Behavioral Health

Health Outcome

Definition of Behavioral Health

Behavioral health includes mental and emotional health. Behavioral health conditions include anxiety, depression, substance use disorders, and many others.

What's Being Done

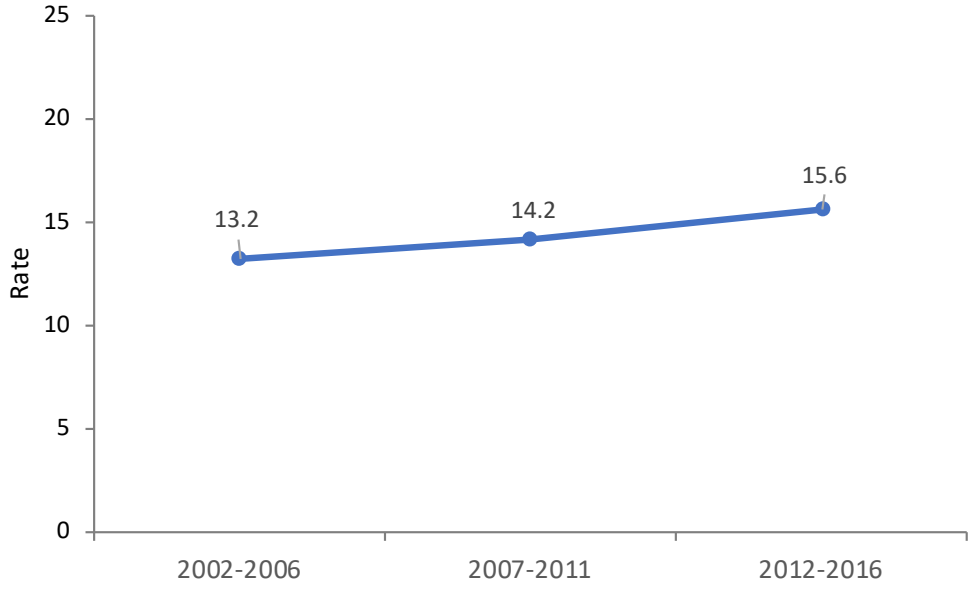
HCWC members are addressing this core issue through:

- Implementing universal depression screenings
- Supporting the Unity Center for Behavioral Health
- Conducting opioid prevention work
- Implementing drug takeback programs
- Forming suicide prevention coalitions
- Working on various housing initiatives, including Housing Is Health that was informed by previous HCWC CHNA work.

Depression and Suicide: Adults

Meeting behavioral health needs is critical, particularly with the high rates of depression and suicide in the region. Across the region almost a quarter (24.1%) of the population has been diagnosed with depression. [57] Figure 11 shows the suicide mortality rate for adults in the region (based on BRFSS data).

Figure 11. Adult Mortality Rates – Suicide.



All rates are per 100,00 population and are age-adjusted to the 2000 U.S. standard population.
Source: Community Health Assessment Tool (CHAT), Oregon Public Health Assessment Tool (OPHAT).

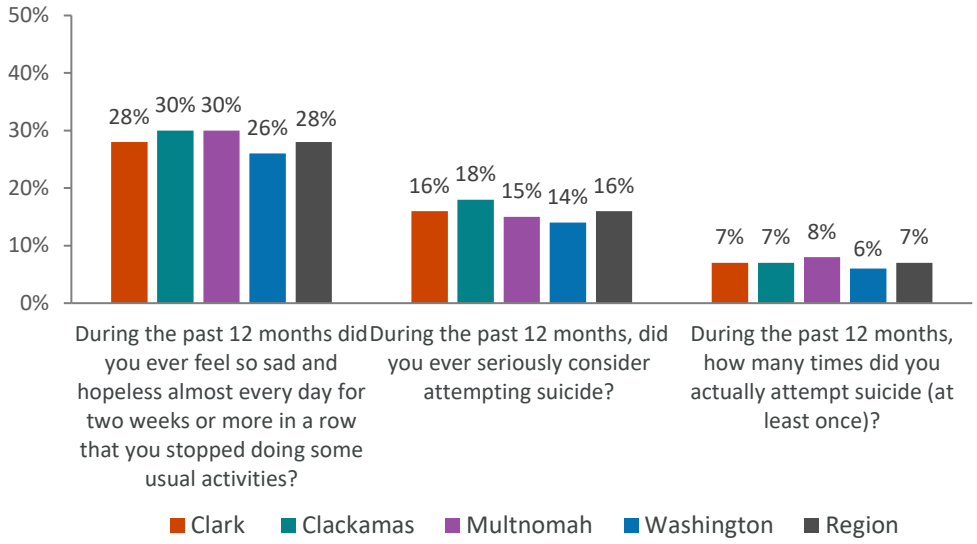
Depression and Suicide: Youth

Suicide is the third leading cause of death for youth between the ages of 10 and 24. More youth survive suicide attempts than die by suicide.[58] Nationally, 16% of students reported seriously considering suicide; 13% created a plan; and 8% reported trying to take their own life in the 12 months prior to taking the survey.[58]

Results from the 2017 Healthy Teens Survey in Oregon and the 2016 Healthy Youth Survey in Washington are similar to those reported nationally (see Figures 12–14).

In the quad-county region, 28% of students in eighth grade reported feeling sad or hopeless for two or more weeks in a row and that this prevented them from doing their usual activities. Also, 16% of eighth grade students indicated that they had considered attempting suicide in the past 12 months.

Figure 12. Youth (Grade 8): Depression and Suicide.



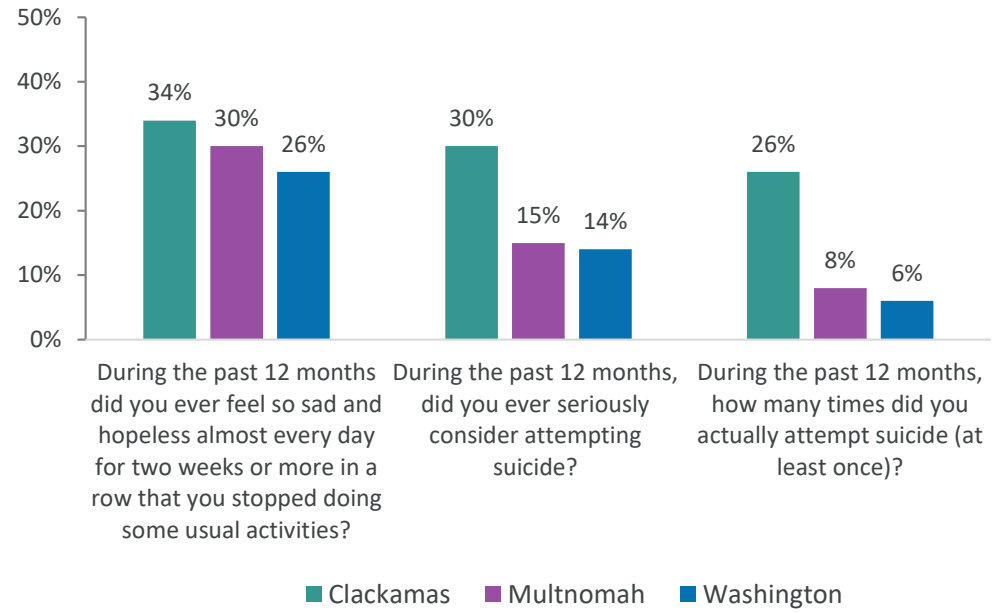
Source: 2017 Oregon Healthy Teens Survey [59] and the 2016 Washington Healthy Youth Survey.[60]

Figure 13. Youth (Grade 10): Depression and Suicide in Clark County.

Source: 2016 Washington Healthy Youth Survey.

Depression and Suicide: Youth

Figure 14. Youth (Grade 11): Depression and Suicide in Clackamas, Multnomah, and Washington Counties.

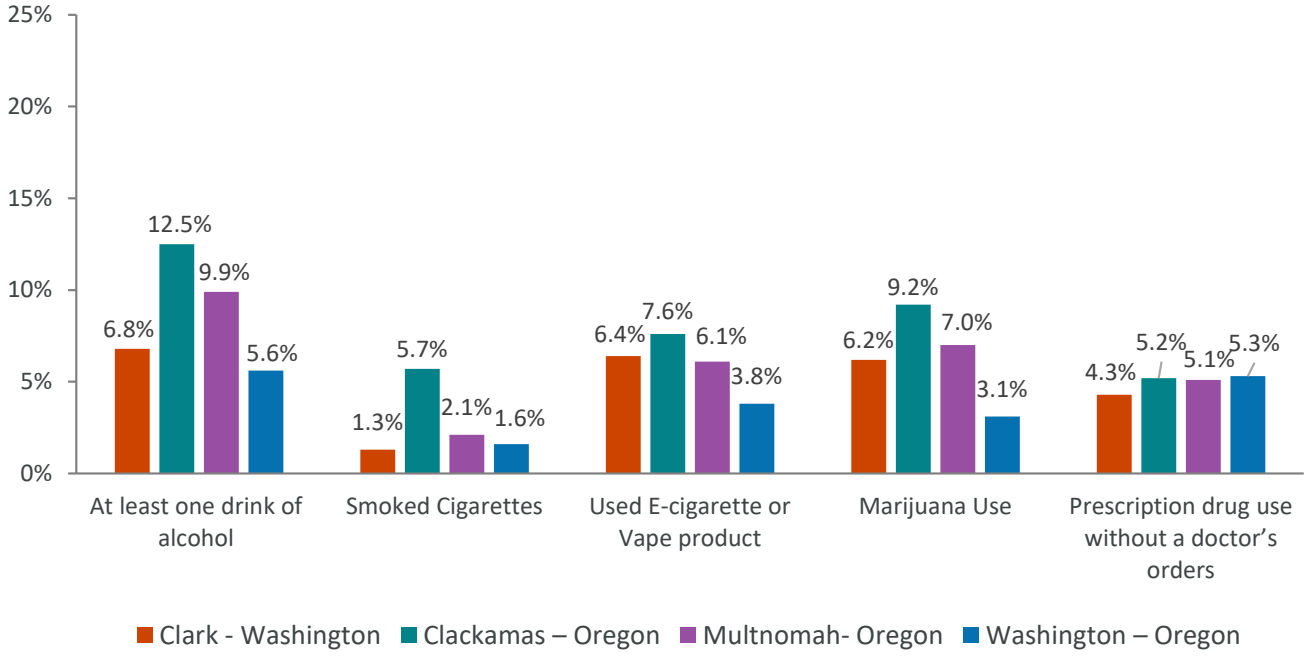


Source: 2017 Oregon Healthy Teens Survey.

Substance Use by Teens

Many listening session participants worried that their children were using substances. Figure 15 shows the percentage of teens who reported drinking alcohol, smoking cigarettes, vaping, using marijuana, or taking prescriptions without a doctor's orders in the last 30 days.

Figure 15. Percent of Teens (8th Grade) who Used Substances in the Last 30 Days.



Source: 2017 Oregon Healthy Teens Survey and 2016 Washington State Healthy Youth Survey.

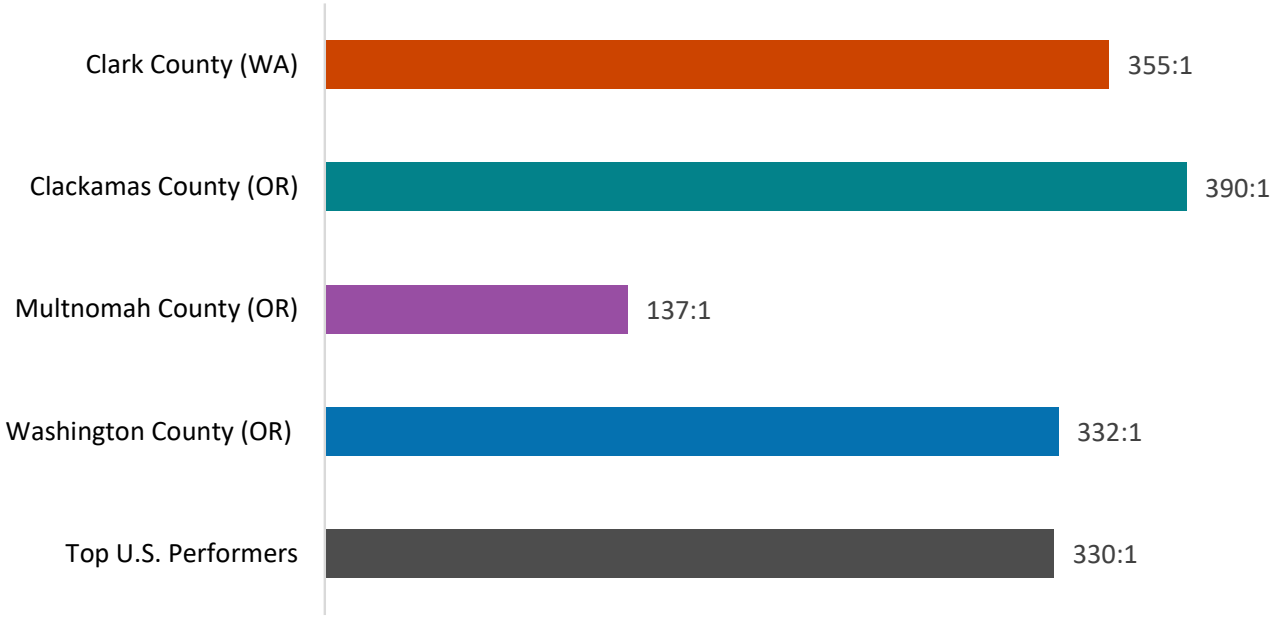
Access to Behavioral Health Care

Peoples' limited access to behavioral health care providers makes this core issue challenging to address. Community members also want culturally relevant behavioral health services and easier access to services even if they do not have health insurance (see Access to Health Care).

The ratio of mental health providers to the population varies substantially, with the highest concentration of providers in Multnomah County, as shown in Figure 16.

Town hall participants highlighted the importance of addressing stigmas associated with mental health treatment and advocating for greater emphasis on preventive care and screening for mental health conditions. Family, community members, and friends were important sources of connection and social support, and participants wanted more access to mental health resources such as greater numbers of providers, school-based interventions, and family-focused programs.

Figure 16. Ratio of Population to Mental Health Providers.



Source: 2017 Oregon Healthy Teens Survey.

The need for culturally and linguistically competent behavioral health services was frequently discussed by both town hall and listening session participants. Listening session participants discussed the lack of mental health providers who look like them or identified with their identities and experiences (see Culturally Responsive Care for more). This disconnect between the providers and participants' experiences made accessing mental health care challenging.

"There aren't a lot of therapists who look like us."
– Listening Session Participant

"We need a Starbucks on every corner, but for mental health."
– Listening Session

Participants also emphasized the importance of ensuring access to mental health services and resources for residents who may not have health insurance.