Housing and Community Services: Margaret Salazar, Connor McDonnell

Oregon State Police: Colonel Travis Hampton, Major Alex Gardner

Oregon Lottery: Barry Pack

Oregon Liquor Control Commission: Steven Marks, Peter Noordijk

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EXECUTIVE SUMMARY

Background

Oregonians experience one of the highest rates of substance use and substance use disorders (SUDs) in the nation, and the personal and financial costs are enormous. On average, four Oregonians die every day from alcohol and other drug (AOD) use and countless more experience significant health and social problems. State spending on substance more than quadrupled since 2005—consuming nearly 17% of the entire state budget in 2017. Less than 1% of those funds, however, were used to prevent, treat, or help people recover from substance misuse. The majority of those dollars went to pay for escalating health and social consequences created by the lack of investment in prevention, treatment, and recovery.

The causes of substance misuse are complex and deeply rooted in an array of intertwined biological, social/cultural, and historical factors such as genetics, norms, trauma, and socio-economic inequity. Structural factors also play a significant role. These include laws and policies that facilitate access to psychoactive substances but penalize addiction; social norms that stigmatize addiction as a behavior choice rather than a medical condition that requires ongoing management and treatment; deeply divergent viewpoints of practitioners across primary care, public and behavioral health, criminal justice, and other professions; and deeply siloed efforts of agencies charged with addressing this public health crisis.

Over the past decade, scores of reports, studies, and white papers, as well as hundreds of findings and recommendations, have been produced in Oregon to address different aspects of this crisis, but very little action has been taken.[1] And while the information collected so far has underscored **what is not working well,** information on **why things are not working well** has often been anecdotal or missing. This strategic plan is not another report; rather, it builds on and supplements the information that already exists to identify and address the primary structural and other factors that have impeded Oregon's ability to prevent, treat, and help its people recover from substance misuse and SUDs. In doing so, it identifies several priority strategies and activities but differs from previous efforts in several ways:

- It commits to measurable improvements in key health, social, and economic indicators and establishes processes for monitoring and publicly reporting progress:
  - Reduce the prevalence of SUDs and increase recovery
  - Reduce deaths from ATOD use and misuse
  - Reduce ATOD-related health disparities
  - Reduce the economic burden of substance-use-related health and social problems
- It establishes processes for coordinating state agency efforts; breaking down siloes; and strengthening state leadership, capacity, and use of effective practices.
- It includes implementation and evaluation information for strategies and activities (e.g., roles, timelines, process and outcome indicators).
- It establishes a process for state budget forecasting, a baseline for current state spending, and processes for monitoring changes in spending and reinvesting cost savings over time.

1 Appendix H contains a list of documents that were referenced during the creation of this strategic plan.

INTRODUCTION

Inadequate data infrastructure, combined with a lack of systems and processes for assessing needs and evaluating outcomes, means that some key information needed to fully address Oregon's substance misuse crisis remains missing. A summary of key questions and how this plan provides processes to collect answers and implement solutions are summarized below.

Who needs SUD treatment and recovery in Oregon? There are no state data sources that adequately capture this information, and information on those who do receive treatment and recovery services is very limited. National estimates placed the number of Oregonians who needed but did not receive treatment somewhere between 266,000 to 362,000 (or 7.6% to 10.4% of all Oregonians) in 2016-2017 but provided no geographic or demographic characteristics. And while national estimates indicate that Oregonians ages 18-25 have twice the prevalence rate of SUDs of all other age groups, the state's formerly robust system of student assistance programming, which could have served as a data source for estimating needs and providing early intervention among youth, no longer exists. In addition, only a quarter of Oregon's public institutions of higher education collect data on student substance misuse.[2] Employee assistance programs (EAP), which could be another key partner in efforts to identify those in need to treatment or recovery supports, have been largely untapped.

How will the plan ensure Oregon can identify those in need of treatment and recovery and connect them to it? This plan outlines strategies for strengthening, rebuilding, and creating new state and local data infrastructure and significantly improving communication, information sharing, and coordination between the key state agencies that administer and fund treatment and recovery services as well as their funding recipients. This includes establishing an interagency data workgroup, enhancing utilization of existing survey and other data collection and analysis processes, strengthening state agency data collection and reporting requirements for funding recipients, and expanding partnerships to supplement existing data. The plan also includes strategies for increasing access and decreasing barriers through enhanced assessment and early intervention; improved case management; and expanded use of peer mentors, liaisons, and other types of system navigator/intermediary supports.

What kinds of treatment and recovery support are needed? The types of treatment and recovery support required for a robust system include individualized early intervention, outpatient, intensive outpatient /partial hospitalization, residential/inpatient, and medically managed intensive inpatient, as well as detox, medication-assisted treatment (MAT), harm reduction, and access to basic needs, such as transportation, housing, employment, and childcare. Identifying the types, levels, and numbers of services needed to increase treatment and to promote recovery for those involved in the correctional system is relatively straightforward because intake and release procedures involve screening and assessment. Identifying the services needed for others, however, will require enhanced data collection, screening, and assessment through the strategies outlined in this plan.

How much will the needed scale of prevention, treatment, and recovery supports cost? Oregon is currently spending an estimated $6.7 billion in state dollars on issues related to substance misuse, but less than 1% of that funding is used to prevent misuse, treat, or help people recover from SUDs. The rest goes to pay for the cost of social and health problems related to substance misuse and regulation and compliance with laws governing the sale and use of substances. This plan lays out a process for state agencies to create an omnibus budget in 2020 that estimates the scope, scale, and cost of services needed through 2023, then annually update and refine the budget as better data

2 Higher Education Coordinating Commission. (December 2018). *Task force on student mental health*. https://www.oregon.gov/highered/research/Documents/Legislative/SB-231-Mental-Health-Task-Force.pdf

become available. The plan also calls for increasing investment in the most critical areas of prevention, treatment, and recovery for the most vulnerable populations first, then working farther "upstream" in future years to promote health and to prevent new problems from arising.

How will funding be secured? Some strategies are already underway to significantly increase treatment resources. For example, the Oregon Health Authority (OHA) is applying for a Medicaid Section 1115 demonstration waiver which would allow that funding to pay for all residential facilities, as well as for prevention, outreach, and recovery support. OHA is also strengthening requirements that Coordinated Care Organizations (CCOs) more fully implement the behavioral health benefit. This plan builds on those strategies by laying out processes for maximizing existing resources, quantifying new investments of state funding that are needed, and identifying potential funding sources. Maximizing existing resources includes enhancing insurance coverage, shifting funding from services and programs that aren't demonstrating value to those that have documentation of effectiveness, improving coordination and service referral between agencies, and maximizing federal funding opportunities. Quantifying new state investments includes constructing an omnibus budget to identify funding shortfalls, considering new sources of revenue (e.g., increased excise taxes, reallocating marijuana and alcohol revenues), and tracking and reinvesting cost savings from reductions in economic burdens caused by social and health problem due to substance misuse.

What needs to be done to eliminate health disparities due to substance misuse? Research is clear that some population subgroups are at much higher risk for substance misuse and SUDs. These include persons of color; rural residents; the LGBTQ+ community; older adults; persons with disabilities; and those experiencing homelessness, with low income or low education, and otherwise adversely impacted by social determinants of health. Gender is also a factor. The strategies identified in this plan, which draw upon previous reports, research, and feedback from stakeholders across the state, include the following: ensuring access to culturally tailored prevention, treatment, and recovery services; ensuring that services and intake processes are linguistically accessible; broadening access points to services by partnering with non-traditional collaborators (e.g., schools, employers, barber shops); increasing access to non-traditional services (e.g., alternative pain management [APM], cultural healing practices); increasing family support and inclusion in services; increasing access to basic resources; and reducing stigma.

How do we prevent substance misuse and SUDs in the first place? The prevention strategies in this plan target factors that Oregon data and research indicate are the most closely associated with substance misuse across the life span, including for those at highest risk. These strategies and activities include more investment in increasing access to family- and school-based intervention programs; decreasing the availability and excessive marketing of harmful products; reducing retail and social access to psychoactive substances for underage persons; increasing perception of harm (particularly among older adults who may be mixing alcohol with prescription and other drug use); decreasing over service of alcohol in restaurants and bars, as well as retail sales of alcohol to those who are impaired; increasing the use of health-promoting laws and policies; strengthening the use of effective early intervention and harm reduction strategies, including Kindergarten-postsecondary student assistance programming and EAP; increasing access to alternative pain and stress management therapies (APSM); and strengthening and expanding the prevention workforce.

Approach and Principles

Key principles that guided this planning process are summarized in the table below. Another key principle is the intentional integration of intervention and harm reduction in the prevention, treatment, and recovery strategies and activities identified by the plan. **Intervention** describes strategies that can be used for a range of purposes, from intervening early in harmful substance use before a SUD develops to helping individuals with SUDs access treatment and needed resources. **Harm reduction** is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. "Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use substances."[3] Intervention and harm reduction are embedded throughout the plan, along with a focus on ensuring equitable, culturally, linguistically, and gender-specific services.

Impactful	The plan identifies significant reductions in substance-use-related problems and disparities in the next five years and establishes benchmarks for monitoring progress.
Data-Based	Strategies and activities are based on objective, reliable, and representative data.
Comprehensive	Strategies to accomplish goals, objectives, and outcomes encompass prevention, treatment, and recovery support.
Sequenced	Strategies and activities address the most critical needs first to stabilize the crisis, then provide for working further "upstream" in coming years.
Strategic	Strategies and activities are matched to readiness to achieve early successes, which can be used to increase readiness for future policy, practice, and program change.
Actionable	Roles, responsibilities, and timelines for initial strategies and activities are identified.
Measurable	Process and outcome measures and benchmarks have been identified to monitor progress.
Aggressive	Plan implementation will require significant commitment from many state and local partners.
Ongoing	The plan is designed to be a "living" document that is continuously reviewed and updated to reflect changing needs and circumstances.

The major activities used to develop this plan are detailed in appendices to this report; this overview lays out the core methodology and planning principles that were used to develop core goals and objectives.

From the outset, the planning approach used data-driven processes to avoid common pitfalls of planning (Appendix C). These included:

- Approaching substance misuse as a complex issue that requires comprehensive solutions coordinated across multiple sectors
- Identifying the primary contributors to ATOD-related problems before jumping to strategies and activities
- Selecting strategies and activities that have the greatest documentation of effectiveness for priority populations and substances

3 Harm Reduction Coalition. (n.d.). *Principles of harm reduction.* https://harmreduction.org/about-us/principles-of-harm-reduction

Throughout the planning process, policy, program, and needs assessment findings were combined with partner and stakeholder input (Appendix D) to identify and map the relationships between:

- ATOD-related problems
- The human and system actions that contribute most to problems related to substance misuse
- The factors and variables that drive the actions that result in problems related to substance misuse

Understanding these relationships enabled planning partners to identify meaningful and measurable impacts and associated goals, objectives, and outcomes ***first*** to ensure that all strategies and activities subsequently identified in the plan would best achieve desired results.

The planning process also used a systems approach to problem solving by recognizing that substance misuse in Oregon is a complex syndemic[4] that is rooted in factors that span multiple disciplines and sectors. This systems approach to planning has involved engaging the partnership and commitment of a continuously expanding number of state agencies and regional and local stakeholders.

4 The term syndemic, which was introduced by medical anthropologist Merrill Singer in the 1990s, is used as a conceptual framework for understanding and addressing the complex health and social issues that arise when two or more problems interact. Syndemics—which are exacerbated by social, economic, environmental, and political inequities—create more burden of harm than the sum of the separate issues that give rise to them.

Section I: Coordinated State System

Vision, Mission, Values, and Approach

Vision: A comprehensive, statewide system where substance misuse policies, investments, and efforts support healthy Oregonians and thriving communities

Mission: Provide data-informed, integrated prevention, treatment, and recovery support services through public and private partnerships using equitable and culturally, linguistically, and gender-specific services

Values: Compassion, equity, transparency, and well-being

Approach: Work in partnership with communities to:

- Reduce the number of Oregonians living with SUDs
- Reduce the number of Oregonians who die from ATOD use
- Reduce ATOD-related health disparities in Oregon

State System Partners

Oregon ADPC, Convener

Oregon Health Authority
Oregon Department of Human Services
Oregon Department of Education
Youth Development Division
Higher Education Coordinating Commission
Oregon Youth Authority
Oregon Department of Consumer and Business Services
Oregon Department of Corrections
Oregon Liquor Control Commission
Oregon Lottery
Oregon Department of Housing and Community Services
Oregon Department of Transportation
Oregon State Police
Oregon Health and Sciences University

Section II: Ultimate Impacts

The following pages describe the ultimate health, social, and economic impacts that will be achieved in the next five years through the implementation of this plan:

- Reduce SUDs and increase recovery
- Reduce ATOD-related deaths
- Reduce ATOD-related health disparities
- Reduce the economic burden of substance misuse in Oregon

Each impact includes a dashboard of measures and associated data sources that will be tracked and publicly reported on an ongoing basis to monitor progress toward the goals and objectives identified in Section III of this plan. The information collected through this process will be used to adjust strategies and activities, as needed, to ensure all outcomes are met or exceeded.

As outlined in Goal 1, ADPC will lead an effort to regularly communicate to stakeholders and decision makers how state resources are being used to prevent substance misuse and to treat and promote recovery from SUDs, as well as progress toward the outcomes identified in this plan. This will involve:

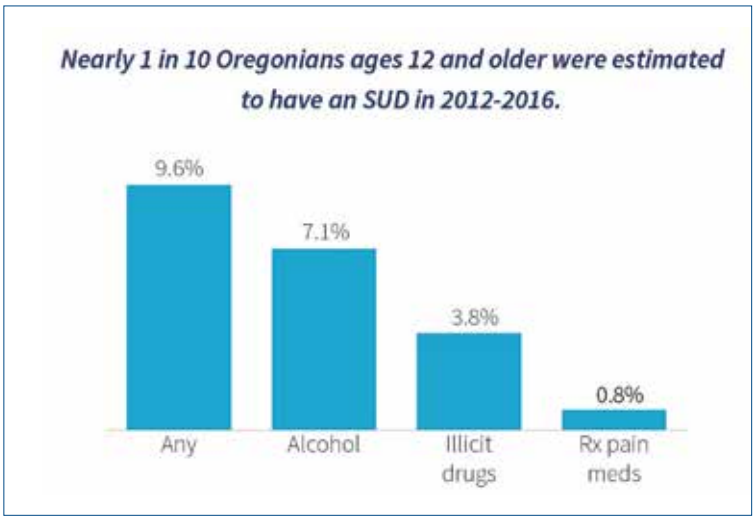
- Assigning responsibility for monitoring and reporting the process and outcome measures identified in this plan to the appropriate state agencies
- Collecting and compiling data from state agency partners on a regular basis
- Convening quarterly meetings to review progress, adjust strategies and activities, and plan implementation, as needed
- Creating and disseminating an annual report of progress
- Providing ongoing opportunities for input and feedback from stakeholders

Impact 1: Reduce Substance Use Disorders and Increase Recovery

Nearly **one in ten** of all Oregonians ages 12 and older—and **one in five** young Oregonian adults ages 18-25—are estimated to have an SUD. [5]

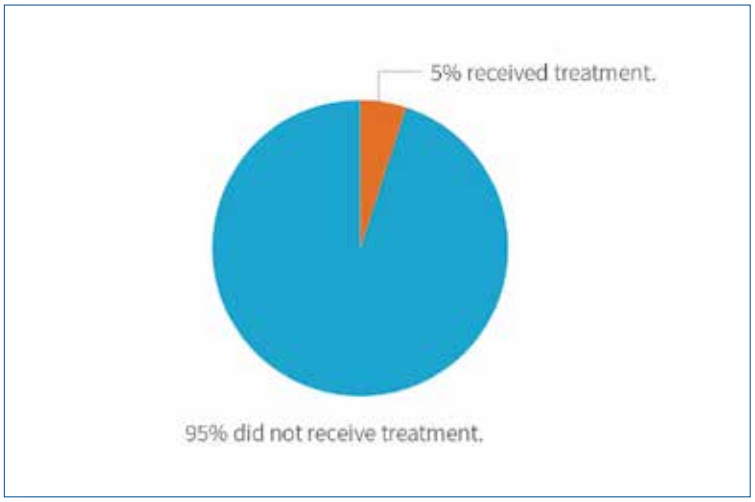
Alcohol use disorder (AUD) is the most common type of SUD—impacting 7% of all Oregonians—followed by illicit drug use disorders (3.8%), and pain reliever use disorders (0.8%). While the SUD rate in Oregon decreased slightly in recent years, the percentage of Oregonians estimated to have an AUD increased in every age group.[6]

In 2016-2017, 329,000 Oregonians were estimated to need treatment for SUD; of these, 250,000 were estimated to need AUD treatment. During that period, however, only 5%—approximately 18,000 people—in need of any kind of SUD treatment received it.[7]



There are multiple, complex, and intertwined reasons for Oregon's high rates of SUDs. Reducing SUDs significantly in the next five years is absolutely achievable but will require accomplishing the following:

- **Reducing the number of new cases of SUDs,** which includes dramatically reducing underage use
- **Increasing access to effective treatment** to help those struggling with SUDs move into recovery
- **Increasing retention in recovery** by increasing access to recovery supports



This plan complements and coordinates with other multidisciplinary planning efforts to reduce SUDs, including the Governor's Behavioral Health Advisory Council, the Governor's Opioid Epidemic Task Force, and Oregon Health Authority's Retail Marijuana Scientific Advisory Committee. The following two pages provide perspectives on SUD from one stakeholder in the field, as well as the long-term outcomes that will be monitored to measure success in reducing SUDs across the state.

5 U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA). (2017). 2016-2017 *National Survey on Drug Use and Health (NSDUH): Model-based prevalence estimates. (50 states and District of Columbia). Table 23.* https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/ NSDUHsaePercentsExcelCSVs2017/NSDUHsaePercents2017.pdf, p. 47

6 U.S. HHS, SAMHSA. (2017). *Table 22,* p. 45.

7 U.S. HHS, SAMHSA. (2017). *Table 26,* p. 53.

Voices from the Field
It's important to note that this plan was developed not only through careful analysis of existing data, studies, and reports, but also through the **professional expertise, lived-life experiences, and insights offered by hundreds of Oregonians across the state.** Some of their stories and perspectives are provided throughout the plan in special profiles to highlight key issues, provide real life insights into what Oregon's epidemic looks like on the ground, and offer solutions and examples of success.

Voices from the Field

J. MILES *sent an email when an online stakeholder survey developed for the planning process didn't include a category for the LGBTQ+ population. After recounting the oppression and trauma experienced by this community—and the disproportionate impact of SUDs it experiences—he wrote: "I understand that the survey has a field for 'other,' but I have been treated as 'other' throughout my life, as have many members of my community. I feel it is no longer acceptable to relegate us to 'other' in this day and age." The omission in the survey was inadvertent and quickly rectified, but that email marked the beginning of many remarkably candid and illuminating conversations.*

When asked for his preferred title, Miles eventually settles on "survivor, provider, and advocate." In addition to his work at a men's shelter, Miles is also a student at Portland State University (PSU), set to graduate in May 2020 with a bachelor's degree in social work. After some time off, he intends to pursue a master's degree in either social work or public administration. Miles says that growing up gay in a conservative Mormon household wasn't always the most supportive or accepting environment. For that reason and others, he began to use alcohol and cannabis to self-medicate starting his second year of high school. Miles says the drinking especially began to get out of control, and one night at a party a friend suggested going to see a man with "something to help sober him up" before driving home to his family who would have been upset about his drunken state. That something was crystal meth. "Six months after that, I lost my first job," he recounts. Miles spent the next 12 years going through treatment, attending 12-step meetings, going back to drinking, ending up back on meth and then back into treatment. "The cycle would repeat over and over," he said, noting the shame and stigma he felt after each relapse. "I didn't know I was sick," he recalls, "I thought I was badly behaved." It wasn't until the age of 30 that he found a way to break the cycle. In a drunk and depressed state, he had an accident changing the blade on his razor and sliced through his fingertip. Upon seeing the blood in the sink, he was struck with the terrible realization that he was, once again, on the path to losing everything. This time though, he was unwilling to see that happen. He'd built a life he loved. He went back to the 12-step program but found that this time it wasn't working for him. In desperation, he turned to the Internet. In a matter of minutes, he says, he found something that changed his life forever—Naltrexone. Also known as Vivitrol, Naltrexone is a medication used to manage alcohol and/or opioid dependence. It was approved by the Food and Drug Administration the year Miles was born. "I was so angry," he says, "because I'd spent 12 years with no one ever telling me about this treatment." Miles says his doctor didn't even initially know he could prescribe it and that some doctors still don't

When Miles began medication assisted treatment, he came to understand that he had an illness, not a behavior problem.

know how it works, which he considers “mind boggling.” As soon as he took his first dose of Naltrexone, he felt able to control his alcohol consumption for the first time. With MAT, he also began to understand that what he had was a medical condition, not bad behavior. “The first time I heard that,” he says, “It was so clear and made so much sense to me.” “I credit MAT with allowing me to break the cycle of addiction in my life,” he notes, “yet there are some people who say that’s not real recovery.” While he finds that incredibly frustrating he says, “I have come to realize that even when my anger is justified, nobody is ever won over by being attacked.” Instead, he does his best to confront ignorance with information. He says that comes out of his slow and ongoing transformation from “being angry to being a person of compassion.” “While everyone has different ideologies,” he says, “I try to remember that we all have common ground, that what we want is the same thing—to see people stop dying from SUDs, to see people living their best lives.” And while Miles’ path was ultimately MAT, he understands that everyone is different. He sees room for multiple approaches, such as 12-step programs or court-mandated treatment, the latter of which he credits with saving the life of his brother. “The more tools we have to fight this condition, the better.” Miles’ outlook on his years prior to discovering MAT is equally remarkable. Having spent his late teens and twenties in and out of addiction, he never anticipated going back to school. “I thought that ship had sailed for me.” Now, he calls that period of his life “research.” He says working at the shelter is “an absolute privilege,” adding, “but so many people shouldn’t be in a shelter; they should be in treatment.” He notes that the stress of being in a shelter is itself a trigger for substance use. “I try to connect them with resources,” he says of the clients he serves, adding that “while most of my job is absolutely wonderful, it’s difficult to see people come in and begin getting their life together but then sometimes spiral back into relapse. Ideally, they would have access to detox, treatment, and supportive housing, but they often don’t and they lose their drive.” He estimates that the vast majority of people he sees relapse would go to treatment but can’t because of a lack of resources. He would also like to see more recovery support on college campuses, such as his own. After learning about the collegiate recovery community at Oregon State University, he discovered PSU offers little in the way of on-campus support for students in recovery. “Last year I was really struggling,” he recalls, “and it would have been amazing to have resources there.” Miles is pleased to note that PSU has since received a grant to develop its own collegiate recovery program and proud that his husband, a doctoral candidate at Concordia University, has picked collegiate recovery programs for the topic of his dissertation.

IMPACT 1: Reduce Substance Use Disorders	Benchmarks	
	2022	2024
Decrease the percentage of Oregonians with a SUD from **9.4%** in 2016-2017 to **6.8% or less** by 2025[8]	8.5%	7.0%

The measures below will be targeted and tracked to monitor progress toward reducing SUDs.

Impact 1 Dashboard		
RECOVERY Outcomes - All Ages	Benchmarks	
	2022	2024
Increase the percentage of Oregonians ages 12+ in recovery from SUD from **9.1%** in 2017 to **11.4% or more** by 2025[9]	9.9%	10.6%
TREATMENT Outcomes - All Ages	Benchmarks	
	2022	2024
Increase the percentage of Oregonians who receive needed SUD treatment from **5.0%** in 2016-2017 to **10% or more** by 2025[10]	7%	9%
PREVENTION Outcomes - Youth	Benchmarks	
	2022	2024
Decrease past 30-day alcohol use[11]	10.9%	10.5%
• 8th graders from **11.3%** in 2019 to **10.2% or less** by 2025		
• 11th graders from **24.3%** in 2019 to **21.8% or less** by 2025	23.5%	26.8%
Decrease past 30-day binge drinking[12]	4.5%	4.4%
• 8th graders from **4.7%** in 2019 to **4.2%** or less by 2025		
• 11th graders from **12.8%** in 2019 to **11.5%** or less by 2025	12.3%	11.8%
Decrease past 30-day marijuana use[13]	7.5%	7.2%
• 8th graders from **7.8%** in 2019 to **7.0%** or less by 2025		
• 11th graders from **20.4%** in 2019 to **18.4%** or less by 2025	19.8%	19.0%
Decrease past 30-day prescription drug misuse[14]	5.7%	5.5%
• 8th graders from **5.9%** in 2019 to **5.3%** or less by 2025		
• 11th graders from **4.8%** in 2019 to **4.3%** or less by 2025	4.6%	4.4%
Decrease AOD-related suspensions/expulsions for K-12 students from **1.2% of students** in 2017-2018 to **1.0 %** by 2025[15]	N/A	1.1%
PREVENTION Outcomes - Ages 18+	Benchmarks	
	2022	2024
Decrease past 30-day heavy drinking from **8.7%** in 2018 to **7.8%** or less in 2024[16]	8.3%	N/A
Decrease past 30-day binge drinking from **17.4%** in 2018 to **15.7%** or less in 2024[17]	16.6%	N/A
Decrease past 30-day use of illegal drugs from **4.7%** in 2016-2017 to **4.2%** or less in 2025[18]	4.6%	4.4%
Decrease past year methamphetamine use from **1.1%** in 2016-2017 to **.99%** or less in 2025[19]	N/A	1.0%

8 U.S. HHS, SAMHSA. (2017). NSDUH collects data annually but uses a weighted sample which is averaged over two years, so the period for this measure will be 2025-2026. The goal of 6.8% represents moving from among the last in the nation to the mid-point
9 U.S. HHS, SAMHSA. (2017).
10 U.S. HHS, SAMHSA. (2017).
11 Oregon Health Authority (OHA). (2019). *Oregon Healthy Teen Survey*. https://www. oregon.gov/oha/PH/BirthDeathCertificates/Surveys/OregonHealthyTeens/Pages/index.aspx
12 OHA. (2019)
13 OHA. (2019)
14 OHA. (2019)
15 Oregon Department of Education. (2019). *School discipline, bullying, restraint and seclusion. 2017-2018 Discipline data media.* https://www.oregon.gov/ode/students-and-family/healthsafety/Pages/School-Discipline,-Bullying,-Restraint-and-Seclusion.aspx
16 OHA. (n.d.-1). *Adult Behavioral Risk Survey (Behavioral Risk Factor Surveillance System [BRFSS])*. https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/SURVEYS/ADULTBEHAVIORRISK/Pages/brfsdata.aspx
17 OHA. (n.d.-1)
18 U.S. HHS, SAMHSA. (2017).
19 U.S. HHS, SAMHSA. (2017).

Impact 2: Reduce ATOD-Related Deaths

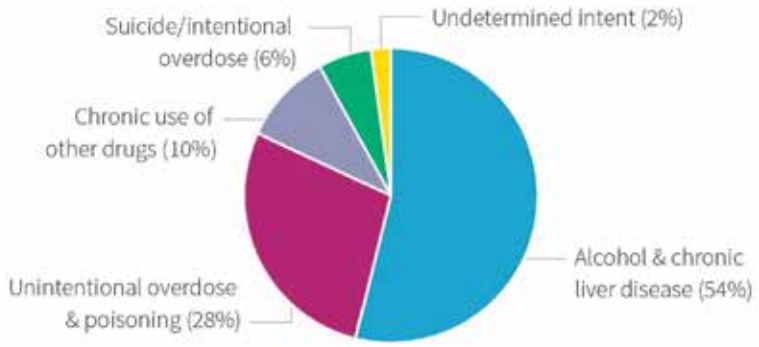
On average, **at least 26 Oregonians died every day** in 2017 due to ATOD misuse.

Tobacco use was linked to the deaths of 7,843 Oregonians in 2017, which comprised 21.4% of all deaths that year. Another 8,744 deaths in 2017 (23.9%) were potentially linked to tobacco.[20]

Alcohol misuse was the second leading cause of death: 522 Oregonians died from chronic alcoholic liver disease, while another 316 died from other alcohol-induced deaths in Oregon. Alcohol, in combination with other drugs, resulted in additional deaths due to unintentional injuries, suicides, and other causes. From 1998 to 2017, the rate of alcohol-induced deaths has nearly doubled from 11.6 per 100,000 to 21.2 per 100,000.[21]

A sharp increase in methamphetamine use in recent years is another leading cause of death. The number of fatalities due to methamphetamine use in Oregon rose more than 400% from 50 deaths in 2009 to 271 deaths in 2018.[22, 23]

1,549 deaths in Oregon in 2017 were due to alcohol or other drugs.



It should be noted that because of differences in how death data are collected and reported, these numbers only reflect confirmed deaths due to ATOD use. Actual numbers may be much higher.

The actions in this plan complement and coordinate with other multidisciplinary planning efforts to reduce SUDs, including the State Health Improvement Plan (SHIP) developed by the OHA in partnership with multiple agencies and stakeholders. Behavioral health, which includes mental health and substance use, has been identified as one of five priorities in the 2020-2024 SHIP.

The following two pages provide perspectives on SUDs from one stakeholder in the field and the long-term outcomes that will be monitored to measure success in reducing ATOD-related deaths across the state.

20 Oregon Health Authority. (2017). *Oregon vital statistics. Annual report. Vol 2. Table 6-19.* https://www.oregon.gov/OHA/PH/BIRTHDEATHCERTIFICATES/VITALSTATISTICS/ANNUALREPORTS/VOLUME2/Documents/2017/Table619.pdf, p. 6-88
21 OHA. (n.d.-2). *Annual Report. Vital statistics.* https://www.oregon.gov/oha/PH/BirthDeathCertificates/ VitalStatistics/AnnualReports/Pages/index.aspx
22 OHA. (n.d.-2).
23 The word tobacco, as used in this plan, includes all forms of tobacco and nicotine products.

Voices from the Field

BLUE VALENTINE *attended the Regional Stakeholder Meeting in Salem as a service provider, then came back to attend the Salem Town Hall meeting later that night to speak as a person with lived experience. As a Harm Reduction Specialist with the Benton County Health Department, she was passionate about her work and highly invested in making sure those involved in developing Oregon's statewide strategic plan understood the critical importance of including strategies and policies that lessen the social and health consequences of substance use. After those meetings, she agreed to share additional experiences and insights.*

Valentine underscored the role of harm reduction across prevention, treatment, and recovery, including for those who may use substances but not have an SUD, are on waiting lists for treatment, and/or might otherwise fall through the cracks. She notes that realistic, fact-based education that doesn't involve scare tactics is an important harm reduction strategy for prevention, adding that harm reduction programs are a bridge to services, including treatment, and engage people who use drugs in care. Harm reduction strategies also keep those who are using drugs as healthy as possible by reducing the unintended consequences of drug use. As a person in long-term recovery for over 22 years, Valentine notes: "Thanks to harm reduction programs, I was able to use a new needle every time I injected; when I stopped using drugs, I could focus on recovery rather than other health issues. Harm reduction programs also gave me the support I needed to stop using drugs." Valentine also feels that harm reduction in treatment, which includes providing MAT, stabilizes people and can eliminate risk of disease transmission for people who inject drugs. She adds that many providers don't understand MAT, however. In a harm reduction framework, she says, providers would not kick patients out of MAT programs for using other substances. When a person relapses, s/he should be embraced, not cut off from services. She believes MAT is recovery, and people should be allowed to take different paths to recovery. Valentine points out that the Substance Abuse and Mental Health Services Administration's (SAMSHA) definition of recovery doesn't mention abstinence anywhere; instead it focuses on improvements in health and wellness, which she terms "pretty great." Much of Valentine's work in Benton County consists of street outreach, HIV and hepatitis C rapid testing and education, and needle exchange services. One of the most important components of harm reduction for her work is disease prevention and preventing overdoses, but she says it's also important that clients feel seen and heard. Another component of her work is changing perspectives on people who use drugs. She says "When people get overwhelmed and don't have coping skills, they use drugs. Trauma history is often a factor. Drug use is sometimes the symptom, not the problem." To address the root of Oregon's drug problem, Valentine notes that many things need to change systemwide. This includes addressing the critical lack of access to treatment, and the fact that there are no detox facilities in Benton County. One of the most important things Valentine may do, however, is validate the dignity and humanity of those she serves. "People doing drugs often don't have support systems, or anyone who isn't judging them. We need to walk alongside them and support them. If people are using drugs, harm reduction means we still help them because their lives are worth saving."

"When people get overwhelmed and don't have coping skills, they use drugs. Trauma history is often a factor."

"People doing drugs often don't have support systems, or anyone who isn't judging them. We need to walk alongside them and support them." Valentine adds "If people are using drugs, harm reduction means we still help them because their lives are worth saving."

IMPACT 2: Reduce ATOD-related Deaths	Benchmarks	
	2022	**2024**
Decrease the rate at which Oregonians die from ATOD misuse	See below	

The measures below will be targeted and tracked to monitor progress toward reducing ATOD-related deaths.

Impact 2 Dashboard		
Outcomes - All Ages[24]	Benchmarks	
	2022	**2024**
Decrease the rate at which Oregonians die from chronic alcoholic liver disease from **10.3** per 100,000 in 2017 to **10.1 or less per 100,000** by 2025	N/A	10.2
Decrease the rate at which Oregonians die from other alcohol-related causes from **39.8** per 100,000 in 2017 to **36.0 or less per 100,000** or less by 2025	38.8	37.5
Decrease the rate at which Oregonians die from drug overdoses (total) from **12.1** per 100,000 in 2017 to **10.8 or less per 100,000** or less by 2025	11.7	11.1
Decrease the rate at which Oregonians die from drug overdoses (unintentional) from **10.0** per 100,000 in 2017 to **9.0 or less per 100,000** or less by 2025	9.7	9.3
Decrease the rate at which Oregonians die from drug overdoses (suicides) from **2.1** per 100,000 in 2017 to **1.8 or less per 100,000** or less by 2025	2.0	1.9
Decrease the rate at which Oregonians die of tobacco- related causes from **148.3** per 100,000 in 20178 to **138.3 or less per 100,000** in 2025	145.3	141.3
Outcomes – Youth[25]	Benchmarks	
	2022	**2024**
Decrease past 30-day cigarette smoking	2.5%	2.4%
• 8th graders from **2.6%** in 2019 to **2.3% or less** by 2025 • 11th graders from **4.9%** in 2019 to **4.4% or less** by 2025	4.8%	4.6%
Decrease past 30-day use of any tobacco products (including vaping products):	10.2%	9.9%
• 8th graders from **10.5%** in 2019 to **9.5% or less** by 2025 • 11th graders from **21.4%** in 2019 to **19.3% or less** by 2025	20.6%	20.0%
Outcomes – Adults[26]	Benchmarks	
	2022	**2024**
Decrease past 30-day heavy drinking by Oregon adults ages 45+ from **7.8%** in 2018 to **7.2% or less** by 2024	7.6%	N/A
Decrease reported rates of past 30-day binge drinking by Oregon adults ages 45+ from **9.9%** in 2018 to **9.2% or less** by 2024	9.7%	N/A
Decrease past 30-day cigarette smoking among adults ages 18+ from **16.3%** in 2018 to **15.3% or less** by 2024	15.9%	N/A
Decrease past 30-day e-cigarette use by adults ages 18+ from **6.0%** in 2018 to **5.7% or less** by 2024	5.9%	N/A

24 OHA. (n.d.-2).
25 OHA. (2019).
26 OHA. (n.d.-1)

Impact 3: Reduce ATOD-Related Health Disparities

Populations in Oregon which are **disproportionately impacted** by ATOD-related disparities also tend to be **significantly underserved**.

Vulnerable and historically underserved populations include communities of color; tribal citizens; rural Oregonians; the LGBTQ+ community; older adults; persons with disabilities; and people experiencing homelessness, with low income and/or low education, and otherwise adversely impacted by social determinants of health. Gender is also a factor. While two-thirds of ATOD-related deaths in Oregon occur among males, more than half of all intentional overdoses and suicides occur among females.

Oregonians ages 55-64 have the highest rates of ATOD-related deaths, and while White Oregonians comprise most ATOD-related deaths, Native Americans die at more than twice their rate.[27]

Social Determinants of Health

Social determinants of health are **economic and social conditions that influence the health of people and communities.** These conditions are shaped by the amount of money, power, and resources that people have, all of which are influenced by policy choices. Social determinants of health affect factors that are related to health outcomes. (U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2019).*

* Frequently asked questions. https://www. cdc.gov/nchhstp/socialdeterminants/faq.html

Differences in Health Outcomes among Counties and for Racial/Ethnic Groups in Oregon

Outcome	Healthiest County	Least Healthy County	American Indians/Alaska Natives	Asian/ Pacific Islander	Black	Hispanic	White
Premature Death (years lost/100,000)	4,100	9,200	8,900	3,500	8,800	4,000	6,300
Poor or Fair Health (%)	12%	17%	20%	11%	N/A	26%	14%
Poor Physical Health Days (avg)	3.4	4.3	4.4	2.4	N/A	3.8	3.8
Poor Mental Health Days (avg)	3.6	4.4	7.0	3.3	N/A	4.1	4.6

Measuring the impact of ATOD-related disparities on many higher risk populations is challenging, particularly when numbers are small or populations are hard-to-reach. Differences in health outcomes in Oregon are vast, however, as illustrated above.[28] Stakeholders at an August listening session on cultural issues held for the planning effort cited many issues impacting access to services, including a lack of services that are culturally tailored for different populations (e.g., age, race/ethnicity, gender, disability, LGBTQ+), language barriers, service models that exclude family participation, discrimination and stigma, cultural norms that preclude seeking assistance, burdensome or bureaucratic intake processes, trust issues, and a lack of access to needed resources (e.g., housing, food, transportation, employment, childcare).

The actions in this plan complement and coordinate with other planning efforts to reduce SUDs, including the Tribal Behavioral Health Strategic Plan, the 2018 Statewide Housing Plan, the Oregon Developmental Disabilities Strategic Plan 2018-2023, and the 2019 Aging and People with Disabilities Strategic Plan.

Perspectives on health disparities from stakeholders in the field are provided below, followed by the long-term outcomes that will be monitored to measure success in reducing ATOD-related disparities across the state.

27 OHA. (n.d.-2).

28 University of Wisconsin Population Health Institute. (2019). *County health rankings. Key findings 2019.* www.countyhealthrankings.org/reports/state-reports/2019-oregon-report.

Voices from the Field

ANTHONY JORDAN, *MPA, CADC II, is Addiction Services Manager at the Multnomah County Mental Health and Addiction Services Division and a member of the ADPC. Anthony is passionate about addressing health disparities throughout the system and was a key organizer of a special listening session held during the planning process to elicit stakeholder feedback on issues involving culturally relevant and linguistically appropriate services.*

> *The lack of culturally relevant and linguistically appropriate services—especially for people of color—is significant, Anthony says, "because if people either do not trust the system that they are entering, or do not feel that the system is addressing their specific needs, then we will continue to see poor outcomes for people of color."*

Anthony says one of the major health disparities he sees in Multnomah County is the lack of culturally specific services for people of color. "This is significant," he says, "because if people either do not trust the system that they are entering, or do not feel that the system is addressing their specific needs, then we will continue to see poor outcomes for people of color." Anthony wants to make sure that the state and local infrastructures created through the implementation of this plan support culturally specific services. "I would start by having dedicated funds to support each community's unique needs. I would also invest in family prevention services earlier, rather than wait for problems to arise." He adds, "The services provided by this infrastructure should include robust, culturally responsive educational components that address racial bias, racial and historical trauma, and systemic racism."

DR. JIM DAVIS *is a community psychologist, gerontologist, educator, and an advocate for seniors and people with disabilities for the past 46 years. He currently serves as the Chair of the Oregon Disabilities Commission and the state's Older Adult-People with Disabilities Behavioral Health Advisory Council, after serving as the Co-Chair of the Oregon Legislative Work Group on Senior and Disability Mental Health and Addictions. Dr. Davis is also the long-time executive director of the Oregon State Council of Retired Citizens and United Seniors of Oregon, national affiliates of the National Council on Aging. He also was coordinator of the state Department of Human Services Senior Mental Health Projects, Mental Health Gerontologist for the Oregon Mental Health Division, and a professor/administrator at both Marylhurst University and the University of Maryland.*

> *"With baby boomers doubling the senior and disability populations, life and health problems related to alcohol and drug use and misuse are expected to grow exponentially, which will seriously strain already severely limited resources."*

Dr. Davis notes that the chemical dependency problems of seniors and people with disabilities—primarily alcohol followed by prescription drugs and over-the-counter (OTC) medications—are being ignored by the public addictions services system in the state of Oregon. Dr. Davis notes that less than 1% of state chemical dependency services are devoted to seniors,

and the majority of those being assessed are linked to DUI. Dr. Davis says, "Senior and disability chemical dependency concerns are frequently underreported, misdiagnosed, and overlooked by clinicians, social workers, and case managers." Nationally, seniors and people with disabilities take more than one-third of all prescribed medications. Dr. Davis notes that a majority of older adults and people with disabilities face myriad chronic physical and emotional health problems that keep physicians searching for answers to help ease their discomfort; as a result, most physician visits end with a prescription. Although in the vast majority of cases, seniors and people with disabilities take medications that are correctly prescribed for legitimate health problems, there is growing concern that a significant number of medications prescribed to these populations are incorrect or unnecessary, creating increased risk for adverse and preventable drug interactions, particularly regarding drugs with addictive qualities, such as opiates, central nervous system depressants, and stimulants. Dr. Davis says misuse of drugs is also a problem. This includes mixing prescription drugs, OTC medications, and/or alcohol in ways that are dangerous and outside the knowledge or approval of prescribing physicians; trading medications with friends and loved ones; and/or taking higher or lower doses of medications than recommended. He says this is most often due to a lack of education on how to responsibly use the medications but notes that self-medication with alcohol and illegally obtained drugs is also an issue. He is also concerned that a growing number of seniors and people with disabilities with SUDs are being admitted to long-term care facilities, where staff are often not trained to respond effectively. With baby boomers doubling the senior and disability populations, life and health problems related to alcohol and drug use and misuse are expected to grow exponentially, which will seriously strain already severely limited resources. In addition, chemical dependency issues are changing as the boomers age, with a marked increase in marijuana and non-medical use of prescription drugs. As a result, Dr. Davis expects treatment admissions for boomers will continue to grow exponentially. Based on his deep experience in this field, he has identified four key needs for this population.

"Seniors and people with disabilities respond well to treatment programs, but they do even better in specialized addiction programs."

1. Public, private, and community-based AOD treatment services, as well as crisis response, geared to the needs of seniors and people with disabilities. This includes developing treatment options that, if not specializing in senior/disability addiction, can at least effectively take into consideration aging and disability issues along with the chemical dependency problems. "Seniors and people with disabilities respond well to treatment programs," he says, "but they do even better in specialized addiction programs."

2. Evidence-based treatment and service options within the senior and disability health and mental health care communities that comprise an array of services. This includes counseling, support groups, community and provider education, outreach, complex case consultation, case management, screening to enable the most appropriate treatment plan and options, and greater capacity for monitoring medication misuse and abuse within the long-term care system (e.g., in-home services, assisted living facilities, adult foster homes, residential care facilities, skilled care facilities).

3. Substantial expansion of geriatric and disability training for current and future health professionals (e.g., physicians, nurses, social workers, mental health professionals). This includes more emphasis on geriatric/gerontology training in the curricula and practica/rotations in the health-related academic programs offered by public and private universities and colleges, as well as expanded geriatric training in the training conferences and continuing education events offered by professional primary care and other organizations.

4. Establishing a statewide public education campaign to create greater public awareness of—and support for—the mental health and addiction issues of seniors and people with disabilities and identifying how best to respond with programs, services, and policy. This could include establishing a statewide education and training program to create greater public awareness of senior/disability mental health and addiction, including community-based education events in key demographic locations around the state in collaboration with local mental health and senior/disability service providers.

IMPACT 3: Reduce ATOD-Related Disparities	Benchmarks	
	2022	**2024**
Decrease ATOD-related health disparities due to age, race/ethnicity, gender, discrimination, stigma, and inequitable access to basic resources, education, and economic opportunities.	See below	

The measures below will be targeted and tracked to monitor progress toward reducing ATOD-related health disparities.

Impact 3 Dashboard		
Health Outcomes	Benchmarks	
	2022	**2024**
Decrease the rate at which Native Americans in Oregon die from alcohol-related causes from **85.5 per 100,000** in 2014-2017 to **78.5 per 100,000 or less** by 2025-2028[29]	83.5	81.5
Decrease the rate at which Native Americans in Oregon die from tobacco-related causes from **200.6 per 100,000** in 2014-2017 to **185.0 per 100,000 or less by** 2025-2028	195.6	190.6
Increase the percentage of Oregonians ages 18+ with less than a high school education who report having good or excellent health from **63.0%** in 2018 to **69.0% or more** by 2024[30]	65%	N/A
Increase the percentage of Oregonians ages 18+, with less than a high school degree who report having any form of health insurance from **76%** in 2018 to **81.0% or more** by 2024[31]	78%	N/A
Social Outcomes	Benchmarks	
	2022	**2024**
Decrease the number of new placements of Oregon children in foster care due in part or whole to parental drug misuse from **52.0%** in 2018 to **46.8% or less** by 2025[32]	50.8%	48.3%
Decrease the number of new placements of Oregon children in foster care due in part or whole to parental alcohol misuse from **13.2%** in 2018 to **11.9%** or less by 2025[33]	12.9%	12.3%

29 OHA. (n.d.-2); OHA. (n.d.-1). In 2018, 84% of Oregonians ages 18+, with a high school degree or more, reported having good or excellent health.
30 OHA. (n.d.-2); OHA. (n.d.-1). In 2018, 92% of Oregonians with a high school degree or more reported having any form of health insurance.
31 Oregon Department of Human Services (DHS), Office of Reporting, Research, Analytics and Implementation (ORRAI). (May 2019). *2018 Child Welfare Data Book*. https://www.oregon.gov/DHS/CHILDREN/CHILD-ABUSE/Documents/2018-Child-Welfare-Data-Book.pdf
32 Oregon DHS, ORRAI. (May 2019).
33 Oregon DHS, ORRAI. (May 2019).

Impact 4: Reduce the Economic Burden of Substance Misuse in Oregon

The amount of state dollars being used to pay for problems related to substance misuse more than **quadrupled** from 2005 to 2017, consuming—by the most conservative estimates—nearly **17% of the entire state budget.**

Burden spending is the amount spent on health and social problems that results from substance misuse and untreated SUDs. **Dedicated spending** is the amount spent to prevent substance misuse, regulate and ensure compliance with ATOD laws, and treat and help people recover from SUDs.

In 2001 and 2009, The National Center on Addiction and Substance Abuse at Columbia University released two iconic reports, *Shoveling Up* and *Shoveling Up II*, which quantified the costs of substance use and addiction to federal, state, and local governments. As part of Oregon's statewide strategic planning effort, JBS International, Inc. consulted with current and former staff from Columbia University and Oregon state budget staff to use the Shoveling Up methodology to calculate current costs of substance misuse in Oregon; the following tables and statistics, unless otherwise cited, come from that research, which used state-reported data to calculate costs. Had there been no change in Oregon state budget line items, the ratio of federal-to-state funding sources, or the prevalence of binge drinking, tobacco, and other drug use, Oregon would be spending $691.31 per capita in 2019 dollars on the impact of substance misuse to the state government.[34] Unfortunately, as the table below shows, the cost to the State of Oregon in 2017 was far higher.

At-a-Glance Changes in Oregon Substance Abuse Spending 2005-2017

	2005			2017		
	Total Spending	% State Budget	Per Capita	Total Spending	% State Budget	Per Capita
Burden Spending	$1,461,714,900	9.5	$394.98	$6,308,912,572	15.8	$1,482
Dedicated Spending						
Prevention	$9,830,600	<1	$47.10	$7,044,296	<1	$1.66
Treatment[35]	$82,340,300			$168,827,299		$39.66
Regulation & Compliance	$1,592,000	1.1	$26.00	$240,475,000	<1	$56.50
Unspecified	$4,050,100	<1		N/A	N/A	N/A
Totals	$1,732,251,900	11.3	$468.08	$6,725,259,167	16.8	$1580.05

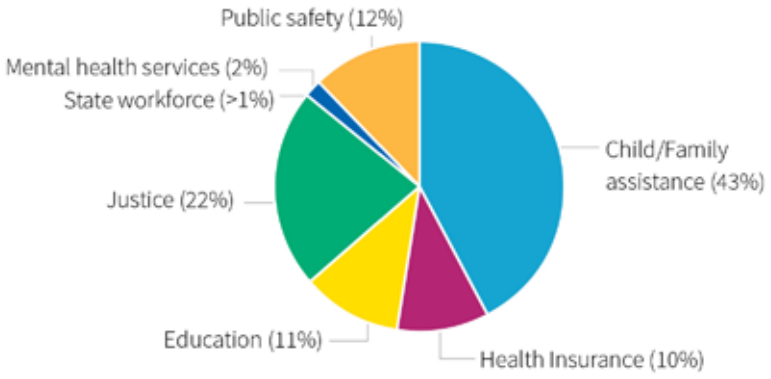
34 As part of the original research conducted by JBS and the consultant, it was found that the simple cost of living increase (as captured by the Consumer Price Index) between 2005 (the year of Shoveling Up II) and 2019 increased by a factor of 1.35.

35 At the time of the study, Oregon was not able to report state expenditures for recovery support services independently from state expenditures for treatment. For this reason, all state-reported expenditures for recovery support services are included in total spending on treatment.

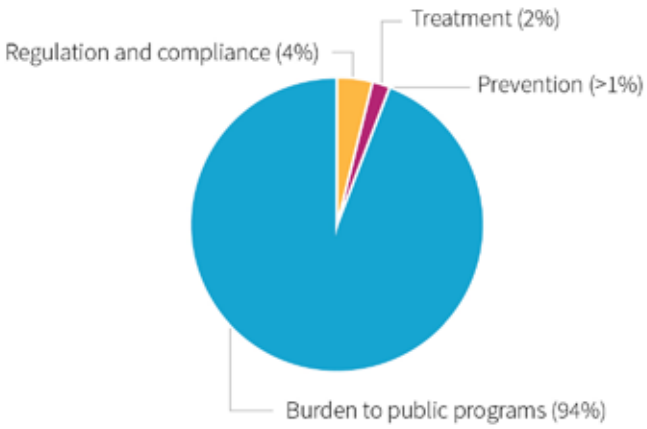
Substance misuse cost Oregon $1,580.05 per capita in 2017, with more spent per capita on regulating and ensuring compliance with laws governing the sale and distribution of substances ($56.50) than preventing or treating substance-related problems ($41.32). The first pie chart illustrates the distribution of substance misuse-related burden spending across state-funded programs. As the second pie chart shows, 94¢ of every dollar—$6.309 billion in state funds comprising 15.8% of the entire state budget—paid just for the burden to public programs.

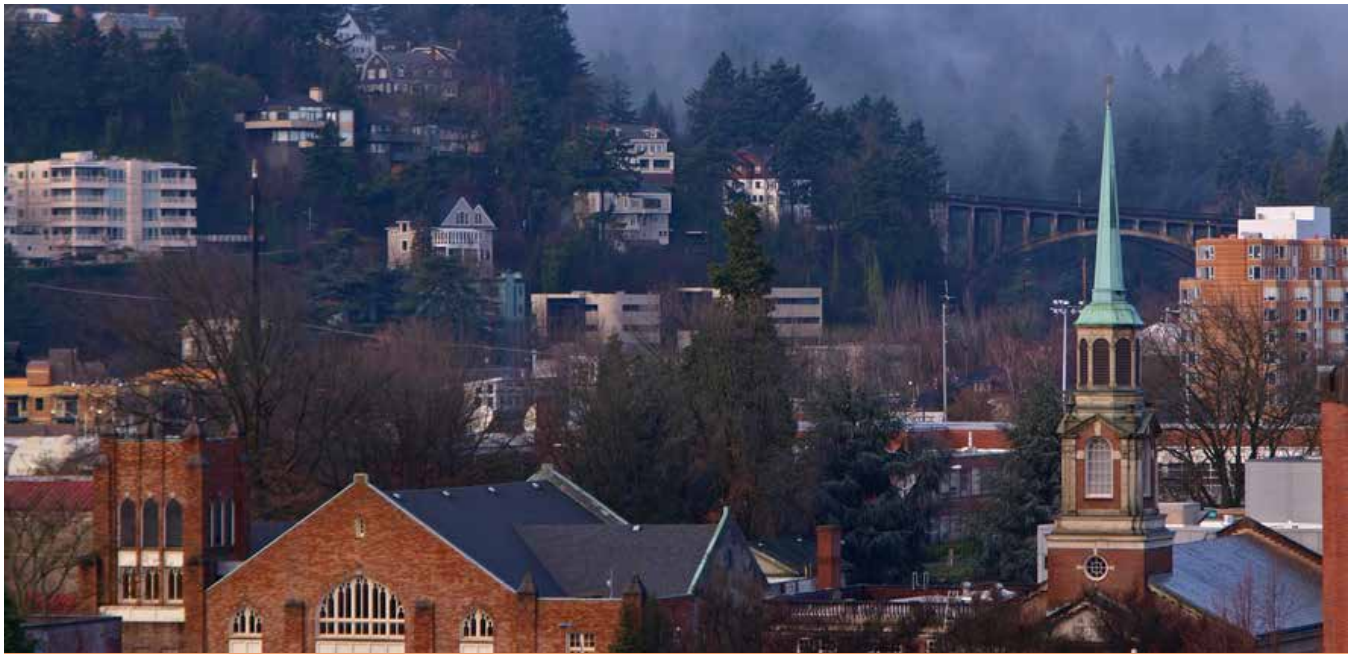
The following page describes the goal of reducing the financial burden of AOD-related problems in Oregon—with associated measurable, long-term outcomes—by increasing state spending on prevention, treatment, and recovery. **Shifting the investment of state funds to increase the proportion spent on prevention, treatment, and recovery will also directly support the achievement of Goals 1-4, which are detailed in Section III of this document.**

Shouldering the Burden of Substance Misuse in Oregon 2017



The Substance Misuse Dollar in Oregon 2017





IMPACT 4: Reduce the economic burden of substance misuse in Oregon	Benchmarks	
	2022	2024
Reduce the estimated amount of state funds spent to pay for the burden of substance misuse-related social and health problems to public programs from **15.8%** of the entire state budget in 2017 to **14.6%** or less by 2025.	15.5%	15.1%

The measures below will be targeted and tracked to monitor progress toward improving the investment of state funding to prevent, treat, and help people recover from substance misuse and SUDs.

Impact 4 Dashboard		
Economic Outcomes	Benchmarks	
	2022	2024
Justice: Decrease the estimated amount of **substance misuse/SUD burden spending** from **87.01%**[36] of all state justice program spending to **80.0% or less** by 2025	85.0%	82.5%
Child and Family Assistance: Decrease the estimated amount of **substance misuse/SUD burden spending** from **80.72%** of all state child and family assistance program spending to **74.2% or less** by 2025	78.2%	75.7%
Mental Health: Decrease the estimated amount of **substance misuse/SUD burden spending** from **66.72 %** of all state mental health program spending to **61.4% or less** by 2025	65.2%	63.5%
Health Insurance: Decrease the estimated amount of **substance misuse/SUD burden spending** from **34.52%** of all state health insurance program spending to **31.7% or less** by 2025[37]	33.6%	32.7%
Public Safety: Decrease the estimated amount of **substance misuse/SUD burden spending** from **29.23%** of all state public safety program spending to **26.9% or less** by 2025	28.5%	27.7%
Education: Decrease the estimated amount of **substance misuse/SUD burden spending** from **17.69%** of all education program spending to **16.3% or less** by 2025	17.3%	16.9%
Overall Investment of State Funds: Increase the proportion of funding spent to prevent substance misuse, promote health and positive social outcomes, and treat and support recovery from SUDs from less than **1¢** of every dollar spent on substance use in 2017 to **10¢ or more** of every dollar spent on substance use by 2025.	3¢	7.5¢

The following pages provide additional perspectives from stakeholders in the field.

36 This figure represents state funds estimated to have been spent on adult corrections, juvenile justice, and the judiciary due to substance misuse and SUDs.

37 This is the estimate of spending that can be traced to the use of ATOD. While there are some conditions completely attributable to ATOD (e.g., cirrhosis of the liver, lung cancer, drug overdoses), there are others where research has determined a certain percentage of cases would not exist if not for substance use (e.g., heart conditions, diabetes, chronic obstructive pulmonary disease, psychotic episodes). In addition, a certain percentage of accidents (e.g., motor vehicle, work related injuries, falls) and the injuries they cause are attributed to substance use. Actual treatment for alcohol and drugs, IF paid by the state-revenue-funded public insurance, would fold into this, but the vast majority is from health issues created as a "byproduct" of someone's substance use. These conditions comprise the majority share of the health insurance PAR (population attributable risk).

Voices from the Field

JAMES WILLIAMS, *Lake County Commissioner, drove 3½ hours to attend the ADPC Town Hall meeting in Bend. As an elected official from an expansive frontier county overwhelmed by substance-use and mental-health-related problems that far outstrip local resources, Williams was looking for solutions. He later convened two local experts, Dr. Trace Wonser, Director of the Lake District Wellness Center, and Jackie Schuler, Substance Use Counselor, to offer additional perspectives to the situation in Lake County.*

Substance use services in Lake County comprise one treatment court, one social worker, five Certified Alcohol and Drug Counselors (CADCs) who provide outpatient services, and Room 107. Not long ago, the jail—a small facility built in the 1950s—doubled as the county's detox center. Now, Room 107, a lockable space at the Lake District Hospital, provides a place where people can detox in a monitored health care setting. Room 107 is also the place, however, where a lack of medical preparedness to address behavioral health crises is most exposed, and communication gaps and differences in practices and philosophies between substance use, mental health, and primary care providers can flare up. Many of those admitted to Room 107 have co-occurring disorders, which, Dr. Wonser notes, can set off a medical "volleyball" to determine whether the substance use or mental health will be treated since state policies don't allow practitioners to bill for integrated SUD and mental health services. What happens when Room 107 is needed by more than one person? "That's when things get really dicey," Williams says. When multiple people need detox at once, those deemed to be the least dangerous go into a regular hospital room, and those deemed too dangerous go to jail. Getting Lake County residents access to residential treatment Is extremely challenging. Williams notes that many residential treatment services won't take people with mental health issues, including meth-induced psychosis, which is being seen more and more in Room 107 occupants. Getting access to residential services also requires competing with other counties for any available beds at the St. Charles Health System in Bend, which is hours away. Transferring Room 107 occupants to St. Charles requires secured transport by the Lake County Sheriff's Office, which, like most public agencies in Lake County, is significantly understaffed and under-resourced. When Lake County residents come out of residential treatment, Schuler says they're counseled to stay where they are because after care and recovery support services are not available in Lake County. In addition, the county's lack of resources dictates an individual-based, crisis-driven approach, with no ability to improve community conditions and foster a recovery-oriented environment. Williams notes that housing is also a significant issue: "We can't keep putting people in motel rooms where they're not supported. The jails are overflowing. We don't have places to put people." He adds, "We're putting out fires constantly. We can't get a breath." Helping people close to home is an important goal in Lake County, from both a human and economic perspective. Williams and his colleagues are working hard to find resources to help Lake County residents be—and stay—healthy, facilitate a sense of growth and community, and provide a hand up, not necessarily a handout. "Nobody moves to Lake County to be homeless," Williams emphasizes. "It's rough not having services or facilities available to provide care," he adds. "We don't want to send people away. We want to treat them right here in the community. If we just had a few beds, we could save the state a lot of money."

"We're working hard to find resources to help Lake County residents be—and stay—healthy, facilitate a sense of growth and community, and provide a hand up, not necessarily a handout. Nobody moves to Lake County to be homeless. It's rough not having services or facilities available to provide care."

LISA POOL *attended the Hillsboro Town Hall with her young son in tow. Her first question was "Is this just an informational meeting or are you here to listen to what people have to say?" As an LAc and alternative pain management (APM) practitioner trying to help her patients stay off prescription opioids and other addictive drugs, Pool had a lot to say.*

"I became a medical provider to help all people and particularly those with chronic pain and debilitating diseases," Pool says. Research confirms the positive impact alternative medicines like acupuncture can play in relieving chronic pain. For example, the National Institutes of Health's National Center for Complementary and Integrative Health states that "a growing body of evidence suggests that some complementary approaches, such as acupuncture, hypnosis, massage, mindfulness meditation, spinal manipulation, tai chi, and yoga, may help to manage some painful conditions." Pool notes that prior to 2016, however, very few APM practitioners in Oregon accepted Oregon Health Plan (OHP) patients because APM either was not covered or covered in very limited circumstances and at reimbursement rates that were well below the cost of providing services. That changed for Pool in 2016 when the CCO in her area revised its alternative medicine benefit, opening it up to physical therapy, acupuncture, and chiropractics and making the fee schedule more feasible. Although Pool was initially skeptical, she signed on as a provider and says she was able to greatly improve functionality for many of her new OHP patients, reducing their need for prescription opioids and emergency department (ED) and primary care visits and helping them become more self-sufficient. Pool says the benefits extended to family members who were able to lessen time away from work due to reduced caregiving needs. **JESSICA RIEGEL,** one of Pool's patients, confirmed her positive experiences. Riegel has medullary sponge kidney disease, which is incurable and results in chronic pain which can become excruciating. Before coming to Pool, Riegel was passing kidney stones on a weekly basis, taking Tramadol (an opioid analgesic) three times a day, and visiting the ED multiple times a year. With acupuncture, Riegel says she only had to use Tramadol twice in three years, and her ED visits were significantly reduced. She also has disc issues in her lower back, which required that she use a wheelchair to get around during one of her pregnancies. She says chiropractic treatment enabled her to walk without assistance, but there were a few times when she ran out of benefits and had to wait for more treatments to be approved. A mother of four, Riegel says acupuncture and chiropractic care has enabled her to live a "semi-normal life with very minimal pain and manage taking care of my family the best I can." In 2018, however, Pool says "the rug was pulled out from beneath us," referring to the impact she and her patients experienced when changes in CCO policies reduced the number of covered APM treatments from 90 to 30 per year and cut reimbursement by 40%. Pool says the new fee schedule went from barely covering her costs to costing her money for each treatment she provided. Reluctant to turn away her OHP patients, Pool kept seeing them but says she had to sell her house and almost lost her practice in the process. She says she also saw drug use and ED visits among her patients increase as they ran out of benefits. Jessica concurs with this impact, noting that while she ideally would receive APM treatments weekly, she now spaces her treatments out but still runs out of benefits by August. At that point, ED and primary care visits, which she says are much less effective in managing her pain, are her only options. "It doesn't make sense to limit APM," Riegel says, noting that her prescription pain relief was limited to Tramadol, which has reduced potential for addiction and withdrawal, due to other addiction issues. "You can go to your primary care doctor as

"A growing body of evidence suggests that some complementary approaches, such as acupuncture, hypnosis, massage, mindfulness meditation, spinal manipulation, tai chi, and yoga, may help to manage some painful conditions."

many times as you need and get opiates," she says, recounting that a frequent refrain on her trips to the ED and primary care visits is, "Would you like pain medication? Would you like nausea medication?" "Yes, I'm in pain," is her standard reply, "but I don't want your pain meds." Riegel would love to see insurance coverage for APM treatments, such as acupuncture and chiropractics, be increased as an alternative to opiates. Pool says there are viable solutions out there, and she is eager to be part of them. These include restoring services and reimbursement rates, increasing the number of patients that can be seen, and changing treatment procedure codes for insurance billing. Pool also welcomes participating in a state study of the efficacy of alternative medicine in treating chronic pain. "We've been around a long time and that's because it works," she says, referring to alternative—or traditional Eastern— medicine, "Western medicine is the new kid on the block."

"Insurance should look at individual cases and how clients are benefiting from ongoing treatments and treatment plans, especially for those with chronic pain and incurable illnesses." Jessica Riegel

Section III: Goals, Objectives, Outcomes, Strategies, and Activities

Goal 1: Implement a statewide system that ensures that substance misuse policies, practices, investments, and efforts are effective and result in healthy and thriving individuals and communities

THE PROBLEM: Oregon's efforts to prevent substance misuse and to treat and help people recover from SUDs have been deeply siloed, with little coordination among the state agencies and providers responsible for administering funding, strategies, and services. This makes it difficult to maximize existing resources, exacerbates gaps in services, and complicates efforts to connect people to already scarce services across the continuum of care. While these siloed services have been extensively noted in prior reports and studies, little has been done to address them. Over the course of the planning process, all the state agencies with major responsibilities for administering or funding substance misuse and supportive services have come together and committed to the goal of building and implementing a comprehensive and sustainable statewide system.[38] The mission, vision, and values they collectively developed are provided in Section I. Objectives, intermediate and immediate outcomes,[39] strategies, and activities for state system development start on page 31. Timelines and roles are also noted.

1.a. Increase the degree to which state agency leadership is working together to coordinate efforts and maximize all resources by:

- Strengthening system leadership
- Establishing conceptual clarity between sectors
- Ensuring inclusivity
- Advancing political will
- Expanding influence

1.b. Increase system capacity to solve substance use problems and implement needed changes to operations by:

- Establishing structures, roles, and responsibilities to coordinate and carry out plan activities
- Strengthening and rebuilding data infrastructure
- Recruiting, developing, and retaining a highly effective workforce

1.c. Increase the system's ability to use the most effective practices, processes, and programs for priority populations and problems by:

- Enhancing communication and information sharing
- Promoting evidence-based practices, policies, programs, and services
- Increasing access to training and technical assistance (TTA)
- Developing and implementing effective monitoring and evaluation processes

38 Appendix B contains a list of state agency roles and responsibilities for substance misuse prevention, treatment, and recovery support.
39 Intermediate outcomes focus on changes in conditions that need to occur in order to achieve long-term outcomes; immediate outcomes reflect changes in knowledge, skills, and/or abilities that need to occur in order to achieve intermediate outcomes.

1.d. Increase the system's ability to reduce health disparities and to promote health equity among all vulnerable and at-risk populations by:

- Developing and implementing policies that promote health equity
- Allocating resources in ways that promote health equity
- Implementing services and strategies that promote healthy equity
- Adopting the Tribal Behavioral Health Plan

1.e. Increase the system's ability to be accountable by:

- Strengthening the ability of the system's leadership to be accountable
- Building systems to support accountability
- Documenting accountable and effective use of all resources

1.f. Increase the system's ability to be sustainable by:

- Developing and implementing policies that cultivate sustainability
- Conducting strategic finance and sustainability planning by developing a collective scope of services and budget for state prevention, treatment, and recovery services
- Securing needed funding and resources
- Implementing programs, practices, and policies that lead to sustainable results

Voices from the Field

MERCEDES ELIZALDE *attended the Town Hall meeting in East Portland. As the Public Policy Director for Central City Concern (CCC), a non-profit agency serving Portland area adults and families impacted by homelessness, poverty, and addictions, Elizalde was articulate and to the point in describing what she sees daily.*

"We often talk about cracks in the system and how we don't want people to fall through cracks," Elizalde says. "From where I sit, there are craters, not cracks, which we have created intentionally because our system doesn't meet everyone's needs. Our system maintains 'limited access' as a policy choice. We have identified need for tens of thousands of people but built programs that serve hundreds. As providers, we have programs built to say yes to as many people as possible, but ultimately our systems are set up to say no. We have lots of ways of saying no to people," Elizalde says, citing preauthorization, limited funding in contracts and reimbursements, and complicated eligibility requirements. She also called out the disconnect between talk and practice when it comes to integrated care. "We talk about integrated services," Elizalde notes, "but we cannot, for example, easily provide mental health services in SUD programs. Regulations and billing encourage division of services. Integration in programs, like CCC has achieved, are done in spite of the systems—not because of them. Insurance providers, and even some service providers, receive incentives to 'screen out' people who might be 'too complex' to serve because of co-occurring disorders or unmanaged physical health needs. Access is even harder for people struggling with poverty, homelessness, and past engagement with the criminal justice system. Health care is really expensive, but we put the blame for costs on patients overusing services, which results in withholding care and ultimately driving up costs." Elizalde also stressed the need to connect health care services to other

components of people's lives, like housing and healthy food. But because so many government agencies are created to address a particular need, it's hard for them to see how services need to be leveraged together to make a difference—no intervention operates alone. "What we have learned here at CCC, with a long history of successful programs, is that success happens when services are coordinated, and connectedness is valued. We need to make a choice: Either we are going to continue to maintain a scarcity model, where we say no to those who ask for care and services, or we are going to do the hard work of really reaching everyone. When we say we're going to try to reach everyone but continue to limit access at the same time, we create inadequate systems that perpetuate illness and poverty. This is what creates the craters. But we can choose to say yes; we can choose to build systems based on health and stability rather than scarcity. We just need to decide that it is our job to say yes."

OBJECTIVE 1.a: Increase the degree to which state agency leadership is working together to coordinate efforts and maximize all resources

Intermediate Outcome: Increase system assessment ratings for leadership from an average score of 1 (on a scale of 1 to 10) from 2019 to an average score of 5 or higher by 2023[40]

Immediate Outcomes	Strategies and Activities	Implementation	Roles
1.a.1. Increase the ability of state agencies to consistently work together to **strengthen system leadership**	Convene quarterly meetings to review progress and to adjust plan goals, objectives, outcomes, and implementation, as needed	Year 1	**Lead:** ADPC **Partners:** State agency partners
	Establish participatory processes for all aspects of system work		
1.a.2. Increase the ability of system leadership to ensure **conceptual clarity** across disciplines and sectors	Establish mutually agreed upon and specific interagency coordination expectations and associated roles and responsibilities		
	Establish common definitions for key concepts and terminology		
1.a.3. Increase the ability of the system to ensure **inclusive leadership**	Advocate that system membership reflects the demographics of the persons and communities served, and includes stakeholders served or impacted by system actions and decisions		
1.a.4. Increase the ability of system leadership to advance **political will** for implementing all plan strategies	Secure the support of key stakeholders, collaborators, opinion leaders, and allies		
1.a.5. Strengthen the ability of system leadership to **influence** others to support plan implementation	Establish roles/expectations for members to serve as system ambassadors and enlist the support of their networks and stakeholders for plan priorities and actions		

OBJECTIVE 1.b.: Increase system capacity to solve substance use problems and implement needed changes to operations.

Intermediate Outcome: Increase system assessment ratings for capacity from an average score of 1 (on a scale of 1 to 10) from 2019 to an average score of 5 or higher by 2025

Note: Baselines for many of the strategies in this section don't currently exist but could be constructed as part of strategy implementation to help Oregon better monitor progress toward meeting this objective, particularly with regard to workforce development. Additional measures could include, but would not be limited to, the following:

- Percentage increase in workforce numbers by types of worker and populations served
- Number of certified alcohol and drug counselors (CADCs) and peer support specialists embedded in medical, academic, clinical, and legal systems
- Percentage increase in reimbursement rates by category
- Percentage increase in numbers of workforce reached by TTA

40 Assessment tool is available upon request from ADPC

Immediate Outcomes	Strategies and Activities	Implementation	Roles
1.b.1. Identify the **organizational structure(s),** roles, and responsibilities needed to coordinate and carry out plan activities	Establish system member roles, responsibilities, and expectations create workgroups/subcommittees needed to implement the plan (e.g., data workgroup)	Year 1	**Lead:** ADPC **Partners:** State agency partners
1.b.2. Strengthen and increase the ability of **data infrastructure** to support plan implementation and outcomes	Identify methods, roles, and responsibilities for collecting, analyzing, and reporting data on process and outcome indicators, benchmarks, and dashboard measures identified in the plan		
	Ensure the development of data infrastructure to: • Capture reporting data on process and outcome indicators, benchmarks, and dashboard measures identified in the plan • Monitor/evaluate substance prevention, treatment, and recovery program data • Identify new and emerging issues quickly		
	Ensure all system members have the ability and access to reliable resources to collect and analyze data		
	Establish an interagency data workgroup that convenes regularly to share and analyze substance use and other epidemiological data and to make system recommendations		
1.b.3. Increase system ability to recruit, develop, and retain a **highly effective workforce**	**General Workforce**		
	Identify core competencies and specialized knowledge, skills, and abilities (KSAs) needed by each sector of the workforce	Year 1	**Lead:** ADPC **Partners:** State agency partners
	Provide TTA to strengthen the KSAs needed to conduct needs assessment, mobilize partners, continuously evaluate outcomes, and revise strategies, as needed		
	Expand population-specific TTA for current and future providers of services to individuals, groups, families of those experiencing substance misuse, including: • Selecting and implementing effective, culturally tailored services/ strategies across the lifespan • Expanding training and practica/rotations in health-related academic programs at Oregon public and private universities and colleges to better prepare graduates to address the behavioral health care needs of vulnerable and underserved populations • Encouraging primary care and other professional organizations to provide TTA (e.g., at conferences, continuing education events) on addressing the needs of vulnerable and historically underserved populations		

	Provide TTA to strengthen the ability of the workforce to select and implement strategies and services that have the highest documentation of effectiveness for priority populations and substances	Year 2	**Lead:** ADPC **Partners:** State agency partners
	Provide TTA to strengthen the ability of the workforce to select and implement culturally tailored and linguistically appropriate services/ strategies across the lifespan for historically underserved communities, such as seniors, people with disabilities, LGBTQ+, persons of color, tribal nations, and rural Oregonians	Year 2	
	Ensure all persons who work with individuals with SUD have a minimum of 6 hours focused on prevention strategies and general SUD education and training; training must continue on an ongoing basis	Year 2	
	Establish adequate reimbursement needed to increase workforce retention	Year 2	
	Increase the number of licensed and unlicensed behavioral health staff that work in underserved communities	Year 1	**Lead:** ADPC **Partners:** OHA, Department of Corrections (DOC), Oregon Youth Authority (OYA), Department of Business and Consumer Services (DBCS)
	Reduce administrative barriers including ongoing reforms for background checks	Year 1	**Lead:** ADPC **Partners:** OHA, Department of Human Services (DHS)
	Explore creation of reimbursement system for smaller, community-based organizations that lose staff to SUD government agencies	Year 1	**Lead:** ADPC **Partner:** OHA
	Expand financial and non-monetary forms of incentives, such as training stipends, tuition assistance, and loan forgiveness, to increase recruitment and retention	Year 1	**Lead:** ADPC **Partners:** OHA, Higher Education Coordinating Commission (HECC), DCBS

	Prevention		
	Recruit and develop a wide array of prevention partners, including com- munity members and organizers, volunteers, professionals, and laypersons who may not identify as being part of the prevention workforce	Year 1	**Lead:** ADPC Partner: State Agencies
	Increase community and program capacity to plan, mobilize, implement, and evaluate community-led, evidence-based, and emerging grassroots efforts to prevent substance misuse and related health and social harms across the lifespan	Year 1	**Lead:** ADPC **Partners:** OHA, Public Health
	Create career paths and opportunities that lead to increased retention of prevention providers and community organizers	Year 2	**Lead:** ADPC **Partner:** OHA
	Peer Mentors, Recovery Support Specialists, System Navigators, Case Managers, and Other Intermediaries		
	Identify and recruit the types of intermediaries needed to increase access to, and retention in, prevention, treatment and recovery, including those with lived experience	Year 1	**Lead:** ADPC **Partners:** State agency partners
	Ensure persons needing treatment and in recovery have access to an appropriate intermediary to facilitate access to all needed services	Year 2	**Lead:** ADPC **Partners:** State agency partners
	Increase KSAs of primary care providers, all potential first responders, and intermediaries to use intervention/harm reduction modalities that have strong documentation of effectiveness		**Lead:** ADPC **Partner:** OHA
	Increase KSAs of workforce to use culturally specific early intervention/harm reduction techniques		**Lead:** ADPC **Partner:** OHA
	Make education and training opportunities easier to complete for peer mentors through online education and local training with virtual supervision		**Lead:** ADPC **Partners:** OHA, HECC
	Develop career ladders and opportunities and peer mentorship programs		**Lead:** ADPC **Partner:** OHA
	Treatment and Recovery		
	Establish reimbursement rates for treatment and recovery workforce members that are commensurate with responsibilities and competitive with similar sector pay (e.g. mental health)	Year 1	**Lead:** ADPC **Partner:** OHA
	Provide T/TA and incentives to increase the ability of primary care providers to use treatment and recovery modalities which have strong documentation of effectiveness—including MAT		**Lead:** ADPC **Partner:** OHA
	Increase the number of providers able to prescribe buprenorphine		

OBJECTIVE 1.c.: Increase the system's ability to use the most effective practices, processes, and programs for priority populations and problems			
Intermediate Outcome: Increase system assessment ratings for use of effective processes from an average score of 1 (on a scale of 1 to 10) from 2019 to an average score of 5 or higher by 2023[41]			
Immediate Outcomes	**Strategies and Activities**	**Implementation**	**Roles**
1.c.1. Increase system ability for **effective communication and information sharing** among members	Develop processes to ensure consistent information sharing with system partners, stakeholders, and key decisionmakers	Year 1	**Lead:** ADPC **Partner:** State agency partners
	Develop formal channels of communication to ensure system partners are informed and routinely share new information		
	Develop protocols for improving information acquisition and minimizing response times when new threats or problems emerge		
	Create an online system that provides real-time information on available prevention, treatment, and recovery services, which is searchable by types, locations, and other key criteria		**Lead:** ADPC **Partner:** OHA
1.c.2. Increase the ability of all system members to use **evidence-based practices, policies, programs, and services**	Develop guidance to ensure those who receive system funding select and implement strategies and provide services that have the highest level of effectiveness and are situationally appropriate for the populations and problems being served and addressed Among other criteria, guidance should require that strategies: • Directly target one or more of the key risk protective factors for substance use • Demonstrate evidence of effectiveness, as published in peer-reviewed journals, with at least moderate effect sizes to ensure adequate return on investment • Demonstrate equal or larger effects with underserved populations. • Be able to reach the target audience • Be sufficiently appealing to actively engage the target audience and not place undue burdens on schools, families, or other participating entities		**Lead:** ADPC **Partners:** OHA, OYA, DOC, DHS, Oregon Criminal Justice Commission
1.c.3. Increase system ability to use data to target **TTA** to improve provider performance and outcomes across all sectors	Use workforce assessment data and study findings to design, secure, and implement TTA to build the core competencies and specialized KSAs the workforce needs to achieve the outcomes identified in the plan	Year 2	**Lead:** ADPC **Partner:** State agency partners

41 Assessment tool is available upon request from ADPC

OBJECTIVE 1.d.: Increase the system's ability to reduce health disparities and to promote health equity among all vulnerable and at-risk populations			
Intermediate Outcome: Increase system assessment ratings for health equity from an average score of 1 (on a scale of 1 to 10) from 2019 to an average score of 5 or higher by 2023			
Immediate Outcomes	**Strategies and Activities**	**Implementation**	**Roles**
1.d.1. Increase the ability of system leadership to ensure practices, resources, programs, and services **promote health equity**	Remove institutional barriers that limit access to culturally appropriate and effective services	Year 1	**Lead:** ADPC **Partner:** State agency partners
	Increase equitable access to culturally tailored and linguistically appropriate prevention, treatment, and recovery supports for historically underserved communities		
	Revise/develop policies to ensure equitable allocation of resources		
	Develop and use formulas for resource allocations that incorporate need as a funding factor		
	Establish a system for early diagnosis and connection to services for infants, children, and families impacted by fetal alcohol spectrum disorder, neonatal abstinence syndrome, and other substance-use-induced disorders	Year 2	**Lead:** ADPC **Partner:** State agency partners
	For higher education:[42] • Ensure every Oregon public higher education institution has a designated liaison to promote and intervene on mental health and substance use on its campus • Promote strategic action planning to address substance misuse and SUDs at every Oregon public higher education institution	Year 3	**Lead:** ADPC **Partner:** ODE, HECC

42 Higher Education Coordinating Commission. (2018).*Task force on student mental health support.* https://www.oregon.gov/highered/research/Documents/Legislative/SB-231-Mental-Health-Task-Force.pdf

	For all vulnerable and underserved populations: • Develop public, private, and community-based AOD services and crisis response that—if not specializing in these populations—can effectively address their specific needs through the most appropriate services (e.g., counseling, support groups, community and provider education, outreach, complex case consultation, case management, screening) • Increase capacity for monitoring medication misuse within the long-term care system (e.g. in-home services, assisted living facilities, adult foster homes, residential care facilities, skilled care facilities) • Establish a statewide public education campaign to create greater public awareness of—and support for—the substance use issues of vulnerable and underserved populations. This could include establishing a statewide education and training program to create greater public awareness, including community-based education events in key demographic locations around the state, in collaboration with local behavioral health service providers	Year 3	**Lead:** ADPC **Partner:** OHA, ODE, DHS
1.d.2. **Adopt the Tribal Behavioral Health Plan**	Training and credentialing • Establish an accredited tribal learning center approved by Mental Health & Addiction Certification Board of Oregon • Secure funds to develop a qualified tribal workforce to provide a total continuum of care • Create a tribal credentialing system to achieve sustainability for tribal-based behavioral health Tribal-based practices • Create a permanent rule or statue in support of tribal-based practices • Secure state funding for TA in implementing tribal-based practices • Develop a centralized database of tribal-based practices Efficient data systems • Conduct an inventory of all baseline behavioral health data from state, federal, tribal, and local resources • Create and identify culturally relevant, specific tribal behavioral health metrics Tribal consultation policy • Establish regular information sharing between the state and tribes • Provide comprehensive, mandatory annual training for all state employees on how to appropriately engage with tribes • Clarify the relationships and expectations between CCOs and tribes/Native American Rehabilitative Association (NARA)	Year 1	**Lead:** ADPC **Partner:** OHA

	Governance and finance • Ensure adequate tribal representation on regional governance entities, with required metrics and reports • Establish a dedicated funding set-aside for tribal and urban programs to provide adequate, flexible funding • Maintain the existing tribal billing structure, including encounter rates and the fee-for-service system, and expand reimbursement codes	Year 1	**Lead:** ADPC **Partner:** OHA

OBJECTIVE 1.e.: Increase the system's ability to be accountable

Intermediate Outcome: Increase system assessment ratings for accountability from an average score of 1 (on a scale of 1 to 10) from 2019 to an average score of 5 or higher by 2023[43]

Immediate Outcomes	Strategies and Activities	Implementation	Roles
1.e.1. Strengthen the ability of the **system leadership** to be accountable	Create an annual report format with identified data points and indicators	Year 1	**Lead:** ADPC **Partners:** State agency partners
	Assign responsibility for monitoring and reporting the process and outcome measures in this plan to the appropriate state agencies		
	Establish a process and timelines for collecting, compiling, and formatting information from state agency partners		
	Establish a process for disseminating the report and disseminate it		
	Strengthen processes for monitoring, evaluating and documenting the outcomes of investments in services and infrastructure		
	Create a system by which counties will develop an implementation and outcomes plan for monies distributed out of the Mental Health, Alcohol, and Drug Services account	Year 2	
	Align expenditures to goals, objectives, and outcomes		
	Record/disseminate information on activities to members and stakeholders		

43 Assessment tool is available upon request from ADPC

OBJECTIVE 1.f.: Increase the system's ability to be sustainable			
Intermediate Outcome: Increase system assessment ratings for accountability from an average score of 1 on a scale of 1 to 10 from 2019 to an average score of 5 or higher by 2023			
Immediate Outcomes	**Strategies and Activities**	**Implementation**	**Roles**
1.f.1. Increase the ability of leadership to create a **sustainable** state system of substance misuse prevention, treatment and recovery	Establish processes for recruiting new leaders and allies during times of turnover and transition	Year 1	**Lead:** ADPC **Partners:** State agency partners
	Establish processes for coordinating, leveraging, and/or braiding funding and other resources across sectors	Year 3	
	Identify/develop public-private partnerships that can advance/ support system work		
1.f.2. Increase system ability to conduct **strategic finance planning**	Quantify the funding and other resources needed for services and infrastructure (see Appendix F)		
1.f.3. Increase system ability to secure **funding and resources** needed to carry out plan activities and to develop/expand/sustain services and infrastructure at the scope and reach needed to achieve outcomes	Map and monitor new and existing public and private funding and resources (e.g., Medicaid 1115 waiver, if approved)	Year 1	
	Identify opportunities for maximizing/braiding existing funding by more intentional coordination and interagency partnership		
	Identify potential for redirecting funding, including funding freed by improved outcomes, to finance needed services and strategies		
	Increase state wine and beer taxes and dedicate revenues to expand prevention, treatment, and recovery supports		
	Increase excise taxes on tobacco pro*ducts and dedicate revenues to expand prevention, treatment, and recovery supports	Year 1	
	Increase federal funding secured to support prevention, treatment, and recovery supports (e.g., Medicaid 115 waiver, increase number of Drug-Free Communities Support Program grantees)	Year 2	
	Establish public-private partnerships (e.g., with businesses, foundations) to maximize existing, untapped resources and to attract new funding and investments	Year 3	
1.f.4 Increase system ability to **adopt and implement programs, practices, and policies** that lead to sustainable results	Establish a conceptual framework of sustainability focused on achieving and sustaining outcomes into the future by continuously monitoring, adapting, and changing strategies, as needed, rather than merely perpetuating existing efforts	Year 3	
	Use enhanced evaluation and monitoring processes to collectively identify, prioritize, and fund at the scope needed for those programs, practices, and policies to achieve sustainable outcomes	Year 4	

Goal 2: Increase the impact of substance misuse prevention strategies across the lifespan

The Problem: Achieving the impacts identified in this plan—reducing SUDs, preventing ATOD-related deaths and harms, and reducing health disparities—will require a significant expansion of the current scope and reach of prevention across the state. Substance misuse, SUDs, and related harms are substantial public health problems that require coordinated solutions.

Prevention is a set of procedures, practices, and policies designed to inhibit the development of a disorder.

The state's changes in prevention administration and leadership are an opportunity to grow a statewide, comprehensive program approach, providing the organizational infrastructure for prevention programs, policies, and systems change to be successful and sustainable. Oregon's historical focus on youth as the primary target of prevention services provides useful knowledge and experience for reducing the number of new cases of SUDs among Oregonians ages 18 to 25, who have the highest SUD prevalence in the state.

There are, however, multiple other critical populations which experience high levels of risk which would benefit from prevention. These include, but are not limited to, adults ages 55+, persons with disabilities, the LGBTQ+ community, racial and ethnic minorities, immigrants and refugees, rural Oregonians, persons experiencing homelessness and/or lack of access to other basic needs, and military personnel and families and veterans. Reaching these important populations will not only require expanded funding and new evidence-based and culturally tailored strategies and service delivery models, but also new competencies and specialized KSAs.

In addition, while many prevention practitioners may be collecting and analyzing data, the state does not require the use of needs assessment and, as with treatment, cannot evaluate or document the impact of prevention funding on preventing and reducing substance misuse and related problems.

Objectives, immediate outcomes, strategies, and activities involving the prevention workforce and selection of evidence-based strategies are outlined under Goal 1 (see 1.b.3 and 1.c.2). Other prevention-specific objectives, intermediate and immediate outcomes, strategies, and activities start on page 44. Timelines and roles are also noted. Objectives and outcomes for prevention address the following:

2.a. Decrease retail and social access to alcohol, tobacco, and marijuana to underaged persons by:

- Increasing the KSAs of beverage servers, retail alcohol clerks, and retail marijuana clerks to refuse sales to underage persons
- Increasing perception of enforcement and consequence for violating state laws prohibiting sales of alcohol, tobacco, and marijuana to underage persons
- Developing and/or strengthening existing laws and policies addressing underage alcohol, tobacco, and marijuana use and associated consequences
- Building community capacity and supporting community health

2.b. Decrease over service of alcohol in restaurants and bars and retail sales of alcohol to alcohol-impaired adults ages 21+ by:

- Increasing the KSAs of **beverage servers** to refuse sales to persons who are intoxicated or at risk of becoming intoxicated

- Increasing the KSAs of **retail alcohol clerks** to refuse sales to persons who are intoxicated or at risk of becoming intoxicated
- Increasing perception of enforcement and consequence for bars, restaurants, and retail outlets that violate state laws prohibiting sales of alcohol to intoxicated persons

2.c. Decrease family and community norms permissive of ATOD use/misuse across the lifespan by:

- Increasing parental, family, and caregiver knowledge of the health impacts of substance misuse
- Increasing the ability of social hosts and event planners to design alcohol-free events for persons across the lifespan
- Increasing community capacity to maintain or expand health protections that influence permissive community norms for ATOD use
- Increasing family protective factors

2.d. Increase perception of harm of ATOD use/misuse across the lifespan by:

- Increasing knowledge of the harm associated with alcohol misuse across the lifespan, including drug and alcohol interactions
- Increasing knowledge of the harm associated with tobacco use across the lifespan
- Increasing knowledge of the harm associated with other drug use/misuse across the lifespan

2.e Increase use of effective prevention across the lifespan by:

- Increasing knowledge of types and quantities of prevention strategies needed to enhance statewide outcomes
- Increasing knowledge of the types and levels of prevention that currently exist to support prevention across the state
- Identifying and expanding prevention models proven to be effective
- Increasing the ability to identify and expand existing prevention strategies that are producing positive outcomes
- Increasing ability to provide an effective system of family support
- Increasing use of effective and culturally and linguistically appropriate prevention programs for historically underserved communities, such as seniors, people with disabilities, LGBTQ+, persons of color, and tribal nations

2.f. Increase access to APSM therapies by:

- Increasing knowledge of types and quantities of APSM needed to prevent substance misuse across the state in community and other settings
- Increasing ability to fund—and adequately reimburse—APSM services at the scale and scope needed
- Increasing knowledge of the types and levels of APSM that currently exist across the state

2.g. Increase collection and use of data to evaluate prevention outcomes by:

- Increasing knowledge of consumer experiences in accessing and using recovery support services
- Increasing knowledge of outcomes from prevention services

Voices from the Field

JULIE SPACKMAN, *Certified Prevention Specialist (CPS), attended the Regional Stakeholder Meeting in Bend. As the Prevention Lead with Deschutes County Health Services, she is passionate about using data-based and community-driven methods to prevent and reduce substance use among youth and young adults in the county.*

Deschutes County Health Services is charged with helping to address the basic health and wellness needs of residents in Bend, La Pine, Redmond, and Sisters, Oregon. The department's Substance Abuse Prevention Program (SAPP) seeks to reduce and prevent substance use and abuse, as well as related risk behaviors (e.g., suicide, bullying, problem gambling), primarily among school- aged youth and young adults ages 18-25 years. SAPP staff use SAMHSA's Strategic Prevention Framework to ensure that programs and strategies produce results by positively impacting the environments in which their target populations population live, work, study, and play. The SAPP team works across multiple topic areas, focusing on substances with the highest prevalence of use: tobacco, alcohol, and marijuana. Over the past four years, it has also increased collaboration with regional stakeholders to reduce prescription drug misuse/abuse and to prevent drug overdoses. Knowing that single-sector efforts alone can't solve substance use problems, Spackman and her colleagues foster cross-sector collaborations, including facilitating the county-wide Shared Future Coalition, to leverage the resources, manpower, and expertise needed to address each community's concerns. "We engage the community in the entire design cycle—to understand and learn about the factors driving substance abuse in our community and to select best practice solutions and the dosage needed to make a difference," she notes. These efforts include a 2019 pilot program with one school district to ensure that all youth who violate school alcohol and drug policies are assessed and referred to appropriate services. Spackman notes that state-level changes in prevention in recent years have been somewhat challenging for practitioners, and her hope for the future includes: (1) a unified agreement about what prevention is and should look like in Oregon, (2) increased use of coalitions to support cross-sector collaboration and to break down siloes, and (3) greater use of a comprehensive array of evidence-based prevention approaches.

CAROLINE CRUZ *is a multi-faceted woman with decades of wisdom and experience. As a member of the Confederated Tribes of Warm Springs, a Commissioner with ADPC, and a CPS, she is a vocal and tireless advocate for her people and all of those she serves. She worked with the State Addictions and Mental Health Division for 21½ years and was a strong force in developing the foundation of prevention.*

Like many in Oregon, Cruz has been concerned with the major changes that have occurred in the field of prevention over the past decade. She feels a lack of leadership and understanding of the science of prevention is impacting the integrity and quality of services. "There is a lot of frustration. Many in the prevention field have voiced their concerns but are not being heard; they feel voiceless," she notes, adding, "There appears to be a lack of trust and/or coordination among state and local prevention partners." In addition, although CCOs are required to implement prevention efforts, Cruz says there are no guidelines for those efforts. "People want a process

they can follow, a process which involves working with families, communities, schools, and individuals, as well as environmental strategies and policies. They want a process that works with community values and needs." Cruz notes that the "Tribal Based Practices" template that she participated in developing for native populations, which was then refined by Native American professionals, Oregon Tribes, and NARA, can also be applied to other indigenous populations. "Indigenous practices that come from our culture have guided us for years, but, in some populations, cultural practices have not been sustained, and some of the population—especially younger people and those born in US—have left their cultural practices," she says. Cruz is also troubled that the state no longer requires the prevention workforce to become certified and is quick to note that the Confederated Tribes of Warm Springs continues to require prevention certification, as do the other tribes, and NARA. Cruz wants to see a comprehensive, rather than siloed, approach to prevention—one in which the workforce understands the foundation and the science of prevention, as well as the impacts of AOD use on families, communities, schools, individuals, and health disparities. "It is crucial," she says, "that the workforce is developed from within the community and Native/Indigenous populations." Cruz ends by noting: "We continue to further understand the trauma we as Native Americans have gone through, which has contributed to higher-than-average SUDs, but we also acknowledge how resilient we have been over the years, which gives us hope. Our culture is prevention, our culture is treatment, and our culture is making us healthier. Our strength is our tribal communities working together and sharing our tribal-based practices with each other."

"Our culture is prevention, our culture is treatment, and our culture is making us healthier. Our strength is our Tribal communities working together and sharing our tribal -based practices with each other."

OBJECTIVE 2.a.: Decrease retail and social access to alcohol, tobacco, and marijuana to underaged persons

Intermediate Outcomes:

- Decrease the retail violation rate (RVR) of alcohol sales to minors from **18%** in 2019 to **10%** or less by 2023[44]
- Decrease the RVR of retail marijuana sales to minors from **18%** in 2019 to **10%** or less by 2023[45]
- Decrease the retail violation rate of tobacco sales to minors from **16.0%** in 2019 to **10.0%** or less by 2023[46]
- Decrease the percentage of students who report it would be sort of or very easy to get beer, wine, or hard liquor
  - 8th grade: from **44.1%** in 2019 to **41.5%** by 2023
  - 11th grade: from **63.7%** in 2019 to **59.9%** by 2023
- Decrease the percentage of students who report it would be sort of or very easy to get marijuana
  - 8th grade: from **30.0%** in 2019 to **28.2%** by 2023
  - 11th grade: from **58.5%** in 2019 to **55.0%** by 2023
- Decrease the percentage of students who report it would be sort of or very easy to get e-cigarettes
  - 8th grade: from **30.6%** in 2019 to **28.8%** by 2023
  - 11th grade: from **56.0%** in 2019 to **52.6%** by 2023

Immediate Outcomes	Strategies and Activities	Implementation	Roles
2.a.1. Increase KSAs of beverage servers, retail alcohol clerks, and retail marijuana clerks to **refuse sales to underage persons**	Provide training to restaurant/bar servers and retail alcohol and marijuana clerks on how avoid sales to underage persons (e.g., requesting and reading identification)	Year 2	**Lead:** ADPC **Partner:** Oregon Liquor Control Commission (OLCC), OHA
2.a.2. Increase **perception of enforcement and consequence** for violating state laws prohibiting sales of alcohol, tobacco, and marijuana to underage persons	Increase/conduct compliance inspections of retail outlets, bars, and restaurants to monitor retail violation rates		
2.a.3. **Develop/strengthen existing laws and policies** addressing underage alcohol, tobacco, and marijuana use and associated consequences	Encourage communities to implement policy interventions, such as alcohol outlet density, signage regulations, and restrictions on days and hours of sale		
	Increase the price of alcohol and dedicate at least 10% of the revenue to alcohol prevention and education programs		
	Increase the number of jurisdictions that protect youth from exposure to tobacco industry marketing and promotion in stores and other retail settings through strategies such as bans of flavored tobacco products and price promotions		
	Increase the price of tobacco through increased tax, coupon limits, and minimum price and dedicate at least 10% of the revenue to tobacco prevention and control programs		

44 Oregon Liquor Control Commission. (2017). *Annual performance progress report, Reporting year 2017.* https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/TOBACCOPREVENTION/Documents/Tobacco_enforcement_1819_ExecutiveSummary.pdf
45 Oregon Liquor Control Commission. (2017).
46 OHA Oregon Tobacco Enforcement

	Eliminate youth access to appealing, flavored, starter tobacco products, including e-cigarettes, little cigars and menthol cigarettes	Year 3	**Lead:** ADPC **Partner:** OLCC, OHA
	Limit density and restrict location of tobacco retail outlets		
	Oregon continues to maintain regulation over alcohol		
	Strengthen Oregon's social host law to include over service of alcohol as a cause of action		
2.a.4. **Build community capacity and support community health**	Support local county and city policies to prevent the misuse of alcohol, tobacco, and cannabis		
	Work to counter the influence of the industry where harms can reduce the health of the public, i.e., youth use and adult abuse of alcohol, tobacco, and cannabis		
	Support the development of local vape- and smoke-free campus policies		

OBJECTIVE 2.b.: Decrease over service of alcohol in restaurants and bars and retail sales of alcohol to alcohol-impaired adults ages 21+

Intermediate Outcomes: Note: Data are not currently available to establish a direct baseline for over service of alcohol and retail sales of alcohol to impaired adults. As data infrastructure is developed (e.g., use of "point of source" data), and the strategies below are implemented, measures should be developed to help Oregon better monitor progress toward meeting this objective. In the interim, state DUI data, including Behavioral Risk Factor Surveillance System data on drinking and driving, could be used as proxy measures (although these would include social, as well as retail, access).

Immediate Outcomes	Strategies and Activities	Implementation	Roles
2.b.1. Increase KSAs of beverage servers to **refuse sales to persons who are intoxicated** or at risk of becoming intoxicated	Conduct TTA designed specifically for the service industry that teaches ways to identify persons who are overserved (e.g. physiological and behavioral characteristics of intoxication) and to know their rights to refuse service	Year 3	**Lead:** ADPC **Partner:** OLCC
2.b.2. Increase KSAs of retail alcohol clerks to **refuse sales to persons who are intoxicated** or at risk of becoming intoxicated	Conduct TTA designed specifically for the retail clerks that teaches ways to identify persons who are overserved (e.g. physiological and behavioral characteristics of intoxication) and to know their rights to refuse a sale		
2.b.3. Increase **perception of enforcement and consequence** for bars, restaurants, and retail outlets that violate state laws prohibiting sales of alcohol to intoxicated persons	Conduct an educational campaign designed to educate outlet managers and staff to understand the liabilities and penalties associated with serving or selling alcohol to intoxicated persons	Year 3	
	Use "point of source" data to identify and target retail, bar, and restaurant violators for increased education and inspections	Year 4	
	Adopt dram shop liability laws to hold retail outlets, bars, and restaurants responsible for damages due to intoxicated patrons		

OBJECTIVE 2.c.: Decrease family and community norms permissive of ATOD use/misuse across the lifespan[47]

Intermediate Outcomes:

- Increase the percentage of students who report their parents would feel it was very wrong for them to drink beer, wine, or liquor regularly
  - 8th grade: from **67.6%** in 2019 to **71.9%** in 2023
  - 11th grade: from **54.8%** in 2019 to **58.3%** in 2023
- Increase the percentage of students who report their parents would feel it was very wrong for them to use marijuana
  - 8th grade: from **75.7%** in 2019 to **80.5%** in 2023
  - 11th grade: from **62.5 %** in 2019 to **66.5%** in 2023

Note: Data are not currently available to establish a direct baseline for norms regarding ATOD use among adults. As data infrastructure is strengthened and developed, and the strategies below are implemented, measures should be developed (e.g., expanding existing ,or creating new adult surveys) to help Oregon better monitor progress toward meeting this objective among adult populations.

Immediate Outcomes	Strategies and Activities	Implementation	Roles
2.c.1. Increase parental, caregiver, and family **knowledge of the health impacts** of substance misuse	Conduct media and other public health education campaigns to educate parents, caregivers, and family members about the developmental and health impacts of psychoactive substances on adolescents, older adults, and other vulnerable populations	Year 1	**Lead:** ADPC **Partner:** OHA, DHS
	Develop an effective system of school- and community-based family supports		**Lead:** ADPC **Partner:** OHA, DHS
2.c.2. Increase the ability of social hosts and event planners to **design engaging, alcohol-free activities** and events for persons of all ages	Increase the number of community and other events that are alcohol-free by producing or making available materials that can be used/ adapted for social events (e.g., existing resources, tools, techniques produced by recovery support, other efforts)	Year 4	**Lead:** ADPC **Partner:** OHA, DHS
	Increase parental and caregiver knowledge of the health impacts of adolescent substance use	Year 2	
	Increase the ability of social hosts and event planners to design engaging, alcohol-free activities and events for persons of all ages	Year 4	
2.c.3. Increase community capacity to **maintain or expand health protections** that influence permissive community norms for ATOD use	Ensure that Indoor Clean Air Act public health protections remain and exposure to indoor cannabis smoke does not proliferate	Year 4	**Lead:** ADPC **Partner:** OHA, DHS
2.c.4. Increase **family protective factors**	Address the major family risk and protective factors affecting child and adolescent substance use through evidence-based family interventions (e.g., parental monitoring and limit setting, positive family relationships)	Year 1	

47 OHA. (2019).

	Address the major peer influences on child and adolescent substance use through evidence based school interventions to: (1) reduce social rejection, marginalization, or discrimination; (2) promote prosocial behaviors, such as self-regulation, cooperation, and academic success; and (3) prevent the formation of deviant peer groups	Year 1	**Lead:** ADPC **Partner:** OHA, DHS, ODE, HECC

OBJECTIVE 2.d: Increase perception of harm of ATOD use/misuse across the lifespan

Intermediate Outcomes:

- Increase the percentage of students who report perceiving great risk from taking one or two drinks of an alcoholic beverage nearly every day[48]
  - 8th grade: from **19.1%** in 2019 to **20.3%** in 2023
  - 11th grade: from **21.5%** in 2019 to **22.9%** in 2023
- Increase the percentage of students who report perceiving great risk of smoking marijuana at least once or twice a week[49]
  - 8th grade: from **30.5%** in 2019 to **32.4%** in 2023
  - 11th grade: from **22.0%** in 2017 to **23.4%** in 2023
- Increase the percentage of student who report perceiving great risk of using e-cigarettes or vaping every day
  - 8th graders: from **68.1%** in 2019 to **72.4%** to 2023
  - 11th graders: from **67.9%** in 2017 to **72.2%** in 2023

Note: Data are not currently available to establish a direct baseline for perception of harm regarding ATOD use among adults. As data infrastructure is strengthened and developed, and the strategies below are implemented, measures should be developed (e.g., expanding existing or creating new adult surveys) to help Oregon better monitor progress toward meeting this objective among adult populations (including perceptions regarding mixing alcohol and prescription and other drugs).

Immediate Outcomes	Strategies and Activities	Implementation	Roles
2.d.1.Increase **knowledge of the harm associated with alcohol misuse** across the lifespan, including drug and alcohol interactions	Develop, implement, and evaluate health education and prevention mass-media campaigns that will reach youth, young adults, and communities with ATOD prevention and education messages Provide culturally tailored education for vulnerable/high risk populations on use of addictive drugs, drug interactions, and mixing alcohol with other drugs	Year 1	**Lead:** ADPC **Partner:** OHA
2.d.2.Increase **knowledge of the harm associated with tobacco use** across the lifespan			
2.d.3.Increase **knowledge of the harm associated with other drug misuse** across the lifespan	Work with the OLCC to evaluate and implement appropriate regulation on advertising for marijuana products in order to limit risk of promoting misuse of, and dependence on, marijuana Consider the approaches of other states who have worked to regulate marijuana advertising to protect health		

48 OHA. (2019)
49 OHA. (2019)

OBJECTIVE 2.e.: Increase use of effective prevention across the lifespan			
Intermediate Outcomes: Note: The data collected in 2.e.1. -2.e.3. will provide information that can be used to establish a baseline and to monitor progress toward this objective.			
Immediate Outcomes	**Strategies and Activities**	**Implementation**	**Roles**
2.e.1. Increase knowledge of **types and quantities of prevention services needed to enhance prevention outcomes** across the state	Implement a process (e.g., Calculating for an Adequate System Tool [CAST] or equivalent) for estimating projected numbers, locations, and characteristics of persons annually needing prevention services across the lifespan—by type and level—in community and other settings[50]	Year 1	**Lead:** ADPC **Partner:** OHA
2.e.2. Increase knowledge of the **types and levels of prevention that currently exist** to support prevention across the state	Create an inventory that includes private- and publicly funded prevention strategies and resources		
2.e.3. **Increase the adoption of evidence-based** family and school-based **interventions**	Ensure that Oregon uses the most effective prevention strategies Address the major peer influences on child and adolescent substance use through evidence-based school interventions to (1) reduce social rejection, marginalization, or discrimination; (2) promote prosocial behaviors, such as self-regulation, cooperation, and academic success; and (3) prevent the formation of deviant peer groups		
	Ensure that every school has a system for tracking (1) the extent of social rejection marginalization and discrimination, (2) students' academic progress, (3) prosocial behavior, and (4) deviant peer group formation	Year 2	**Lead:** ADPC **Partner:** OHA, ODE
2.e.4. Increase ability to **identify and expand existing prevention strategies** that are producing positive outcomes	Once evaluation systems are developed, use data to formally identify and increase investments in those prevention and associated early intervention and harm reduction services that are producing desired outcomes across the lifespan, including using lessons learned to adapt/scale them up, as needed	Year 3	**Lead:** ADPC **Partner:** OHA
	Ensure continued strong enforcement of sales restrictions that hold accountable retailers who sell tobacco to kids under age 21		**Lead:** ADPC, OLCC
	Ensure comprehensive alcohol screening, referral, and treatment benefits are available through public and private health plans		
	Ensure linkages and referrals to culturally appropriate tobacco quit services		**Lead:** ADPC **Partner:** OHA
2.e.5. Increase ability to **provide an effective system of family supports**	Ensure the provision of effective positive behavioral supports in all early learning settings and schools		**Lead:** ADPC **Partner:** OHA, DHS, ODE, HECC
	Establish a system for monitoring the well-being of children and adolescents		

50 Other settings include, but are not limited to, schools (e.g., student assistance programs), places of employment (e.g., EAP), higher education, congregate living facilities, medical and psychiatric facilities, and correctional facilities

2.e.6. Increase **effective, culturally and linguistically appropriate prevention programs** for historically under- served and vulnerable populations	Use data collected through 2.e.1. and 2.e.2, combined with needs assessment data, to identify and address gaps in prevention services for historically underserved and vulnerable populations	Year 3	**Lead:** ADPC **Partner:** OHA
	Develop/increase partnerships with postsecondary institutions to develop prevention infrastructure sufficient to address the needs of all student populations	Year 1	**Lead:** ADPC **Partner:** OHA, HFCC

OBJECTIVE 2.f.: Increase access to APSM therapies

Intermediate Outcomes: Note: The data collected in 2.f.1. -2.f.2. will provide information that can be used to establish a baseline and to monitor progress toward this objective.

Immediate Outcomes	Strategies and Activities	Implementation	Roles
2.f.1. Increase knowledge of **types and quantities of APSM needed** to prevent substance misuse across the state in community and other settings	Create a process for using available data and information on prescription drug and medical service utilization rates to estimate the numbers of persons with chronic pain who might benefit from APSM and reduce reliance on ER and other higher-cost services	Year 1	**Lead:** ADPC **Partner:** OHA
2.f.2. Increase **knowledge of the types and levels of APSM that currently exist** across the state	Create an inventory that includes private and semi-private, as well as publicly funded, APSM		
2.f.3. Increase ability to **adequately fund—and reimburse—APSM services**	Work with insurers, primary care providers, and provider networks to establish policies that facilitate referral to APSM when appropriate; increase the number of covered treatments; and increase reimbursement rates to cover the cost of providing services		**Lead:** ADPC **Partner:** OHA, HBCS

OBJECTIVE 2.G.: Increase collection and use of data to evaluate prevention outcomes

Intermediate Outcomes: Note: Oregon does not currently have a statewide system for collecting and using evaluation data to analyze prevention outcomes. As evaluation capacity is developed and resourced, measures should be developed to help Oregon monitor progress toward meeting this objective and the strategies below.

Immediate Outcomes	Strategies and Activities	Implementation	Roles
2.g.1. Increased **knowledge of consumer experience**s in accessing and using recovery support services	Create a feedback system that can continuously elicit process and out-come evaluation data from consumers and their families about their experiences and outcomes	Year 2	**Lead:** ADPC **Partner:** OHA
2.g.2. Increased **knowledge of outcomes** from prevention services	Strengthen funding recipient requirements for collecting and reporting process and outcome treatment data.		
	Develop a state evaluation system that can use data tools and infra-structure to regularly and accurately collect and analyze provider and other data and report outcomes		

Goal 3: Increase rapid access to effective SUD treatment across the lifespan

The Problem: Oregon has some of the highest rates in the nation for substance misuse and SUDs, as well as some of the lowest rates of access to treatment. A September 2019 report, released by the Oregon Criminal Justice Commission in response to Senate Bill 1041, summarized the state's rankings as follows:

> **Addiction treatment services** are designed to engage individuals and their families in the discontinuation of the misuse of alcohol and other drugs, to return to the previous level of biopsychosocial functioning, to address the root causes of SUD, and to move into a system of recovery and support (ADPC Framework, 2018)

Oregon ranks among the most challenged states in the nation for substance abuse and mental health problems, while at the same time ranking among the worst states for access to and engagement with care. In 2017, Oregon ranked first in marijuana use and pain reliever misuse, second in methamphetamine use, and fourth in cocaine use nationally. The same year Oregon ranked fourth in both alcohol use disorders and substance use disorders. Also, in 2017, Oregon had the second highest rate of mental illness and ranked third for needing but not receiving treatment for alcohol and illicit drugs, and fifteenth for receiving mental health services.[51]

The SB 1041 report found, as did previous reports, that persistent and significant limitations in data infrastructure, reporting, and assessment and evaluation capacity mean the state is unable to document any outcomes (positive or negative) that are being produced by the state's public or commercially-funded SUD treatment programs. As noted elsewhere in this plan, other serious gaps in information include counts, characteristics, and geographic locations of those who need SUD treatment, as well as the types, scale, and scope of SUD services needed.

These concerns and capacity issues are symptomatic of historical underfunding and a lack of attention at all levels. While health care reform in Oregon has made earnest gains in the physical health sector, behavioral health services for substance misuse, SUDs, and mental health have languished due to an inconsistent, fractured, and reactive funding environment that inhibits the development of a continuum of care.

For example, Oregon currently has very few residential SUD treatment beds for youth. As a result, families fortunate enough to obtain treatment for their children often find themselves hours from their child's treatment facility. This makes whole family treatment unlikely and burdensome for families, which are likely already under strain. Families with commercial insurance often must either pay out of pocket for services or send their children out of state for treatment due to poor service coverage in Oregon. When the latter happens, sustained recovery upon return to Oregon can be compromised by a lack of follow-up services and community recovery supports. In addition, Oregon lacks appropriate treatment resources to meet the specific needs of seniors and persons with disabilities.

While the issues with Oregon's substance misuse service system have been clearly documented, the state has struggled to realize its potential and vision because of the lack of a clear path forward for connecting and expanding the reach of services. The state has also struggled to address new and changing trends in substance misuse and an ongoing crisis involving workforce recruitment and retention. Without immediate action to significantly increase treatment access and enhance the state's ability to recruit, train, and adequately reimburse a highly qualified substance misuse services workforce, Oregon will continue to languish among those states with the poorest outcomes for its citizens. Creating a coordinated, statewide SUD continuum of care that is responsive, accessible, culturally informed, capable of serving priority populations across the lifespan, and able to meet emerging and changing trends will require a robust partnership of state-level and commercial-sector leadership, continuum of care providers, and stakeholders. It will also require addressing SUD through a chronic disease model across the lifespan that integrates co-occurring services.

51 Analysis of Oregon's Publicly Funded Substance Abuse Treatment System: Report and Findings for Senate Bill 1041. Oregon Criminal Justice Commission. https://www.oregon.gov/cjc/CJC%20Document%20Library/SB1041Report.pdf

Objectives, immediate outcomes, strategies, and activities involving the treatment workforce and selection of evidence-based strategies are outlined under Goal 1 (see 1.b.3 and 1.c.2). Other treatment-specific objectives, intermediate and immediate outcomes, strategies, and activities start on page 54. Timelines and roles are also noted. Objectives and outcomes for treatment address the following:

3.a. Increase access to all levels and types of SUD treatment, intervention, and harm reduction for those in need of treatment by:

- Identifying the gaps in types, levels of care, and access of medically necessary SUD treatment, intervention, and harm reduction that are needed compared to current public and commercial network adequacy and access across the state
- Supporting state guidance, rules, payment structures, and accountability that supports the access and operationalization of the identified needs in the SUD treatment continuum of care, including over- and underutilization of services
- Supporting the ability of a responsive SUD system in identifying and investing in expanding treatment, intervention, and harm reduction models that are proven to be effective and meet population needs over time
- Identifying persons at risk of or experiencing health, social, or legal consequences from ATOD use and providing them with intermediaries to facilitate access to needed SUD treatment services, and bolstering existing resources, such American Society of Addiction Medicine, in the state to efficiently work across continuum of care partners.
- Expanding culturally responsive and specific SUD treatment access to underserved communities and populations
- Developing innovative new SUD treatment solutions, including behavioral telehealth and emerging technology

3.b. Decrease barriers to treatment by:

- Increasing public awareness of SUD as a chronic public health issue that requires medically necessary health care service attention and ongoing management
- Increasing public knowledge of available treatment resources and how to access them
- Increasing access to basic need supports and other resources
- Increasing access to whole family supports and other resources
- Supporting parents/guardians experiencing addiction by providing assessment, parenting and family strengthening classes, counseling, and trauma-informed childcare
- Supporting youth and children experiencing addiction by providing assessment, parenting and family strengthening classes, and counseling
- Reducing Medicaid gap coverage for persons exiting correctional facilities

3.c. Improve collection and use of data to evaluate treatment access, processes, and outcomes by:

- Increasing knowledge of consumer experiences in accessing and using treatment services
- Increasing knowledge of consumer outcomes from accessing treatment services
- Increasing knowledge of consumers' payors success in SUD access and payor success in improving network adequacy
- Increasing knowledge of population needs to support gap analysis and SUD treatment capacity, including, but not limited to, screening outcomes, number of screenings leading to assessment and referral, number of individuals assessed for different levels of care, and engagement between levels of care

Voices from the Field

OSCAR BECERRA, *a CADC I at the Centro Latino Americano in Eugene, was visiting his family in Hood River when he heard about the ADPC stakeholder meetings in The Dalles. Although the afternoon meeting was well attended, Becerra was the only person to show up for the Town Hall meeting later that night. While others might have beat a hasty retreat upon entering the near empty room, he pulled up a chair, eager to learn what he could while sharing his journey as a young alcohol and drug counseling professional.*

Becerra was the first in his family to attend college. "After high school, I wasn't sure what I wanted to do," he says, "but I was very interested in psychology and how culture played out in my life in terms of choices and decision-making." In Hispanic/Latinx culture, he notes, "there is an emphasis on community. I really wanted to do something to help others. That was a cultural value, but I was also a beneficiary of youth group and family support." Becerra found the first two years of college difficult. His friends didn't have same motivation he did, dropping out and taking roofing and other jobs with people who were older and using substances. "I wasn't ever one to seek out that kind of company," he says, "but because they were my friends, I went out with them." When Becerra was charged with a DUI at 19, it was a pivotal point in his life. "When I met other people in the DUI group," he says, "I became interested in the holistic view of things—upbringing, family values, living environment. I could quickly see that if the community didn't take care of its people, they could fall to substance abuse." Becerra spent the next two years two years juggling his certification courses with undergraduate school and part-time work at Centro. He is now 24 years old and also the first in his family to graduate from college. He splits his time between preventing and treating SUDs—the best of both worlds, he calls it. His prevention world includes implementing a school-based prevention program with middle school students, which he says can be challenging because "there is a need for programming to be adapted for our culture." For example, one of the lessons teaches kids how to be assertive, but in Hispanic/Latinx culture, assertiveness is viewed as a sign of being rebellious. "This is why it is important to have facilitators that are not only bi-lingual but also bi-cultural," Becerra notes. He finds that students respond positively when their experiences are validated and they feel heard. When working with the men's alcohol addictions group—his treatment world—Becerra says he is sometimes called "Muchacho," or "young man." Becerra says he humbles himself, recognizes his own limitations, and draws from the principles he was taught during his upbringing to earn their respect and to get them to see him as the group's leader. "Earning respect is the most important thing" he says. "I could be the most educated person in the room, but if I don't have their respect it's not going to work." Nearly 10% of Lane County's population is Hispanic/ Latinx, and this population is extremely diverse, with language and cultural differences depending on their country of origin. Becerra laughs and says the students and adults he works with from countries such as Guatemala and El Salvador sometimes respond to his words by saying, "That's a Mexican thing." Becerra says some of the biggest challenges in his work involves the challenges of men seeking help and the role of gender in the workplace. "There are only four males in my workplace. It can be isolating," he says. "There are not a lot of young people or

> *"If the community doesn't take care of its people, they can fall to substance misuse."*

> *"There is a need for programming to be adapted for our culture. It is important to have facilitators that are not only bi-lingual but also bi-cultural."*

males in my office, and going to lots of parties in Eugene is not what I want to do. It would be nice," he continues, "to have coworkers to socialize with." When asked what the biggest barrier young people going into behavioral health face, Becerra responds, "It might be the age thing." Overall, however, Becerra is extremely happy with his career choice. "I feel that I'm making a difference," he says, "that my life experience is valuable. I love working with my community to use both sets of skills to prevent and treat substance abuse. It's the best of both worlds."

OBJECTIVE 3.a.: Increase access to all levels and types of SUD treatment, intervention, and harm reduction for those in need of treatment

Intermediate Outcomes: Although data do not exist for those covered by commercial- or private-pay-funded services, the following measures could be used at the public payor level to monitor progress toward this objective for those receiving publicly funded services (although obtaining non-Medicaid data will require first repairing or replacing Measures and Outcomes Tracking System):

- Decrease wait time for treatment/numbers of persons on waitlist (including by type of need and level of care)
- Increase access to community-based treatment alternatives to decrease AOD-related prosecution/incarceration
- Increase treatment retention rates at 3, 6, and 9 months

Changes over time from the baselines are established through 3.a.1.-3. a.3. below.

Immediate Outcomes	Strategies and Activities	Implementation	Roles
3.a.1. Increase knowledge of the priority **types, levels of care, and access of quantities of SUD treatment needed** across the state in community and other settings[52]	Implement a process (e.g., CAST or equivalent) for estimating projected numbers, locations, and characteristics of persons annually needing treatment and associated intervention and harm reduction across the state—by type and level—in community and other settings	Year 1	**Lead:** ADPC **Partner:** OHA
3.a.2. Increase knowledge of the **types, levels of care, access to SUD treatment that currently exist** in all community and other settings, as well as payor success in improving network adequacy	Create a system to collect wait times that does not penalize providers and payors but incentivizes success		
	Implement a system to track screening and or referred individuals (waitlist potentials) that provides, but is not limited to, the following information: screening outcomes, number of screenings leading to assessment and referral, number of individuals assessed for levels of care, and engagement between levels of care		
	Implement system(s) to monitor access to and to identify need for statewide priorities, including but not limited to: alcohol treatment services, MAT, methamphetamine/psychostimulant-focused treatment, underserved populations, whole family, youth and pregnant and parenting persons		
	Require members of the criminal justice system working with individuals in treatment to undertake six hours of continuing education designed to increase their knowledge of issues related to SUD and treatment concepts	Year 2	**Lead:** ADPC **Partner:** OHA, ODE, HECC
3.a.3. Increase ability to **maximize and expand existing effective treatment capacity** (e.g., increase types and numbers of needed services), while strategically targeting areas for new service development	Implement an infrastructure that supports increasing the percentage of providers who provide state-identified priority SUD treatment types, based on priority populations and usage trend, needed in both community and institutional settings	Year 1	**Partner:** DCBS
	Once evaluation systems are developed, use data to formally identify and increase investments in those treatment services that are producing desired outcomes across the lifespan, using lessons learned to scale them up as needed	Year 2	**Lead:** ADPC **Partner:** OHA

52 Other includes, but is not limited to, college/university housing, other congregate living facilities, medical and psychiatric facilities, and correctional facilities

3.a.4. Increased ability to identify persons at risk of or experiencing health, social, or legal consequences from AOD use and provide them with appropriate **intermediaries to facilitate access to needed treatment services**	Build on existing state screening, level of care, and assessment structures to improve ease of referral and to increase data collection for statewide continuum of care system analyses and operations • Establish infrastructure that ensures that all K-12 and postsecondary students who violate school AOD policies or otherwise may be experiencing substance-use-related problems are assessed and referred to appropriate levels of service • Require primary care providers to administer a validated screening tool to each of their patients on an annual basis	Year 1	**Lead:** ADPC **Partner:** OHA, ODE, HECC
	Establish relationships with workplace EAP to connect them to service networks and to enhance their ability to refer employees experiencing substance-use-related problems to appropriate assessment and/or treatment services	Year 2	**Lead:** ADPC **Partner:** OHA
	Strengthen assessment processes used in correctional facilities, as needed, to ensure that the treatment needs of persons in custody are fully identified and documented		**Lead:** ADPC **Partner:** OHA
	Provide law enforcement officers and other first responders with biannual training on SUDs that is responsive to identified state priorities and community needs over time		**Lead:** ADPC **Partner:** OHA
3.a.5. Increase ability of intermediaries and practitioners[53] to **connect clients to same day access to appropriate levels of treatment,** including detox, residential, and/or outpatient treatment	Evaluate and implement system supports, including but not exhaustive to, regulations, rules, and payment structures that enable SUD providers to deliver services the same day they are requested	Year 1	**Lead:** ADPC **Partner:** OHA
	Require hospitals to have a certified SUD specialist available 24 hours a day, seven days a week		**Lead:** ADPC **Partner:** OHA
	Increase funding for treatment service types that are in highest demand to providers that can document outcomes and in locations where they are most immediately needed		**Lead:** ADPC **Partner:** OHA, DBCS
	Implement an online system that provides real-time information on available prevention, treatment, and recovery services and basic supports, which is searchable by types, locations, and other key criteria		
	Require that individuals seen in urgent care and EDs for opioid use disorders be discharged with naloxone kits and referrals to assessment/treatment		**Lead:** ADPC **Partner:** OHA

53 Practitioners include, but is not limited to those employed in social services, peers, behavioral health, medical/primary care, education, law enforcement, and corrections

3.a.6. Increase ability to **expand treatment access** to underserved persons and communities, as well as those at higher risk	Expand use of distance technologies (e.g., telemedicine) to provide high-quality care (basic and specialized) in underserved areas	Year 2	**Lead:** ADPC **Partner:** OHA, DBCS
	Increase access to specialized residential and outpatient treatment for all vulnerable/higher-risk populations		
	Increase the number of providers who accept Medicare funding for treatment		**Lead:** ADPC **Partner:** OHA
	Fund a level of treatment for individuals that are justice involved that ensures a continuum of care before, during, and post incarceration		**Lead:** ADPC **Partner:** OHA, OYA, DOC, OSP
	Use data collected through 3.a.1., 3.a.2., and 3.a.3. to partner with postsecondary institutions to develop assessment and treatment infrastructure sufficient to address the needs of all student populations		**Lead:** ADPC **Partner:** OHA, HECC
	Increase use of mobile, outreach-focused treatment services that engage homeless populations in shelters and on the street using a bio-psycho-social model that doesn't require them to come to a clinic.		**Lead:** ADPC **Partner:** OHA
	Establish policies and provide funding, as needed, to ensure that parents/guardians with an SUD, whose child is placed in protective services, are provided immediate access to the appropriate level of SUD treatment	Year 1	**Lead:** ADPC **Partner:** OHA, DHS
	Increase the number of residential treatment programs where parent/guardians may enter with their children	Year 2	
	Create co-occurring options for treatment billing and reimbursement		**Lead:** ADPC **Partner:** OHA, DCBS
	Work with private and public insurers to increase coverage for all needed types of SUD treatment		
	CCOs need to contract for residential care at funding levels not required to be subsidized by the provider		**Lead:** ADPC **Partner:** DCBS
3.a.7. Increased ability to **conduct research and produce innovative new treatment solutions** for SUDs for which there are limited effective treatment modalities	Create a futures and innovation workgroup to develop, explore, and recommend new and emerging modalities	Year 3	**Lead:** ADPC **Partner:** DCBS
	Increase state funding for innovative research on new treatment solutions		**Lead:** ADPC **Partner:** DCBS

OBJECTIVE 3.b.: Decrease barriers to treatment			
Intermediate Outcomes: Note: Data are not currently available to establish a direct baseline for reducing barriers to treatment or for monitoring changes in public awareness of SUD or knowledge of resources. As data infrastructure is strengthened and developed, and the strategies below are implemented, measures should be developed (e.g., expanding existing or creating new adult surveys or other data collection processes) to help Oregon better monitor progress toward meeting this objective.			
Immediate Outcomes	**Strategies and Activities**	**Implementation**	**Roles**
3.b.1. Increase **public awareness of SUD as a chronic public health issu**e that requires medical attention and ongoing management	Create a statewide public education campaign (e.g., print, social media, broadcast) that links to the interface in 3.b.2.	Year 3	**Lead:** ADPC **Partner:** OHA, DHS
	Launch periodic, universal, public education campaign at the state and local levels that addresses substance use behavior and stigma targeted at different developmental stages that considers the lifespan of an individual		
3.b.2. Increase **public knowledge of available treatment resources** and how to access them	Create user-friendly interfaces (e.g., "warm line," case manager, liaison, peer mentor) with the online system above to help those needing treatment and their friends and families use it	Year 1	
3.b.3. Increase knowledge of and access to the types and quantities of **basic need supports and other resources** required to ensure those in need of treatment can access and remain in treatment	Implement a process (e.g., CAST or equivalent) for estimating the types and levels of basic need supports and other resources required to support access to—and retention in—treatment in community and other settings	Year 1	
	Ensure persons receiving SUD services have arrays of supports, such as housing, employment, childcare, and transportation	Year 2	
	Incorporate technology in treatment delivery, especially for transitional-aged youth ages 18-25	Year 2	
3.b.4. Increase access to **whole family support and other resources**	Support seniors and persons with disabilities experiencing addiction by providing, at a minimum, assessment, treatment, and family counseling	Year 1	
	Provide parent/guardians with SUD assessment and parenting and family strengthening classes and counseling Support youth and children experiencing addition by providing, at a minimum, assessment, treatment, parenting, and family counseling		
3.b.5 Reduce Medicaid gap coverage for persons **exiting correctional facilities**	Work with the State Medicaid Director to develop a system to ensure the timely reinstatement of Medicaid coverage	Year 1	**Lead:** ADPC **Partner:** OHA, DOC

OBJECTIVE 3.c. Improve collection and use of data to evaluate treatment access, processes, and outcomes

Intermediate Outcomes: Note: Oregon does not currently have a statewide system for collecting and using evaluation data to analyze treatment outcomes. As evaluation capacity is developed, measures should be developed to help Oregon monitor progress toward meeting this objective and the strategies below.

Immediate Outcomes	Strategies and Activities	Implementation	Roles
3.c.1. Increase system **knowledge of consumer experiences** in accessing and using treatment services	Create a feedback system that can continuously elicit process and outcome evaluation data from consumers and their families about their experiences and outcomes	Year 1	**Lead:** ADPC **Partner:** OHA
3.c.2. Increase system **knowledge of consumer outcomes** from accessing treatment services	Strengthen provider requirements for collecting and reporting process and outcome treatment data	Year 1	
	Develop a state evaluation system that can use data tools and infrastructure to regularly and accurately collect and analyze provider and other data and report outcomes Ensure these processes are consistent and streamlined to support compliance and to reduce redundancy	Year 2	
	Implement a system to improve and analyze engagement and transitions across levels of care and into recovery services for ongoing system support and gap analysis	Year 3	

Goal 4: Increase access to recovery supports across the lifespan.

The Problem: While there is limited information on prevention and treatment needs and services in Oregon, even less is known about the number of Oregonians who need recovery support or the services that are currently available to them. There is no state estimate of Oregonians in recovery (although that is slated to change with new recovery questions added to the National Survey on Drug Use and Health), and previous state studies and reports have tended to focus on treatment needs and services without addressing recovery. The lack of state infrastructure for collecting and reporting data on substance use services contributes to the absence of information, but an even bigger issue is the lack of state processes and protocols for providing for recovery supports in the first place. What is known for sure about recovery supports in Oregon is that they are scarce.

While recovery is not new, efforts to define and develop guiding principles for creating effective, recovery-oriented systems of care have only come about in the last 15 years or so. And while there is not complete consensus on any one definition or set of principles, there are core beliefs that guide recovery support efforts:

- Recovery is an individual and self-directed process.
- Recovery does not follow a linear progress.
- Recovery is ongoing, not time limited.
- There are multiple access points and routes to recovery.
- Persons in recovery thrive best in community settings.

The recovery support objectives, immediate outcomes, strategies, and activities in this plan seek to create a continuum of care that includes medical, social, and community supports, services, and resources. Information on workforce issues and the use of evidence-based strategies are outlined under Goal 1 (see 1.b.3 and 1.c.2). Other recovery support objectives, intermediate and immediate outcomes, strategies, and activities start on page 63. Timelines and roles are also noted. Objectives and outcomes for recovery support address the following:

4.a Increase access to all levels and types of needed and effective recovery supports, as well as intervention and harm reduction for those in recovery by:

- Identifying the types, levels of care, and quantities of recovery supports, intervention, and harm reduction that are needed versus what currently exists across the state in community and other settings
- Identifying and expanding recovery support, intervention, and harm reduction models that have proven to be effective
- Identifying persons at risk of relapsing or otherwise experiencing health, social, or legal consequences from ATOD use and providing them with intermediaries to facilitate access to needed services
- Expanding access recovery supports to underserved communities and populations
- Developing innovative new recovery support solutions

4.b Decrease barriers to recovery by:

- Increasing public awareness of SUD as a chronic public health issue that requires medical attention and ongoing management
- Increasing public knowledge of available recovery support resources and how to access them

- Providing parent/guardian and family strengthening support to those in recovery
- Increasing access to basic need supports and other resources

4.c Increase collection and use of data to evaluate recovery support processes and outcomes by:

- Increasing knowledge of consumer experiences in accessing and using recovery support services
- Increasing knowledge of consumer outcomes from accessing recovery support services

Voices from the Field

LARRY HOWELL *is a Certified Recovery Mentor and Peer Support Specialist (PSS) at The Alliance and a recent graduate of Umpqua Community College. He attended the Regional Stakeholder Meeting in Roseburg, then returned that evening with a client to attend the Town Hall. Both Larry and his client were generous in sharing their life experiences and insights.*

Transportation, lack of access to treatment and medication, and being treated without dignity are the three major issues Howell says his clients experience. While those with OHP coverage can get rides to appointments and treatment, people with Medicare don't have that option. Howell notes that bus passes are available for local travel for those with money to pay for them but says this doesn't help when people need to get from Roseburg to Medford, Eugene, or Springfield for medical appointments. As a result, Howell and other PSSs can spend half a day transporting people to a single appointment. Creative problem solving, maximizing resources, and fostering a sense of community is an integral part of being a PSS, however, and Howell and his colleagues have found a partial "workaround." OHP allows those covered to have someone accompany them to distant medical appointments (called a "rider"), so when it's appropriate and works out, transportation is coordinated so that the "rider" is someone who also needs to get to the same medical facility but doesn't have transportation.

> *"The mission remains the same: saving the world one person at a time."*

Stigma from medical providers is another huge issue for Howell's clients. He says many of the people he serves have significant disabilities but are "trying to get by without abusing their medications." He finds the challenges that his clients face trying to get hepatitis C treatments and medications frustrating. "Doctors often put barriers in place," he says. "Clients must not smoke; they must be sober for a certain amount of time." When asked why that is, Howell says he believes it's personal bias: "There are no rules that stipulate that." Howell described one client with a history of SUD who was hit by a train and suffers chronic pain as a result, noting that it took seven months of visits to multiple doctors to get him referred to a pain clinic, even though he had demonstrated 1½ years of sobriety. Howell says one doctor told this client he had "old lady clients with more problems than you, and they don't need pain medication." "It's about the person in front of you," Howell says. "I was trained to believe that what that person believes to be real is real." Clients with previous methamphetamine use in their medical file are also often dismissed as being drug seeking, he says, even when they are suffering acute pain. "I've gone toe-to-toe with doctors that have taken dignity away from my clients." With OHP transitioning to a telehealth model in January for addressing hepatitis C, Howell and his colleagues will be tapped with new responsibilities for supporting this pilot program. In response, they have been working to transition their clients who aren't hepatitis C reactive to other kinds of supports, such as ensuring they know where the food banks are and connecting those without transportation to those who have it to maximize ride-sharing opportunities. Howell loves doing peer work but notes it's very hands on with a lot of traveling. "You have to be

there in every way for your clients," he says, ruminating that it may be more of a role for a younger person. "I'm getting old," he laughs. Howell has completed all the requirements for becoming a CADC and just needs to take the test, which he plans to do in January. The Alliance is willing to pay the $200 fee, for which he is grateful. Howell says his current work is really rewarding, but he's looking forward to settling down into an office and serving his clients in a different way. In the end, he'll still be focusing on the mission that drives him: "saving the world one person at a time."

> *"It's about the person in front of you. I was trained to believe that what that person believes to be real is real. I've gone toe-to-toe with doctors that have taken dignity away from my clients."*

EILEEN SALSIG *and* **DONNA REEDY** *attended the Town Hall in Baker City. Both work at OYA's Camp Riverbend Youth Transitional Facility, which is a 25- bed facility for males up to age 25 near La Grande. Transition programs such as Riverbend provide a bridge from secure facilities to a community placement upon release. Salsig, a Qualified Mental Health Professional with master's degree in counseling, works as a Psychiatric Social Worker, while Reedy is a Group Life Coordinator with a master's degree in Psychology. At Riverbend, they say, the "kids come from everywhere and go back to everywhere."*

Oregon youth remanded to an OYA facility may be committed under the auspices of the DOC or OYA, depending on their age and the type of offense. The differences in commitment types can be significant. For example, while a DOC commitment carries a sentence with a specified release date, an OYA commitment ends when youth are considered rehabilitated and ready for release into the community or have reached their 25th birthday, whichever comes first. For youth with SUDs, the differences between the two types of commitment are even more significant regarding access to treatment, recovery, and community supports. For example, while both agencies screen everyone at intake for SUDs, only OYA provides treatment to all who need it. Because treatment is such a priority, OYA helps its staff gain their CADC and helps qualified youth become certified peer mentors. DOC's limited resources mean that treatment is rationed and approached as a recidivism prevention program rather than a medical intervention. This means those assessed to have a high need for treatment but a low risk of recidivism may not receive any treatment, while those with a high risk of recidivism and a high need for SUD treatment are much more likely to receive it.

> *"When a system is overloaded, how do you manage the current stuff? If it's not a crisis situation the kid is overlooked." Eileen Salsig*

Other significant differences involve release procedures. For both types of commitments, those in custody are released back into the county where they were sentenced, which often may not have treatment, recovery support, or other basic resources, such as housing, available for them. (In some cases, releasees can receive a waiver to be released to another county where there are resources but only if that county agrees.) When youth committed through OYA are approaching release, case managers and other staff, like Salsig and Reedy, start preparing months in advance. This includes arranging for treatment and recovery support, as well as housing and other basic needs—and getting their kids on waiting lists as soon as possible so there is no interruption in needed services upon release. Salsig says this sometimes involves helping youth relocate to a different county. "We do this when we think the youth will have better success elsewhere," she says, adding, "sometimes home is where the negative influences, such as drugs and peers, occur." Reedy concurs, "For example, we just found housing for a young man who originally wanted to go back home, but we knew that would pull him back into his old lifestyle. We found him housing in another county instead;

now we need to find him services." Youth committed to an OYA facility through DOC are not eligible for OYA reintegration services upon release, so parole officers (POs) play an extremely important role. Salsig and Reedy say they start planning for a DOC release six months in advance, working closely with the PO to make sure they have the best information available to make determinations about the county of release and connections to resources. Salsig notes that POs also play an important role in helping OYA and DOC commitments reintegrate successfully into the community. "I help POs find residences for our youth and determine what type of care they are going to need," she says. Reedy is an especially accomplished networker, skilled in ferreting out resources wherever they may be. She states, "Normally the parole officer handles the placement; however, I know more about resources that I can recommend to them." She continues, "The resources are out there; we just don't know about them all. And those that have resources often don't realize how valuable they are." Among the resources that Reedy cites are churches and ranch families that take youth in, employ them, or otherwise help them out. "It's all about making the connections," she says.

"The resources are out there – we just don't know about them all. And those that have resources don't realize how valuable they are… It's all about making connections." Donna Reedy

Salsig notes that she had just recently learned about the CCO system and plans to reach out to learn what resources are available. One unresolved challenge that both women cite, however, involves disparities in insurance. For example, some insurance plans pay for residential treatment and/or rehabilitation, but others don't, and some plans only cover people until age 25. In addition to receiving treatment, all youth placed in OYA facilities attend school and have the opportunity to develop vocational skills. At transitional facilities like Riverbend, they can also work on community service projects, supervised work crews, and town jobs to instill a sense of work ethic, accountability, and responsibility. It also helps them pay restitution to those impacted by their violations. Salsig and Reedy say that while the treatment protocols OYA uses are very similar to those used with adults, treatment can have a profound impact on changing thought patterns and behaviors with youth because their brains are still developing.

When asked what would make the biggest positive impact for their youth, Salsig and Reedy quickly respond with three things. The first is uninterrupted access to treatment and recovery support for all who leave OYA facilities. The second is more prevention to keep kids from committing offenses in the first place. Salsig notes that some youth housed at OYA didn't know they were committing an illegal offense, and many in custody are already fathers—some starting as young as 15. She cites a basic lack of health education as a contributing factor.

She recounts a recent case involving a grandparent raising a grandchild who was concerned about his well-being and asked the school for an assessment. Because of a lack of community resources, however, the assessment didn't occur until the situation reached a crisis point. "When a system is overloaded," she asks, "how do you manage the current stuff? If it's not a crisis situation, the kid is overlooked." Finally, with regard to access to resources, both Reedy and Salsig dream of a real-time, computerized system that catalogs all services and resources; is searchable using a variety of filters; and is accessible to OYA and DOC staff, POs, and everyone else working to connect those with SUDs to treatment, recovery, and basic needs. "Some kids keep coming back time after time," Reedy notes, "sometimes because they didn't get the support they needed once they left our program. We have a great group of POs, but it can be difficult for these kids to resist going back to previous behaviors because of peer pressure."

"One unresolved challenge involves disparities in insurance. For example, some insurance plans pay for residential treatment and/or rehabilitation, but others don't; and some plans only cover people until age 25—an age when many youth are released from OYA facilities and reintegrating into the community."

OBJECTIVE 4.a.: Increase access to all levels and types of needed and effective recovery supports, as well as intervention and harm reduction for those in recovery

Intermediate Outcomes: Note: Oregon currently has very little data on recovery supports that could be used to develop a baseline for access to recovery supports. While the data collected in 4.a.1.-4.a.3. will provide information that can be used to establish a baseline and monitor progress toward this objective, data infrastructure development should include processes for monitoring changes in access to recovery supports. Examples of measures could include the following:

- Increase in the number of recovery supports provided by treatment centers
- Increase in the number of recovery support services and programs for vulnerable and underserved populations
- Increase in the number of collegiate recovery centers
- Decrease in wait times for return to treatment for stabilization when needed
- Increase in the number of culturally specific sober social spaces
- Increase in the percentage of those in recovery who can access basic needs and resources (e.g., housing, transportation, childcare)

Immediate Outcomes	Strategies and Activities	Implementation	Roles
4.a.1. Increase **knowledge of the types, levels of care, and quantities of recovery support, intervention, and harm reduction needed** across the state in communities and other settings[54]	Implement a process (e.g., CAST or equivalent)[55] for estimating projected numbers, locations, and characteristics of persons annually needing recovery support and associated intervention and harm reduction services across the state, by type and level, in community and other settings	Year 1	**Lead:** ADPC **Partner:** OHA
4.a.2. Increase **knowledge of the types, levels of care, and quantities of recovery support, intervention, and harm reduction that currently exist** across the state in all community and other settings	Create an inventory of private, semi-private, and publicly funded recovery support and associated intervention and harm reduction services that currently exists (e.g., campus-based, non-profit)	Year 1	**Lead:** ADPC **Partner:** OHA
	Members of the criminal justice system working with individuals in recovery must undertake continuing education designed to increase their knowledge of current issues related to SUD and recovery supports.	Year 2	**Lead:** ADPC **Partners:** Judicial Department
4.a.3. Increase ability to **maximize and expand current effective recovery support, intervention, and harm reduction strategies** while strategically targeting areas for new service development	Once evaluation systems are developed, use data to formally identify and increase investments in recovery support services that are producing desired outcomes, using lessons learned to scale or adapt them, as needed	Year 2	**Lead:** ADPC **Partner:** HECC
	Publicly funded institutions of higher education will provide recovery support services that are rooted in national best practices	Year 3	

54 Other includes, but is not limited to, college/university housing, other congregate living facilities, medical and psychiatric facilities, and correctional facilities.
55 CAST is an expansion of the SAMHSA continuum of care. It includes five categories along the continuum (promotion, prevention, referral, treatment, and recovery) and produces community-specific assessments of the capacity of the components of a community substance abuse care system, as well as recommendations by applying social and community determinants of health as risk coefficients to each estimate of component need.

4.a.4. Increase ability to **ensure persons in recovery have access to a peer mentor or other appropriate intermediary** to facilitate access to all needed recovery support services (see also objective 1.b. workforce)	Increase funding specifically to support Peer Mentor and Recovery Support Specialist positions funded across the state in school, community, correctional, and other settings	Year 1	**Lead:** ADPC **Partners:** DOC, OHA, HECC, Oregon Department of Education (ODE)
	Establish infrastructure that ensures that all K-12 and postsecondary students in recovery have access to intermediaries that can refer and connect them to needed recovery supports	Year 1	**Lead:** ADPC **Partner:** ODE
	Establish relationships with workplace EAPs to help them ensure employees in recovery have access to intermediaries that can refer and connect them to needed recovery supports (see also 1.f.3. re public-private partnerships)	Year 2	**Lead:** ADPC **Partners:** OHA, DCBS
4.a.5. Increase ability to provide **recovery support access** to underserved persons and communities	Expand access to APSM	Year 1	**Lead:** ADPC **Partner:** OHA
	Increase access to specialized/culturally tailored recovery supports for vulnerable and historically underserved populations		
	Fund services that ensure all persons in recovery released from DOC custody are connected to recovery support services in the community in which they are released		**Lead:** ADPC **Partners:** DOC, OYA
	Require treatment providers, consistent with patient desire and need, to provide a warm hand-off to a recovery supports resource	Year 2	**Lead:** ADPC **Partners:** OHA
	Use data collected through 3.a.1., 3.a.2., and 3.a.3. to partner with postsecondary institutions to develop recovery support infrastructure sufficient to address the needs of all student populations	Year 3	**Lead:** ADPC **Partners:** OHA, DCBS
	Work with private and public insurers to increase coverage for all needed types of recovery supports	Year 2	**Lead:** ADPC **Partner:** DCBS
	Create an online recovery housing hub where a person in recovery can easily identify certified sober housing units	Year 1	**Lead:** ADPC **Partner:** Department of Housing and Community Services
	Develop legislative concept ensuring individuals with past criminal histories may not be denied access to safe and affordable housing	Year 3	

OBJECTIVE 4.b.: Decrease barriers to recovery support

Intermediate Outcomes: Note: Data are not currently available to establish a direct baseline for reducing barriers to recovery supports or for monitoring changes in public awareness of SUDs or knowledge of resources. As data infrastructure is strengthened and developed, and the strategies below are implemented, measures should be developed (e.g., expanding existing or creating new adult surveys or other data collection processes) to help Oregon better monitor progress toward meeting this objective.

Immediate Outcomes	Strategies and Activities	Implementation	Roles
4.b.1. Increase **public awareness of SUD as a chronic public health issue** that requires medical attention and ongoing management	Create a statewide, public education campaign (e.g., print, social media broadcast)	Year 3	**Lead:** ADPC **Partners:** OHA, Public Health
	Launch periodic, universal, public education campaign at the state and local levels that addresses substance use behavior and stigma targeted at different developmental stages that consider the lifespan of an individual		
4.b.2. Increase **public knowledge of available recovery supports** and how to access them	Create user-friendly interfaces (e.g., "warm line," case manager, liaison, peer mentor) with the online system above to help those needing treatment and their friends and families use it	Year 2	**Lead:** ADPC **Partner:** OHA
4.b.3. Increase knowledge of and access to the **types and quantities of basic needs supports required** to ensure those in recovery can remain in recovery	Implement a process (e.g., CAST or equivalent) for estimating the types and levels of basic need supports and other resources required to support recovery in community and other settings	Year 1	
	Ensure persons in recovery have arrays of supports, such as housing, employment, childcare, and transportation	Year 2	**Lead:** ADPC **Partners:** OHA, DHS, Housing and Community Services
	Expand recovery models for children and adolescents (e.g., Recovery High Schools)	Year 3	**Lead:** ADPC **Partners:** OHA, DCBS
4.b.4. Increase ability to **fund recovery support** services	Access to long-term recovery (i.e., beyond the point of treatment plan completion when Medicaid/insurance doesn't pay for recovery support services anymore. There is need for continued assistance even after a person is deemed clinically stable.)	Year 1	**Lead:** ADPC **Partners:** OHA, DCBS
	Increase public and private insurance coverage for peer support and other necessary recovery support		
4.b.5. Increase ability to **support parents/guardians in recovery**	Provide parents/guardians in recovery with parenting classes and family counseling	Year 1	**Lead:** ADPC **Partners:** OHA, DHS

4.b.6. Under Oregon's Medicaid Waiver expand access to **peer-delivered services**	Allow individuals in long-term recovery to engage in services on an as-needed basis Allow access to peer-delivered services without a treatment plan	Year 1	**Lead:** ADPC **Partners:** OHA

OBJECTIVE 4.c.: Increase collection and use of data to evaluate recovery support processes and outcomes

Intermediate Outcomes: Note: Oregon does not currently have a statewide system for collecting and using evaluation data to analyze recovery outcomes. As evaluation capacity is developed, measures should be developed to help Oregon monitor progress toward meeting this objective and the strategies below.

Immediate Outcomes	Strategies and Activities	Implementation	Roles
4.c.1. Increase **knowledge of consumer experiences** in accessing and using recovery support services	Create a feedback system that can continuously elicit process and outcome evaluation data from consumers and their families about their experiences	Year 2	**Lead:** ADPC **Partners:** OHA
4.c.2. Increase system **knowledge of consumer outcomes** from accessing recovery support services	Strengthen provider requirements for collecting and reporting process and outcome recovery data	Year 2	
	Develop a state evaluation system that can use data tools and infrastructure to regularly and accurately collect and analyze provider and other data and report outcomes	Year 3	

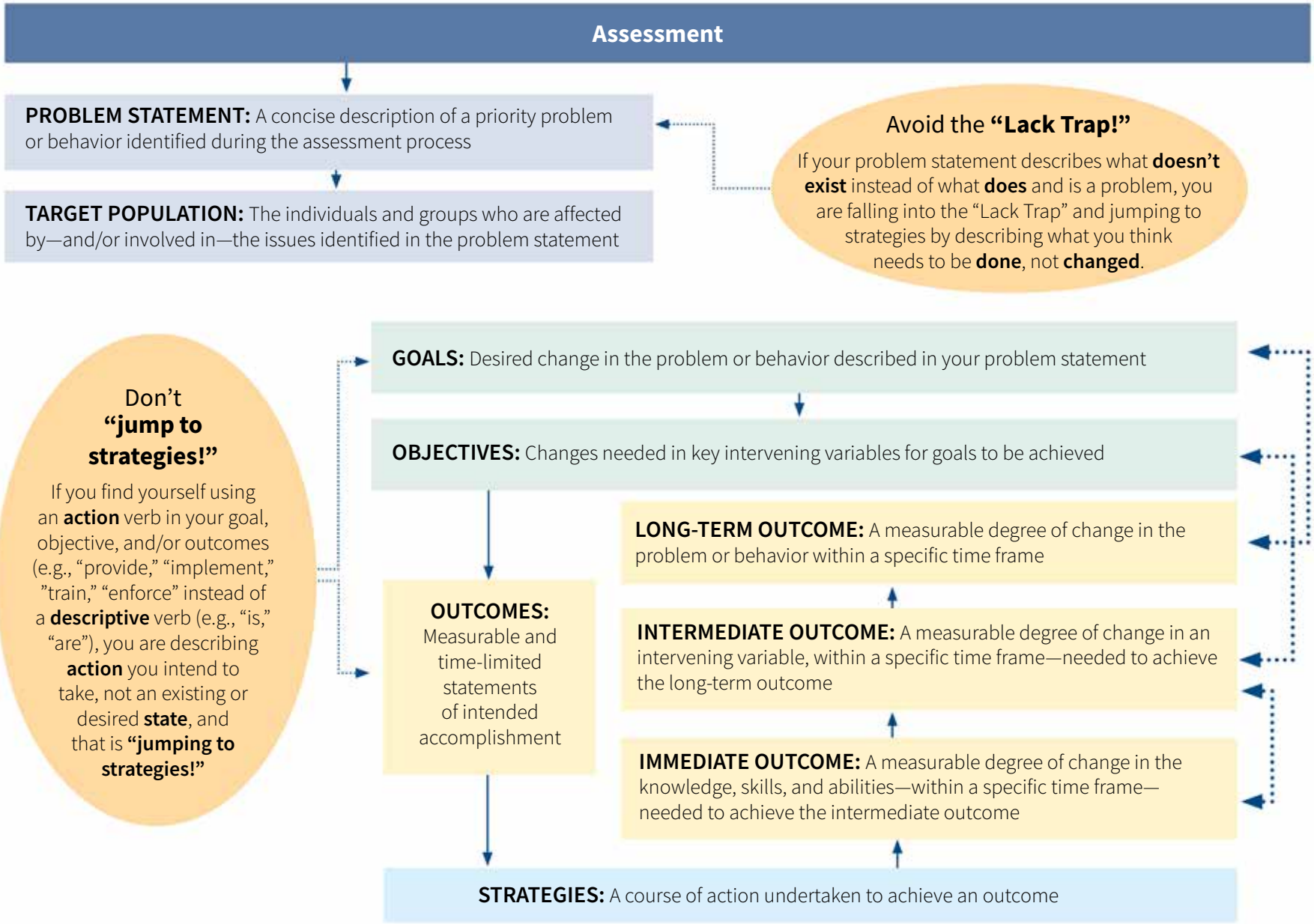
APPENDIX A: Acronyms

ADP	Alcohol and Drug Policy
ADPC	Alcohol and Drug Policy Commission
AOD	alcohol and other drugs
APM/APSM	alternative pain management/alternative pain and stress management
ATOD	alcohol, tobacco, and other drugs
AUD	alcohol use disorder
CADC	Certified Alcohol and Drug Counselor
CAST	Calculating for an Adequate System Tool
CCC	Central City Concerns
CCO	Coordinated Care Organization
CJC	Criminal Justice Commission
CPS	Certified Prevention Specialist
DCBS	Department of Consumer and Business Services
DHCS	Department of Housing and Community Services
DHS	Department of Human Services
DOC	Department of Corrections
DOE	Department of Education
EAP	employee assistance program
ED	emergency department
HECC	Higher Education Coordinating Commission
HIDTA	High Intensity Drug Trafficking Area
KSAs	knowledge, skills, and abilities
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning Plus
MAT	medication-assisted treatment
NARA	Native American Rehabilitative Association
NSDUH	National Survey on Drug Use and Health
OHA	Oregon Health Authority
OHP	Oregon Health Plan
OHSU	Oregon Health and Sciences University
OLCC	Oregon Liquor Control Commission
OSP	Oregon State Police
OYA	Oregon Youth Authority
PAR	population attributable risk
PO	probation officer
PSS	Peer Support Specialist
PSU	Portland State University
RVR	retail violation rate
SA	substance abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPP	Substance abuse prevention program
SHIP	State Health Improvement Plan
SUD	substance use disorder
TTA	training and technical assistance
YDD	Youth Development Division

APPENDIX B: State Agency Roles & Responsibilities

Alcohol and Drug Policy Commission—State System Convener	Key State System Members														
	Health & Human Services		Education			Corrections		Law Enforcement		Regulation			Basic Needs Infrastructure		TTA Research
Responsibilities	OHA	DHS	DOE	YDD	HECC	OYA	DOC	OSP	HIDTA	DCBS	OLCC	Oregon Lottery	DHCS	DOT	OHSU
Substance Use Systems Development	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Workforce Development	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Individual & Family Strengthening/ Support	●	●	●	●	●	●	●					●	●	●	
Illegal Access to Substances Prevention	●							●	●		●		●		
Misuse of Legal Substances Prevention	●	●	●	●	●	●	●					●		●	
Policies & Practices Development/ Implementation/Support	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
State Laws & Regulations Enforcement	●							●	●	●	●	●			
Assessment & Screening	●	●	●		●	●	●								●
Intervention/Harm Reduction	●	●	●	●	●	●	●	●				●			●
SUD Treatment	●					●	●					●			●
Peer Support	●	●	●	●	●	●	●					●			●
Case Management	●	●	●	●	●	●	●					●			

APPENDIX C: Planning Map



APPENDIX D: Stakeholder Engagement

Background

ADPC's strategic planning process included a strong focus on stakeholder engagement across sectors at all levels. Toward that end, contract requirements included conducting at least six qualitative assessment activities (e.g., focus groups, key informant interviews, town hall meetings) to identify community needs, with one of the assessments mandated to include policy decision makers.

The first qualitative assessment involving state agency policy decision makers and their key staff was held on April 23, 2019. Representatives from the agencies that attended these meetings are listed in the box at the right.

Governor's Office | Oregon Alcohol and Drug Policy Commission | Oregon Health Authority | Oregon Department of Human Services | Oregon Youth Authority | Department of Housing and Community Services | Department of Consumer and Business Services | Youth Development Council | Oregon Department of Education | Department of Corrections | Lottery | Oregon State Police | Oregon Criminal Justice Commission

A series of 13 regional town halls and stakeholder events were held May 28 through June 6, 2019, in eight locations across the state. The meetings provided an overview of the state strategic planning process and collected input from practitioners, community members, and other stakeholders. Approximately 300 persons from 129 known organizations attended these events. In August 2019, a listening session, focused on culturally specific issues, was held in Portland. Two additional stakeholder events, both organized by Oregon Recovers, were held June 8, 2019, in Eugene and November 7, 2019, in Portland. The first focused on recovery, while the second provided an opportunity for stakeholders across the continuum of services to review and comment on the draft plan. Approximately 200 people attended those two events.

The planning process also involved a number of one-on-one key stakeholder interviews with commissioners, state agency staff, tribal representatives, professionals and practitioners, persons with lived life experience, and others.

State Agency Stakeholder Meetings

The April 23, 2019, meeting was held in Salem and included an opening address by Governor Kate Brown. Attendees were provided an overview of the planning process, as well as upcoming regional stakeholder engagement events to be held across the state. Because a key focus of the planning process was to move away from siloed services and to develop a comprehensive and coordinated state system for substance misuse, attendees developed a draft state mission and vision statement and began to collectively assess the current functioning of the system in terms of leadership, capacity, and use of effective processes. General consensus among attendees was that their agencies had partnered effectively on other issues but were at a beginning level with regard to substance misuse. Several of the indicators used for the assessment have been incorporated into the plan in Objective 1, and the assessment will be re-administered on a biennial basis as one measure to monitor progress. Attendees also discussed long-term health and social outcomes that could be incorporated into the plan to monitor progress.

Subsequent state agency meetings were held on July 29, October 14, and December 9, 2019. These meetings involved the same agencies and were used to finalize the state mission and vision statement; develop a state values statement; finalize desired outcomes systemwide; and shape the plan's goals, objectives, and strategies. The meeting on December 9, 2019, provided state agencies an opportunity to review the plan and to make final recommendations and edits.

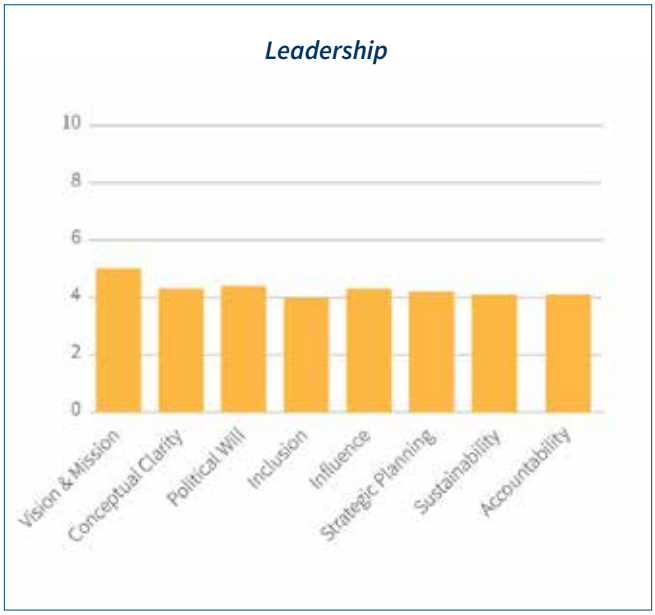
Regional Stakeholder and Town Hall Meetings

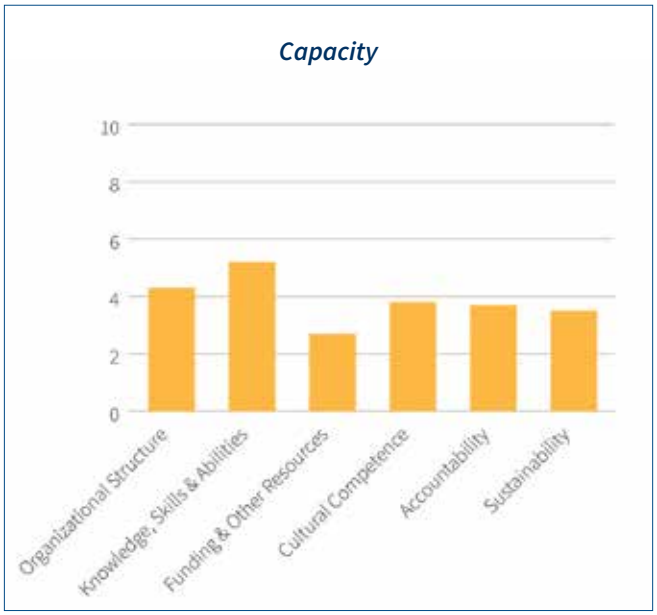
Date	Location	Stakeholder Meeting	Town Hall
May 28	The Dalles	✓	✓
May 29	Baker City	✓	✓
May 30	Bend	✓	✓
June 3	Roseburg	✓	✓
June 4	Salem	✓	✓
June 5	Portland (East)		✓
June 6	Portland (West)	✓	
June 6	Hillsboro		✓

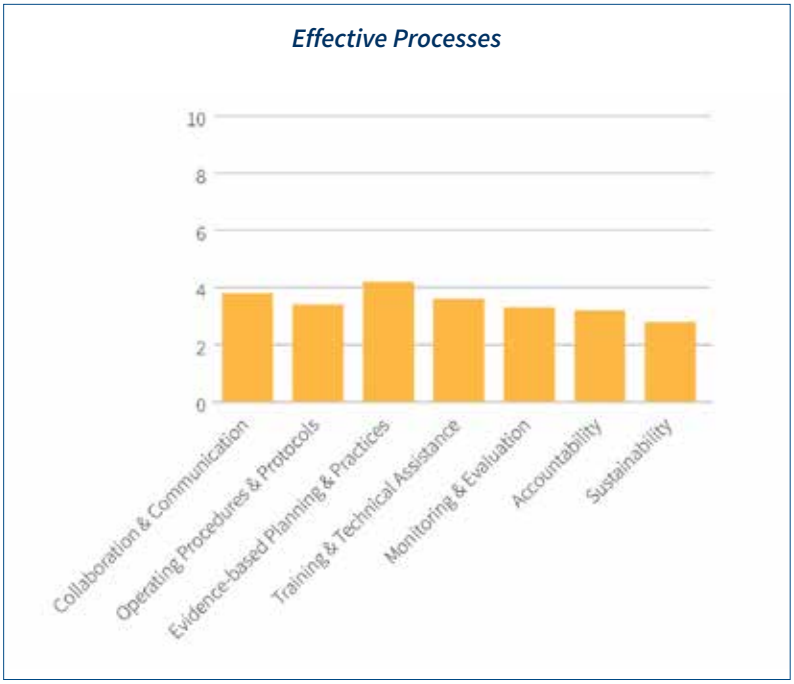
The Regional Stakeholder Meetings, which were held in the afternoons, were designed and marketed to those working in fields that involved or were impacted by substance use. The Town Halls, which were held in the evenings, were intended to provide opportunities for community members, consumers, and others to learn about the planning effort and to provide input. In actuality, both Stakeholder Meetings and Town Halls were heavily attended by those working in fields involved in or impacted by substance use. In some cases, this was because agencies split staff attendance between the afternoon and evening meetings to maintain coverage. And several people attended both sessions, coming to the afternoon meeting in their work capacity, then returning for the evening session in their capacity as a person with lived-life experience. Some came back with colleagues or clients, or because they wanted to her what community members had to say. The table at right shows the dates and locations of the meetings.

The agendas for these meetings included a brief overview of the planning process, with time for questions and answers, then a discussion of state and local issues needs involving prevention, treatment, and recovery. To start those discussions, attendees in each location participated in a short group assessment of local leadership, capacity, and use of effective practices regarding substance misuse prevention and SUD treatment and recovery. The assessment was an abbreviated version of the one used by state agencies, with attendees voting anonymously using their cell phones and an online polling software program to rate the degree to which they felt their local systems collectively had the leadership and capacity needed across sectors to significantly reduce substance misuse and the degree to which they felt the most effective practices were being used.

On a scale of 1 to 10, with 1 being low, community attendees scored their local systems much higher than state agencies had, but still left significant room for local system building. Averaged scores across the state are provided below. A brief summary and definitions for the categories used is provided in Appendix E.







While there were some regional differences, overall, attendees across the state rated their local systems highest on having a collective vision and mission for preventing and reducing problems related to substance misuse and having a knowledgeable and skilled workforce engaged in using the most effective practices. Not surprisingly, perhaps, most rated funding and resources as their lowest area, although some disagreed, saying existing resources needed to be better utilized. Other areas that tended to have lower ratings included cultural competence, accountability, and sustainability. Nearly all agreed that while there was definitely work to be done with regard to system strengthening at the state level, there was also similar work to be done at the local level. Consistent themes that emerged across the state included the following:

- Insufficient funding and infrastructure
- Low rates of pay and reimbursement
- Need to comprehensively address SUDs, mental health, and basic needs
- Siloed state agency policies and practices
- Punitive federal and state policies and practices
- Questions about how this planning process will be different from previous efforts

While these discussions sometimes unearthed differences in opinions and perceptions—including perceived power and resource differentials between metropolitan and rural frontier parts of the state and majority versus non-majority populations—they also often highlighted commonalities and a shared vision and determination for significantly improving outcomes for Oregonians across the lifespan. Finally, the discussions also provided multiple opportunities for learning from the professional and life experiences of those at the frontlines of Oregon's substance misuse epidemic. Some of those stories are included throughout this plan as "Voices from the Field."

A list of state, regional, and local agencies known to have had one or more representatives attend state and/or stakeholder events is provided below.

Agencies with Known Representation at Stakeholder Events

4D

Adapt Alkermes

Baker Circuit Court Baker City

Baker County

Baker House Men's Program Benton County Health Department Best Care

Blue Sky Acupuncture Boys and Girls Club Bridgeway Recovery

Center on Addiction and

Substance Abuse (CASA) of Douglas & Curry Counties

Cascadia Behavioral Healthcare

Catalyst Counseling

Center for Family Development

Center for Human Development

Central City Concern

Centro Latino Americano Children

First for Oregon Choices Counseling Center City of Eugene

Clackamas County CLEAR Alliance

Coast Community Health

Services, Inc.

CODA, Inc.

Columbia Community Mental Health Compass

Confederated Tribes of Grande Ronde

Confederated Tribes of Warm Springs Crook County Public Health

Deschutes County Health Services

Douglas C.A.R.E.S.

Douglas Public Health Network Eugene Mission

Families in Recovery

Governor's Commission on Senior Services

Grand Ronde Hospital and Clinics

Greater Oregon Behavioral Health HIV Alliance

Hood River County Prevention Dept. Jackson County

Jackson County Public Health Josephine County

Josephine County Juvenile Justice Kaiser Permanente

La Clinica - Medford

Lake County Commissioner

Lifeways Lifeworks Lines for Life

Linn County Alcohol & Drug Program Lutheran The Bend Clinic

Marion County

Marion County Health & Human Services

Marion County Sheriff's Office

Marion County Community Corrections

Mental Health & Addiction Association of Oregon (MHAAO)

MHAAO, Project Nurture

Providence Milwaukie

Mid-Columbia Center for Living Milestones Recovery

Morrison Child & Family Services

Multnomah County

Multnomah County Mental Health & Addiction Services Division

Multnomah County Human Services New Directions Northwest

North Central Public Health District North Wasco School District Northeast Oregon Network Northwest Family Services Northwest Human Services Northwest Treatment

Office of Rep. Tawna Sanchez

Oregon Alcohol & Drug Policy Commission

Oregon Criminal Justice Commission

Oregon Department of Consumer and Business Services

Oregon Department of Corrections

Oregon Department of Education

- Youth Development Division

Oregon Department of Housing and Community Services

Oregon Department of Human Services

- Addiction Recovery Team
- Child Protective Services/Child Welfare

- Self-Sufficiency Program
- Vocational Rehabilitation

Oregon Employment Department

Oregon Health Authority

- Public Health Division, Health Promotion & Chronic Disease Prevention
- Behavioral Health Services

Oregon Health & Sciences University

- Oregon Poison Center
- Hospital - Adult Acute Care

Oregon/Idaho High Intensity Drug Trafficking Area

Oregon Judicial Department

Oregon Liquor Control Commission

Oregon Lottery

Oregon Primary Care Association

Oregon Recovers

Oregon Recovery High School

Initiative

Oregon State Police Oregon State University Oregon Youth Authority

APPENDIX E: System Assessment Criteria

LEADERSHIP: The ability to develop, communicate, and carry out a vision for the common good based on mutual trust and respect and collaborative, inclusive, and effective methods	
Vision and mission	Members share a common vision, mission, and belief that the system is capable of making a difference.
Conceptual clarity	Members have developed common definitions, language, and understandings across sectors.
Political will	Members have public support and the ability to generate political will to create positive change.
Inclusion	Leadership is inclusive, shared, and transparent and reflects demographics.
Influence	The system is able to influence its members and others within the external environment to achieve its outcomes.
Strategic planning	Members engage in coordinated planning that is based on data and guides resources and action across sectors.
Accountability	System actions are guided by collective—rather than individual—needs. Activities, use of resources, and outcomes are reported regularly to system members and other stakeholders.
Sustainability	The system engages in ongoing planning for capacity development that will enable it to sustain positive outcomes into the future and has developed an organizational development plan.

CAPACITY: The combination of knowledge, experience, and ability needed to solve problems and implement change	
Organizational structure	Members have clearly defined roles and responsibilities. The organizational structure includes specialized, multi-sector workgroups to carry out assessment, capacity development, mobilization, planning, implementation, and evaluation functions of the system.
Knowledge, skills, and abilities	Members have access to resources; needed discipline-specific knowledge, skills, and abilities; and core competencies in performance management processes
Funding and other resources	The system is able to leverage, "braid," and allocate financial and non-financial resources from multiple sources, including member budgets, to support priorities.
Cultural competence	The system operates with a deep understanding of—and responsiveness to—the cultural and contextual conditions of its environment
Accountability	The system has strong internal systems that can monitor and report outcomes from expenditures and investments
Sustainability	The system engages in ongoing planning for capacity development that will enable it to sustain positive outcomes into the future, and has developed an organizational development plan

USE OF EFFECTIVE PRACTICES & PROCESSES: Practices or actions that have been documented to produce desired results, which are performed to achieve a given purpose	
Collaboration, communication, and recognition	Members communicate and share information and data regularly and openly across sectors and organizational boundaries and reward and celebrate successes.
Operating procedures and protocols	The system has well-defined procedures and protocols that guide its actions, including procedures for decision making and conflict resolution.
Evidence-based planning and practices	The system uses strategies and approaches that are supported by research.
Training and technical assistance	The system and its members regularly utilize high quality training and technical assistance that allows them to work to maximum effectiveness
Monitoring and evaluation	The system conducts ongoing monitoring and evaluation and adjusts processes, as needed, to ensure continuous improvement and progress toward goals.
Accountability	The system and its members are results oriented and accountable to each other and stakeholders for achieving outcomes that meet individual and overarching needs. Resource allocations are based on objective analysis of data and identified priorities through bias-free allocation processes that minimize duplication of services and address service gaps.
Sustainability	The system engages in ongoing sustainability planning to leverage resources needed to sustain outcomes into the future and has developed a strategic financing plan.

APPENDIX F: Economic Evaluation

Background

In 2001 and 2009, the Center on Addiction and Substance Abuse (CASA) at Columbia University released two iconic reports, Shoveling Up and Shoveling Up II, which quantified the costs of substance use and addiction to federal, state, and local governments. Oregon was included in both of those studies. As part of ADPC's statewide strategic planning effort, JBS consulted with current and former staff from CASA (now the Center on Addiction at Columbia University) to discuss the possibility of updating and using the Shoveling Up methodology to calculate current costs of substance use in Oregon. We are very grateful to Lindsey Vuolo and Linda Richter at the Center on Addiction and Susan Foster (former CASA staff now with the American College of Academic Addiction Medicine) for their enthusiastic support of this effort. We are particularly grateful to them for putting us in contact with Elizabeth Peters, who was the primary data analyst for both Shoveling Up reports. Peters updated the methodology and worked with JBS and Oregon state budget staff to produce the 2017 profile for Oregon. Although the Center on Addiction was not involved in the preparation of this report, the information and resources it provided were instrumental in creating the updated estimates for the State of Oregon.

Overview of Original Methodology

To conduct the Shoveling Up studies, CASA conducted exhaustive literature reviews; aggregate analyses on peer-reviewed, published studies; extensive interviews with experts in the field of tobacco, alcohol, and drug research; and original analysis of restricted national data to develop "attributable fractions" that could be used to monetize government spending on substance use and related problems on a national scale. It's important to note the fractions were created using the most conservative estimates available to err on the side of under- rather than overestimating costs. Donald Boyd at the Rockefeller Institute then created an algorithm to adjust the fractions by variations in the prevalence of tobacco, alcohol, and drug use from one state to another and from one year to another. CASA conducted detailed surveys and studies of state and federal budgets and used the fractions and algorithm to produce national and state-specific profiles of the burden of substance-use-related spending, as well as state-reported dedicated expenditures for substance misuse prevention; SUD treatment and recovery; and compliance and regulation of alcohol, tobacco, and other substances. A detailed explanation of the entire methodology is provided in Appendix B of the Shoveling Up II report.

Detail of Burden and Dedicated Spending in Oregon by Sector

OREGON SUBSTANCE ABUSE (SA) SPENDING BY BUDGET SECTOR USING 2017 SA SHARE (excludes regulation and compliance)			
	Total Budget $	Total SA $	SA % of Agency Budget
All Affected Programs	**$15,746,826,649.76**	**$6,474,391,380.19**	**41.12%**
Burden Expenditures	**$15,705,476,554.50**	**$6,308,912,572.19**	**40.17%**
Prevention, Treatment, & Research	**$175,871,595.00**	**$175,871,595.00**	**100.00%**
Adult Corrections Program Expenditures	**$1,035,062,186.00**[56]	**$895,402,380.26**	**98.85%**
Burden	$1,029,923,880.00	$895,402,380.26	86.94%
Prevention, Treatment, & Research	$10,392,787.00	$10,392,787.00	100.00%
Juvenile Corrections Program Expenditures	**$172,637,496.50**	**$136,811,701.15**	**79.25%**
Burden	$172,141,530.00	$136,315,734.65	79.19%
Prevention, Treatment, & Research	$495,966.50	$495,966.50	100.00%
Judiciary Expenditures	**$358,041,871.00**	**$325,832,195.39**	**91.00%**
Burden	$57,735,992.00	$325,526,316.39	91.0%
Prevention, Treatment, & Research	$305,879.00	$305,879.00	100.00%
Education Expenditures	**$3,994,000,000.00**	**$706,470,014.68**	**17.69%**
Burden	$3,994,000,000.00	$706,470,014.68	17.69%
Prevention, Treatment & Research			
Health Program Expenditures	**$1,903,939,442.50**	**$670,942,220.24**	**35.24%**
Burden	$1,883,000,000.00	$650,002,777.74	34.52%
Prevention, Treatment, & Research	$20,939,442.50	$20,939,442.50	100.00%
Child Welfare Program Expenditures	**$3,284,125,152.50**	**$2,688,394,785.15**	**81.86%**
Burden	$3,284,125,152.50	$2,688,394,785.15	81.86%
Prevention, Treatment, & Research			
Income Support Expenditures	**$78,000,000.00**	**$25,422,034.59**	**32.59%**
Burden	$78,000,000.00	$25,422,034.59	32.59%
Prevention, Treatment, & Research			

56 The figure of $1,035,062,186.00 adds up to more than the sum of burden and prevention, treatment, and research because it includes capital expenditures.

Mental Health & Developmentally Disabled Human Service Expenditures	**$208,339,815.00**	**$139,603,152.63**	**67.01%**
Burden	$206,550,000.00	$137,813,337.63	66.72%
Prevention, Treatment & Research	$1,789,815.00	$1,789,815.00	100.00%
Public Safety Expenditures	**$2,500,000,000.00**	**$730,836,164.15**	**29.23%**
Burden	$2,500,000,000.00	$730,836,164.15	29.23%
Prevention, Treatment & Research			
State Workforce Expenditures	**$2,200,000,000.00**	**$12,729,026.95**	**0.58%**
Burden	$2,200,000,000.00	$12,729,026.95	0.58%
Prevention, Treatment & Research			
Human Services Prevention, Treatment & Research Program Expenditures	**$141,947,705.00**	**$141,947,705.00**	**100.00%**
Burden			
Prevention, Treatment & Research	**$141,947,705.00**	**$141,947,705.00**	**100.000**

APPENDIX G

EXAMPLE Strategic Financing Template

Strategies and activities to be launched or expanded (describe current sites, scope, and funding sources)	SCALE TO BE ACHIEVED # sites, # served, target populations, and range of activities			Time period for strategies and activities to be implemented
	2020-2021	2021-2022	2022-2023	
Peer Mentors Currently employ 10 peer mentors in Alpha City on a 20 hour/ week basis to serve 10 clients each Funding: 5-year SAMHSA discretionary grant	• Expand to Dupont; hire 10 peer mentors at 30 hours/week to serve 10 clients each • Hire 5 new Peer Mentors in Alpha City; increase time for all to 30 hours/week to serve 10 clients each	• Expand to Ewing; hire 10 peer mentors at 30 hours/week to serve 10 clients each • Hire 5 new Peer Mentors in Dupont at 30 hours/week to serve 10 clients each • Sustain scope in Alpha City	• Expand to Gage; hire 10 peer mentors at 30 hours/week to serve 10 clients each • Hire 5 new Peer Mentors in Ewing at 30 hours/week to serve 10 clients each • Sustain scope in Alpha City and Dupont	Continue indefinitely and increase scope as needed
Therapeutic Groups Currently in 4 sites (Alpha City, Bellview, Syracuse, and Palmyra); 3 groups of 12 persons per site, 2 weekly sessions per group Funding: SAPT Block Grant	• Expand to 2 new sites: Dupont and Ewing (3 groups of 12 persons per site, 2 weekly sessions per group) • Continue scope at Alpha City, Bellview, Syracuse, and Palmyra	• Expand to 1 new site: Gage (3 groups of 12 persons, 2 weekly sessions per group) • Increase from 2 to 3 sessions/ week in Alpha City and Syracuse • Sustain 2 weekly sessions each in Palmyra, Dupont, and Ewing	• No new sites • Increase from 3 to 4 weekly sessions in Alpha City • Increase to 3 weekly sessions in Syracuse • Sustain scope in Palmyra, Bellview, Dupont, Ewing, and Gage	Re-evaluate at end of Year 3 to consider whether new approach or changes are needed
Retail Compliance Checks Currently funding tobacco compliance checks across Griswald County Funding: State general funds	No expansion; use resources to cultivate a permanent home for this in the county using local resources and existing trained coalition members	No expansion; use resources to cultivate a permanent home for this in the county using local resources and existing trained coalition members	Permanent home established for continued implementation of compliance checks	"Pass baton"

EXAMPLE Strategic Financing Template

Strategies and activities to be launched or expanded (describe current sites, scope, and funding sources)	SCALE TO BE ACHIEVED – WHAT WILL IT COST? # sites, # served, target populations, and range of activities											
	2020-2021				2021-2022				2022-2023			
	Scale	Total Cost	Current Funding	Funding Gap	Scale	Total Cost	Current Funding	Funding Gap	Scale	Total Cost	Current Funding	Funding Gap
Example: Peer Mentors												
Salaries	25 Peer Mentors at .75 FTE = 39,000 hours/year at $TBD/hour		$	$	40 Peer Mentors at .75 FTE = 62,400 hours/year at $TBD/hour	$	$	$	55 Peer Mentors at .75 FTE = 85,800 hours/year at $TBD/hour	$	$	$
Fringe benefits												
Training												
Equipment												
Travel/mileage												
Materials and supplies												
Cell phone												
Administrative												
Other direct costs												
Indirect costs												

APPENDIX H

Selected References

Reports, Studies, White Papers

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